STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145601	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviston Countryside Manor	450 West 1st Street Aviston, IL 62216

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents were free from verbal and mental abuse from staff for 3 of 5 residents (R2, R4, and R5) review for abuse and neglect in the sample of 10.This failure resulted in harm to R2 and R4 who were observed crying and emotionally distressed at the time of the said incidents, along with R5 who was scared, feeling of being unsecure and wanting to move.The findings include:1.R2's admission Record documents an admission date of 11/23/24 and diagnoses including malignant neoplasm of overlapping [NAME] of left female breast, cerebral infarction, depression, generalized anxiety, unspecified mood disorder, and mild cognitive impairment. R2's Minimum Data Set (MDS) dated [DATE], documents under Section C a Brief Interview for Mental Status (BIMS) score of 5 which indicates severely cognitively impaired. Section B document's ability to hear as adequate.R2's Care Plan documents a focus area of R2 is at risk for abuse/neglect due to residing in a congregate facility with interventions of address all complaints/concerns promptly with grievance and procedures and report any suspected abuse/neglect to administrator immediately.On 01/15/26 at 9:34AM R2 stated that she doesn't remember if anyone has ever yelled at her or told her that her mother has passed. R2 said that if someone did tell her that her mother was dead that it would upset her very much.On 01/15/26 at 10:42AM V7 (Physical Therapy Assistant) stated that she heard that V11 (Licensed Practical Nurse/LPN) was rude to the residents. V7 said that she knows that V15 (Director of Physical Therapy) was the one who has witnessed V11 (LPN) being rude to R2.On 01/15/26 at 12:19PM V15 (Director of Physical Therapy) stated that she witnessed V11 (LPN) being hateful to the residents. V15 said that one day R2 was asking for her mother recently she said that R2 kept asking for her mom and that V11 turned around to R2 and yelled Dead, that is where your mom is at, she is dead. V15 said that R2 got really upset and was crying after V11 said that. V15 said that V11 just isn't nice to all the residents, she is just rude. V15 said that she did not report V11 stating that to R2. V15 said that she did have another time when V11 (LPN) was rude to another resident, and she did report that to V2 (Director of Nursing/DON). V15 said that only thing that happened to V11 when she reported it to V2 was that V2 talked to V11. V15 said that the way that V11 talked to R2 was verbally and mentally abusive. V15 said that when this happened it was on the weekend and there were no managers in the building at the time, so she didn't report the incident to anyone.2.R4's admission Record documents an admission date of 08/01/2021 and diagnoses Alzheimer's disease, unspecified dementia, major depressive disorder, and insomnia.R4's MDS dated [DATE], documents under Section C a BIMS score of 5 which indicates severely cognitively impaired. Section B documents ability to hear as adequate.R4's Care Plan documents a focus area of R4 is at risk for abuse/neglect due to residing in a congregate facility with interventions of address all complaints/concerns promptly with grievances policy and procedure and report any suspected abuse/neglect to administrator immediately.On 01/15/26 at 12:05PM R4 stated that she doesn't remember staff yelling at her, but she said (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few	that she forgets things often and she doesn't know. R4 said that she just doesn't have the best memory. R4 said that someone could have yelled at her and that she might have ignored it she really doesn't remember she doesn't really remember anyone yelling, but she isn't saying that it didn't happen. R4 said that she is just trying to stay out of trouble. R4 said that she does remember one time she wanted to call her son, and they wouldn't let her use the phone to call them. R4 said that it made her so upset and mad.On 01/15/26 at 9:53AM V3 (Registered Nurse/RN) stated that the facility has a newer nurse V11 (LPN) who is verbally mean to the residents. V3 stated that it is most of the residents that V11 talks mean to. V3 said that she has seen V11 be not so nice to R4. V3 said that V11 will yell at R4. V3 said that R4 likes to sleep in and V11 will yell at R4 from the hallway and tell her that she needs to get out of bed. V3 said that R4 will want to stay in bed longer and V11 will tell her that she is getting up. V3 said that she did not report V11 when she was yelling at R4 because it will put a target on your back. V3 said that way V11 was yelling at R4 she would consider it verbal and mental abuse.On 01/15/26 at 10:38AM V4 (Licensed Practical Nurse/LPN) stated that V11 is not very nice to the residents. V4 said that a couple of weekends ago R4 was crying and asking V11 to call her son. V4 said that V11 wouldn't call R4's son so she ended up calling R4's son for her and it helped calm R4 down. V4 said that V11 was sitting at the nurse's station one day and R4 was just sitting by the nurse's station and that V11 was yelling at R4. V4 said that she couldn't remember the content of the yelling, but it was very loud and rude. V4 said that it was upsetting R4.3.R5's admission Record documents an admission date of 04/03/25 with diagnoses of cerebral palsy, paraplegia, vascular dementia, bipolar disorder, major depressive disorder, anxiety disorder, and unspecified intellectual disabilities.R5's MDS dated [DATE] documents under Section C a BIMS score of 11 which indicates moderately impaired cognition. Section B documents ability to hear as adequate.R5's Care Plan does not document a focus area of abuse.On 01/15/25 at 1:57PM R5 state that she did have a day when they got out of bed and made her take a shower. R5 said that V11 told her in a loud voice that she had to get up and take a shower. R5 said that she always takes a bed bath, and she didn't want to get up and take a shower. R5 said that V11 told her that she had to take a shower. R5 said that she has back and spine problems and that she doesn't get up and take showers only bed baths. R5 said that V11 made the staff get her up for the shower. R5 said that she is a mechanical lift, and she had an incident at another facility where she fell out of the mechanical lift sling so now every time, she gets in the mechanical lift it scares her. R5 said that when V11 made her get up to take the shower that she was crying and so upset. R5 said that she is not happy at the facility. R5 said that she doesn't want to be at the facility anymore because they make her do things she doesn't want to do, and they raise their voices at her at times.On 01/15/26 at 10:38AM V4 (LPN) stated that she witnessed V11 (LPN) telling staff that they had to get R5 up out of bed and get her into the shower. V4 said that she couldn't remember the Certified Nurse Assistant that was working that day, but that R5 was saying that she didn't want to get a shower. V4 said that R5 is a mechanical lift and that she came from another facility and they dropped her out of the mechanical lift and now R5 is scared of the mechanical lift. V4 said that V11 was yelling at R5 that she was getting up and taking a real shower not a bed bath. V4 said that staff did get R5 up and she was crying and screaming she was so upset. V4 said that she never reported any of this to V1 (Administrator/ADM) or V2 (DON).On 01/15/26 at 10:50AM V9 (Certified Nurse Assistant/CNA) stated that she gave R5 a shower that usually she gets a bed bath, but V11 told her that R5 needed a shower. V9 said that R5 was refusing to get up out of bed to take a shower, but V11 said that I need to get R5 up and into the shower. V9 said that she doesn't remember if R5 was upset or not.On 01/15/26 at 1:58PM V21 (CNA) stated that on 01/06/26 she was (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	working on her C hall and she could hear R5 yelling out and screaming from B hall. V21 said that was the first time she has ever seen R5 get up out of bed for a shower and V11 was the nurse who made her get up and take a shower. V21 said that R5 was so upset and just yelling out the whole time she was in the shower.On 01/15/26 this surveyor reported allegation of possible abuse to V1 (ADM) on R2, R4, and R5.On 01/15/26 at 2:57PM V2 (DON) stated that she just found out that V15 told V1 (Administrator/ADM) that V11 told R2 that her mom was dead. V2 stated that V15 didn't report anything to her about V11 yelling at R2 or about V11 saying to R2 that her mom was dead. V2 stated that V15 did report to her a while back that she overheard V11 telling another resident who was yelling out to quit yelling that no one needed to hear that. V2 said that she did talk to V11 about the incident, but she hasn't had any more reports about V11 being rude or yelling at any other resident. V2 stated that it is hard to get R5 to take a shower she said that R5 was at another facility and was dropped out of the mechanical lift and that is how she is transported so she is scared to get up out of bed. V2 said that if R5 didn't want to get a shower that V11 should not have made R5 get a shower. V2 said that no staff should yell at any resident. V2 said that no staff should yell at any resident for any reason. V2 said that if a resident such as R4 wanted to use the phone to call her son she should have been allowed to call her son. On 01/15/26 at 3:23PM V1 (ADM) stated that he is currently investigating the allegation of abuse and that he has suspended V11 at this time until the investigation is completed.On 01/16/26 at 9:41AM V11 (LPN) stated that there has been a misinterpretation with R2 that she was asking R2 how old she was and then how old R2's mother would be. V11 said that she never told R2 that her mother was dead. V11 said that she has raised her voice, because R2 is hard of hearing. V11 said that she did have R5 get up out of bed to take a shower, but she never refused. V11 said that R5 was doing her normal yelling when she was in the shower. V11 said that R5 does cry and yell with all care. V11 stated she had been at her medication cart when she told R5 that she needed to take a shower. V11 said that she assists R4 up every day and that she has not yelled at her. V11 said that she feels yelling is being misinterpreted because she is speaking louder for hard of hearing residents. V11 stated she would be across the room helping R4's roommate and she would tell her time to get up and get ready, but she is not yelling at her. V11 stated that she has never told R4 that she could not call her son, she did say that there are times during report that she has told R4 she would come find her to call her son once she had been done with report. V11 said that she has only raised her voice to resident that are hard of hearing not in a yelling or abusive way. V11 stated that yelling or screaming at a resident is considered abuse.The facility policy titled Abuse Prevention Program Facility Procedures (Undated) documents under Establishing a Resident Sensitive Environment: This facility desires to prevent abuse, neglect or misappropriation of property by establishing a resident sensitive and resident secure environment.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility staff failed to identify a situation of staff to resident verbal abuse and report to the Administrator immediately, for 3 of 5 residents (R2, R4, and R5) reviewed for abuse and neglect in the sample of 10. The findings include: 1.R2's admission Record documents an admission date of 11/23/24 and diagnoses including malignant neoplasm of overlapping [NAME] of left female breast, cerebral infarction, depression, generalized anxiety, unspecified mood disorder, and mild cognitive impairment.R2's Minimum Data Set (MDS) dated [DATE], documents under Section C a Brief Interview for Mental Status (BIMS) score of 5 which indicates severely cognitively impaired. Section B document's ability to hear as adequate.R2's Care Plan documents a focus area of R2 is at risk for abuse/neglect due to residing in a congregate facility with interventions of address all complaints/concerns promptly with grievance policy and procedures and report any suspected abuse/neglect to administrator immediately.On 01/15/26 at 9:34AM R2 stated that she doesn't remember if anyone has ever yelled at her or told her that her mother has passed. R2 said that if someone did tell her that her mother was dead that it would upset her very much.On 01/15/26 at 10:42AM V7 (Physical Therapy Assistant) stated that she heard that V11 (Licensed Practical Nurse/LPN) was rude to the residents. V7 said that she knows that V15 (Director of Physical Therapy) was the one who has witnessed V11 (LPN) being rude to R2.On 01/15/26 at 12:19PM V15 (Director of Physical Therapy) stated that she witnessed V11 (LPN) being hateful to the residents. V15 said that one day R2 was asking for her mother recently she said that R2 kept asking for her mom and that V11 turned around to R2 and yelled Dead, that is where your mom is at, she is dead. V15 said that R2 got really upset and was crying after V11 said that. V15 said that V11 just isn't nice to all the residents she is just rude. V15 said that she did not report V11 sating that to R2. V15 said that she did have another time when V11 (LPN) was rude to another resident, and she did report that to V2 (Director of Nursing/DON). V15 said that only thing that happen to V11 when she reported it to V2 was that V2 talked to V11. V15 said that the way that V11 talked to R2 was verbally and mentally abusive. V15 said that when this happen it was on the weekend and there were no managers in the building at the time, so she didn't report the incident to anyone.2.R4's admission Record documents an admission date of 08/01/2021 and diagnoses including Alzheimer's disease, unspecified dementia, major depressive disorder, and insomnia.R4's MDS dated [DATE], documents under Section C a BIMS score of 5 which indicates severely cognitively impaired. Section B documents ability to hear as adequate.R4's Care Plan documents a focus area of R4 is at risk for abuse/neglect due to residing in a congregate facility with interventions of address all complaints/concerns promptly with grievances policy and procedure and report any suspected abuse/neglect to administrator immediately.On 01/15/26 at 12:05PM R4 state that she doesn't remember staff yelling at her, but she said that she forgets things often and she doesn't know. R4 said that she just doesn't have the best memory. R4 said that someone could have yelled at her and that she might have ignored it she really doesn't remember she doesn't really remember anyone yelling, but she isn't saying that it didn't happen. R4 said that she is just trying to stay out of trouble. R4 said that she does remember one time she wanted to call her son, and they wouldn't let her use the phone to call them. R4 said that it made her so upset and mad.On 01/15/26 at 9:53AM V3 (Registered Nurse/RN) stated that the facility has a newer nurse V11 (LPN) who is verbally mean to the residents. V3 stated that it is most of the resident that V11 talks mean to. V3 said that she has seen V11 be not so nice to R4. V3 said that V11 will yell at R4. V3 said that R4 likes to sleep in and V11 will yell at R4 from the hallway and tell her that she needs to get out of bed. V3 said that R4 will want to stay in (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bed longer and V11 will tell her that she is getting up. V3 said that she did not report V11 when she was yelling at R4 because it will put a target on your back. V3 said that way V11 was yelling at R4 she would consider it verbal and mental abuse.On 01/15/26 at 10:38AM V4 (Licensed Practical Nurse/LPN) stated that V11 is not very nice to the residents. V4 said that a couple of weekends ago R4 was crying and asking V11 to call her son. V4 said that V11 wouldn't call R4's son so she ended up calling R4's son for her and it helped calm R4 down. V4 said that V11 was sitting at the nurse's station one day and R4 was just sitting by the nurse's station and that V11 was yelling at R4. V4 said that she couldn't remember the content of the yelling, but it was very loud and rude. V4 said that it was upsetting R4.3.R5's admission Record documents an admission date of 04/03/25 with diagnoses of cerebral palsy, paraplegia, vascular dementia, bipolar disorder, major depressive disorder, anxiety disorder, and unspecified intellectual disabilities.R5's MDS dated [DATE] documents under Section C a BIMS score of 11 which indicates moderately impaired cognition. Section B documents ability to hear as adequate.R5's Care Plan does not document a focus area of abuse.On 01/15/25 at 1:57PM R5 state that she did have a day when they got her out of bed and made her take a shower. R5 said that V11 told her in a loud voice that she had to get up and take a shower. R5 said that she always takes a bed bath, and she didn't want to get up and take a shower. R5 said that V11 told her that she had to take a shower. R5 said that she has back and spine problems and that she doesn't get up and take showers only bed baths. R5 said that V11 made the staff get her up for the shower. R5 said that she is a mechanical lift, and she had an incident at another facility where she fell out of the mechanical lift sling so now every time, she gets in the mechanical lift it scares her. R5 said that when V11 made her get up to take the shower that she was crying and so upset. R5 said that she is not happy at the facility. R5 said that she doesn't want to be at the facility anymore because they make her do things she doesn't want to do, and they raise their voices at her at times.On 01/15/26 at 10:38AM V4 (LPN) stated that she witnessed V11 (LPN) telling staff that they had to get R5 up out of bed and get her into the shower. V4 said that she couldn't remember the Certified Nurse Assistant that was working that day, but that R5 was saying that she didn't want to get a shower. V4 said that R5 is a mechanical lift and that she came from another facility, and they dropped her out of the mechanical lift and now R5 is scared of the mechanical lift. V4 said that V11 was yelling at R5 that she was getting up and taking a real shower not a bed bath. V4 said that staff did get R5 up and she was crying and screaming she was so upset. V4 said that she never reported any of this to V1 (Administrator/ADM) or V2 (DON).On 01/15/26 at 10:50AM V9 (Certified Nurse Assistant/CNA) stated that she gave R5 a shower that usually she gets a bed bath, but V11 told her that R5 needed a shower. V9 said that R5 was refusing to get up out of bed to take a shower, but V11 said that I need to get R5 up and into the shower. V9 said that she doesn't remember if R5 was upset or not.On 01/15/26 at 1:58PM V21 (CNA) stated that on 01/06/26 she was working on her C hall, and she could hear R5 yelling out and screaming from B hall. V21 said that was the first time she has ever seen R5 get up out of bed for a shower and V11 was the nurse who made her get up and take a shower. V21 said that R5 was so upset and just yelling out the whole time she was in the shower.On 01/15/26 this surveyor reported allegation of possible abuse to V1 (ADM) on R2, R4, and R5.On 01/15/26 at 2:57PM V2 (DON) stated that she just found out that V15 told V1 (Administrator/ADM) that V11 told R2 that her mom was dead. V2 stated that V15 didn't report anything to her about V11 yelling at R2 or about V11 saying to R2 that her mom was dead. V2 stated that V15 did report to her a while back that she overheard V11 telling another resident who was yelling out to quit yelling that no one needed to hear that. V2 said that she did talk to V11 about the incident, but she hasn't had any more reports about V11 being rude or yelling at any (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	other resident. V2 stated that it is hard to get R5 to take a shower she said that R5 was at another facility and was dropped out of the mechanical lift and that is how she is transported so she is scared to get up out of bed. V2 said that if R5 didn't want to get a shower that V11 should not have made R5 get a shower. V2 said that no staff should yell at any resident. V2 said that no staff should yell at any resident for any reason. V2 said that if a resident such as R4 wanted to use the phone to call her son she should have been allowed to call her son.On 01/15/26 at 3:23PM V1 (ADM) stated that he is currently investigating the allegation of abuse and that he has suspended V11 at this time until the investigation is completed.On 01/16/26 at 9:41AM V11 (LPN) stated that there has been a misinterpretation with R2 that she was asking R2 how old she was and then how old R2's mother would be. V11 said that she never told R2 that her mother was dead. V11 said that she has raised her voice, because R2 is hard of hearing. V11 said that she did have R5 get up out of bed to take a shower, but she never refused. V11 said that R5 was doing her normal yelling when she was in the shower. V11 said that R5 does cry and yell with all care. V11 stated she had been at her medication cart when she told R5 that she needed to take a shower. V11 said that she assists R4 up every day and that she has not yelled at her. V11 said that she feels yelling is being misinterpreted because she is speaking louder for hard of hearing residents. V11 stated she would be across the room helping R4's roommate and she would tell her time to get up and get ready, but she is not yelling at her. V11 stated that she has never told R4 that she could not call her son, she did say that there are times during report that she has told R4 she would come find her to call her son once she had been done with report. V11 said that she has only raised her voice to resident that are hard of hearing not in a yelling or abusive way. V11 stated that yelling or screaming at a resident is considered abuse.The facility policy titled Abuse Prevention Program Facility Procedures (Undated) documents under Internal Reporting Requirements and Identification of Allegations: Employees are required to report immediately any incident, allegation or suspicion of potential abuse, neglect, or misappropriation of property they observe, hear about, or suspect to the administrator. Serious bodily injury- 2-hour limit if the events that cause the reasonable suspicion result in serious bodily injury to a resident, the covered individual shall report the suspicion immediately, but not later than 2 hours after forming the suspicion. All others withing 24 hours if the event that cause the reasonable suspicion do not result in serious bodily injury to a resident, the covered individual shall report the suspicion immediately but not later than 24 hours after forming the suspicion. Employees shall immediately inform the administrator of all reports of incidents, allegations or suspicion of potential abuse, neglect or misappropriation of property. Upon learning of the report, the Administrator shall initiate an incident investigation.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint investigation: 25812914/2705654 and 25412177/26911261 Based on interview and record review, the facility failed to provide an environment free of accident hazards for 2 (R1, R3) of 3 residents reviewed for accidents in the sample of 10. The findings include:1.R3's admission Record documented an admission date of 4/3/2025 and diagnoses including unspecified dementia, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, bipolar disorder, current episode manic severe with psychotic features, schizoaffective disorder, bipolar type, other schizophrenia, unspecified asthma, uncomplicated, cerebral infarction, unspecified, other seizures, unspecified. R3's Minimum Data Set (MDS) dated [DATE], documented under section C- (cognitive patterns) C0100, No (resident is rarely/never understood) a BIMS (Brief Interview for Mental Status) not completed, indicating R3 was severely impaired cognition. This same document under section GG- Mobility documented that R3 is partial/moderate assistance, which means helper does less than half the effort. Helper lifts or holds trunk or limbs and provides less than half the effort for wheel 150 feet: once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space. R3's Care plan documented a focus area of R3 having a risk for falls/injuries related to weakness, dementia, and poor safety awareness with an intervention of use proper assistive device (wheelchair/walker) as needed and cue/redirect as needed. This same document had a focus area documented R3 having cognitive loss as evidenced by BIMS Score less than 13, dementia diagnosis with an intervention of allow resident time to process thoughts. Do not rush resident or show impatience when they are making a decision and use a slow/unhurried manner with all care. On 1/15/2026 at 10:48 AM V8 (Physical Therapy Assistant/PTA) stated, R3 is receiving therapy services at this time related to previous falls. V8 stated, she is not aware of the fall events or investigation details for R3. V8 stated, any staff member assisting a resident by pushing them in a wheelchair, then the resident should have foot pedals in place. V8 stated, foot pedals can be adjusted to the side of the wheelchair when promoting self-propelling. On 1/15/2026 at 11:44 AM V10 (Certified Nurse Assistant/CNA) stated, on 11/28/2025 R3 had been self-propelling down the A hallway when she went to help her return to the nurse's station. V10 stated, R3 is known to go down that hallway to try to get in beds and she had been asked to go push her back to the nurse's station. V10 stated, she started to push R3 in her wheelchair back towards the nurse's station when one of R1's foot had got caught in the wheel of the chair causing her to fall forward out of the wheelchair, hitting her head on the floor and reopening the laceration to her forehead. V10 stated, R3 did not have any foot pedals on her wheelchair at the time she had been pushing her down the hall. On 1/15/2026 at 2:35 PM V2 (DON) stated, R3 had fallen from her wheelchair in the hallway on 11/28/2025 while being pushed in her wheelchair by V10 (CNA). V2 stated, R3 had put her feet on the ground while V10 had been pushing her causing R3 to fall out of her wheelchair. On 1/16/2026 at 9:54 AM V11(LPN) stated, she had been notified on 11/28/2025 while in the dining room that R3 had fallen from her wheelchair. V11 stated, R3 had been on A Hall when V10 (CNA) attempted to push her wheelchair back down the hallway. V11 stated, R3 is known to go down A Hall to try to get in another resident's bed. V11 stated, when V10 had been pushing R3 down the hallway, R3 put her feet down to stop V10 from going forward and R3 caught her foot in the wheelchair which caused her to fall forward out of the wheelchair and hitting the left side of her head on the floor. V11 stated, R3 did not have any feet pedals on her wheelchair at the time she had been assisted down the hallway by V10. V11 stated, staff should check feet position prior to pushing a resident in a wheelchair.R3's Progress Note dated 11/28/2025 at 12:15 PM by V11 (LPN) documented V10 (CNA) came to get her because R3 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145601	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviston Countryside Manor	450 West 1st Street Aviston, IL 62216

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had been on the floor bleeding from her forehead and arm. V10 informed her that she had been pushing R3 to her room when R3's foot got stuck under the wheel causing R3 to fall forward. V10 stated that she attempted to catch R3, but it was too late. R3 reopened previous gash on left side of forehead 2cm by 1.5cm then got a skin tar on right elbow.The facility event report dated 11/28/2025 documented R3 got her foot caught in the front wheel while being pushed to hallway with R3 falling forward.On 1/16/2026 at 11:52 AM V15 (Director of Rehab) stated, R3 does require maximum verbal and tactile cues. V15 stated, she can become confused at times and her comprehension is very low.R3's Physical Therapy Evaluation & Plan of Treatment dated 1/4/2026 documented under Initial Assessment/Current Level of Function & Underlying Impairments, Functional Mobility Assessment: Resident uses a wheelchair and/or scooter? = Yes, Wheel 50 feet with two turns = Substantial/maximal assistance, Type of wheelchair or scooter used? = Manual, Wheel 150 feet = Substantial/maximal assistance Type of wheelchair or scooter used? = Manual. The facility policy Wheelchair Use, Safety and Position Policy (undated) documented under Policy Statement-The facility is committed to ensuring that all residents who use wheelchairs do so safely, comfortable, and in a manner that promotes independence, dignity and quality of life. Wheelchairs will be properly assessed, fitted, maintain, and used in accordance with resident-centered care principles and applicable regulations. This same document under Safe Use & Supervision documented staff will ensure proper foot placement on footrests, brakes are engaged during transfers, resident positioning is checked routinely, residents are not left in wheelchairs for prolong periods without repositioning and residents will be encouraged to mobilize and reposition independently when able. 2.R1's admission Record documented an admission date of 8/28/2025 and diagnoses including Cerebral infarction, unspecified-L frontal, chronic obstructive pulmonary disease, unspecified, acute bronchitis, unspecified, acute upper respiratory infection, unspecified, unspecified asthma, uncomplicated, essential (primary) hypertension, other seizures, major depressive disorder, single episode, unspecified, generalized anxiety disorder, primary osteoarthritis, left shoulder. R1's Minimum Data Set (MDS) dated [DATE], documented under section C- (cognitive patterns) a BIMS (Brief Interview for Mental Status) 14, indicating R1 was cognitively intact. This same document under section GG- Mobility documented that R1 required partial/moderate assistance, which means helper does less than half the effort. Helper lifts or holds trunk or limbs and provides less than half the effort. R1's Care Plan documented a focus area of R1 requires assistance with ADLs (Activity of Daily Living) related to weakness with an intervention follow occupational therapy, physical therapy, and speech therapy recommendations. This same document had a focus area of risk for falls and injuries related to weakness, need for assistance with ADLs with an intervention to observe for safety. On 1/15/2026 at 11:02 AM, V4 (LPN) stated, when she arrived to work on 12/15/2025, R1 had complaints of pain to her left shoulder area, with bruising noted and limited movement. V4 stated, R1 did tell her at that time she had fallen the week prior but was not sure if she had been on the toilet or ambulating towards the toilet.On 1/15/2026 at 11:44 AM V10 (CNA) stated, on 12/11/2025 in the evening R1 had put on her call light for assistance to the toilet. V10 stated, she did help R1 ambulate with walker to the bathroom. V10 stated, R1 had gotten off balance, which she does at times, so she grabbed R1's shirt and pants on her left side to help guide her to the floor. V10 stated, R1 had been sitting in the floor with her back against the bathroom door. V10 stated, her and V12 assisted R1 off the floor to the toilet and then back to her chair after using the bathroom.On 1/15/2026 at 1:52 PM V12 (CNA) stated, she did work the evening that R1 did have a fall event. V12 stated, she had been in another room when V10 (CNA) came to her and ask for assistant to get R1 up from the floor. V12 stated, R1 had been sitting in the floor in the bathroom with her back towards the door. V12 stated, she does not (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recall if R1 had a gait belt on during that time. V12 stated, she and V10 assisted R1 to the toilet and then back to her recliner.On 1/16/2026 at 9:03 AM V10 (CNA) stated, she did not use a gait belt during R1's transfer from her recliner to standing or while assisting her to ambulate to the toilet on 12/11/2025. On 1/16/2026 at 9:06 AM V8 (PTA) stated, she did have direct care with R1 in therapy services. V8 stated, R1 required partial/moderate assistant with self-care and mobility. V8 stated R1 had episodes of being unbalanced and falling backwards when ambulating. V8 stated, it is standard of practice for a gait belt to be used for all transfers and assistance with ambulating.R1's Progress Note dated 12/17/2025 at 9:26 AM by V4 (LPN) documented primary physician notified with new order for imaging to left shoulder. Resident is having uncontrolled pain and very little movement. New order urinalysis to rule out urinary tract infection. R1 is having some confusion. R1's Patient Report dated 12/17/2025 documented under Procedure: Left Shoulder, complete 2+ Views. This same documentation has documented by V18 (Nurse Practitioner) Left shoulder separation-please refer to ortho. May be old injury. Please apply a sling to left arm in the meantime. Arthritis also noted. On 1/16/2026 at 9:17 AM V2 (DON) stated, it is facility policy that a gait belt be in place during a transfer or assisting a resident with ambulating and her expectations would be that all staff follow this policy. On 1/16/2026 at 9:21 AM V1 (Administrator) stated, his expectations are staff to follow the facility policy and procedure for transferring/ambulating assistance with a resident, that included use of a gait belt, and all steps on the facility fall policy and procedure.On 1/16/2026 10:31 AM R1 stated, she did not have a gait belt on during her fall event while transferring or ambulating with assists of V10 (CNA) on 12/11/2025.The facility Gait Belt Use policy and procedure (dated July 2014) documented under Policy: It is the policy of the facility name that gait belts will be used when staff are transferring weight bearing residents or assisting them with walking for the safety of the resident or the employee.The facility Fall Management policy dated (April 21, 2022) documented under Definition: The definition of a fall refers to unintentionally coming to rest on the ground, floor or other lower level, but not as a result of an overwhelming external force (e.g., resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for staff intervention, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is observed on the floor, a fall is considered to have occurred.