STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145708	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Health	2304 C R 3000 N Gifford, IL 61847

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. Based on observation, interview, and record review, the facility failed to ensure residents were free from abuse for two (R4 and R6) of three residents reviewed for resident-to-resident physical contact on a sample list of three residents. The facility failed to assess, care plan, and implement effective interventions following repeated altercations. This failure resulted in a physical injury (skin tear) to R6, with actual harm.Findings include:Review of the facility's Abuse Policy, revised 01/29/2026, documented that all residents have the right to be free from verbal, sexual, physical, and mental abuse. The policy further required that appropriate interventions be implemented and included in the resident's care plan, updated with changes in condition, and communicated to direct care staff.R4's Review of the Electronic Health Record (EHR) revealed R4 had diagnoses including Frontotemporal Neurocognitive Disorder, Dementia with Agitation, Mood Disorder, and anxiety disorder.R4's care plan, initiated 01/20/2026, identified behaviors including agitation, hallucinations, exit-seeking, and entering other residents' rooms. Interventions included monitoring behaviors and administering psychotropic medications; however, the care plan lacked specific, individualized interventions to prevent resident-to-resident altercations.Record review revealed a pattern of ongoing aggressive and intrusive behaviors:On 02/01/2026, R4 hit another resident in the dining room.On 03/26/2026, R4 raised a fork toward staff in a stabbing motion.On 04/20/2026, R4 made verbal threats toward staff.On 04/12/2026 at 12:25 PM, R4 was observed swatting at R6 in the hallway. Documentation indicated both residents were actively striking one another. R6 sustained a skin tear three centimeters by one centimeter by five centimeters to the right wrist.Review of the record failed to show the facility implemented effective or consistent interventions following prior incidents to prevent recurrence, such as increased supervision, environmental modifications, or individualized behavioral strategies.On 04/20/2026 at 9:05 AM, R4 was moving rapidly throughout the hallways in a wheelchair and reaching toward others, indicating ongoing intrusive behaviors without staff intervention.On 04/21/2026 at 10:44AM, V10 (R4's) Power of Attorney (POA) revealed a history of behavioral issues requiring additional support and services.On 04/21/2026 at 1:00PM, V11 Clinical Director of Operations confirmed the facility does not provide behavioral services and relies on hospital transfers when behaviors escalate.R6 had diagnoses including Dementia, Severe Protein-Calorie Malnutrition, Adult Failure to Thrive, Anxiety Disorder, Major Depressive Disorder, Repeated Falls, and multiple chronic medical conditions. The care plan identified behaviors including agitation, yelling, resistiveness to care, and potential for making false allegations. Interventions included monitoring behaviors, identifying triggers, and providing redirection.On 02/01/2026, documentation indicated R6 was involved in an altercation with R6 in which both residents engaged in physical contact. R6 sustained a skin tear to the right wrist.Record review failed to show evidence of an abuse-specific assessment or a comprehensive post-incident skin/body assessment following the altercation. There was no documented evidence the facility completed a full assessment to identify the extent of injury or potential additional injuries. Further review revealed the facility failed to revise the care plan to address the risk of continued resident-to-resident altercations or implement individualized interventions following the incident.Record review identified repeated altercations (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	between R4 and R6 from 02/01/2026 through 03/14/2026, indicating an ongoing and unaddressed risk.On 04/21/2026 at 11:00 AM, R6 was observed sitting alone at a dining table.On 04/21/2026 at 11:05 AM, V2 Certified Nursing Assistant stated R4 sits alone due to behaviors of belittling other residents and calling them names, and that behaviors are reported to nursing; however, no evidence was provided that effective interventions were implemented to prevent further altercations.On 04/21/2026 at 12:05 PM, V6 Licensed Practical Nurse stated that allegations of abuse are reported to administration and indicated the behaviors were related to resident diagnoses, suggesting normalization of aggressive behaviors rather than implementation of preventative measures.The facility failed to:Implement its own Abuse Policy requiring interventions and care plan updatesIdentify and address a pattern of aggressive behaviorsProvide adequate supervision and preventative interventionsConduct and document a thorough post-incident assessmentRevise care plans following known altercations These failures resulted in repeated resident-to-resident altercations, including the incident on 02/01/2026, which caused actual harm (skin tear) to R6. The facility's failure to intervene after the initial incident allowed the risk of continued harm to persist.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and staff interviews, the facility failed to ensure physician-ordered direction and care planning for an indwelling urinary catheter and failed to maintain an accurate and updated care plan reflecting the resident's current clinical condition and skin integrity needs. This deficient practice affected one resident (R1) of three residents on sampled list reviewed.Findings Include: R1 was admitted to the facility on [DATE]. R1's diagnoses include Malignant Neoplasm of the Colon, Malignant Neoplasm of the Breast, Chronic Diastolic Heart Failure, Hypertension, Type 2 Diabetes Mellitus, Coronary Artery Disease, Acute Kidney Failure, Neuromuscular Dysfunction of the Bladder, Generalized Weakness, Muscle Wasting and Atrophy, and is receiving hospice/palliative care services. The admission assessment documented an indwelling urinary catheter (16 French) that was patent; however, the electronic health record and staff interviews revealed there was no physician order for catheter placement, maintenance, or indication for ongoing use, and no corresponding care plan interventions addressing catheter management or monitoring.The resident also presented with multiple skin integrity issues on admission, including a surgical wound to the right breast mastectomy site, moisture-associated skin damage to the buttocks measuring 10 cm (centimeters) by 12 cm, and moisture-associated skin damage to the labia, in addition to other areas of skin concern. Although the care plan identified the resident is at risk for impaired skin integrity related to diabetes and muscle wasting, it was not updated to reflect current wound status or a suspected in-house acquired pressure injury to the left thigh.On 4/20/2026 at 8:45AM, R1 was observed lying in R1's bed reading a book. R1, who is cognitively intact stated that R1 had a catheter when being admitted to the facility and every time a Certified Nursing Assistants would reposition R1 the plastic part on the catheter would have pressure on it and it would hurt. R1 stated R1 told many Certified Nursing Assistants that it was hurting, but nobody looked at the catheter tubing to see what was hurting. R1 stated that when V8 Registered Nurse/Wound Nurse looked on 4/9/26, there was an open wound underneath the catheter tubing. R1 stated V8 Registered Nurse/Wound Nurse cleaned the wound which made it feel better and less painful, but R1 was going to see the wound doctor during their rounds. R1 stated nobody had changed the catheter since being admitted into the facility, but the Certified Nursing Assistants have emptied out the catheter bag daily. On 04/20/2026 at 12:40 PM, V6 Registered Nurse stated that R1 had a catheter since admission and confirmed there were no physician orders for catheter use and no care plan interventions related to the catheter.On 04/20/2026 at 12:46 PM, V7 Licensed Practical Nurse confirmed the resident had a catheter but was unable to determine when it was placed and further confirmed there were no physician orders or care plan interventions in the electronic medical record addressing catheter care.On 04/20/2026 at 12:50 PM, V8 Registered Nurse/Wound Nurse stated V8 had not been informed of the left thigh wound until 4/9/26 and identified it as a potential pressure injury acquired in-house and confirmed the resident's care plan had not been updated to reflect current skin conditions or interventions. V8 further confirmed that updates were needed to ensure the care plan reflected current physician orders and wound management needs.The facility failed to ensure coordination of care, timely care plan updates, and implementation of physician-ordered interventions for a resident with complex medical conditions and active skin integrity issues, resulting in noncompliance.

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F 0742 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. Based on observation, interview, and record review, the facility failed to ensure appropriate behavioral health services were provided for two (R4 and R6) of three residents reviewed for behavioral concerns, when the facility failed to implement effective behavioral health interventions, failed to provide coordinated behavioral health services, and failed to ensure adequate assessment and communication regarding psychotropic medication management. These failures resulted in continued unsafe behaviors and a resident-to-resident physical altercation that caused actual harm (skin tear) to R6.Findings Include:Facility has no Policy on Behavioral ServicesReview of the Electronic Health Record (EHR) revealed R4 had diagnoses including Frontotemporal Neurocognitive Disorder, Dementia with Agitation, Mood Disorder, and Anxiety Disorder.R6's EHR revealed R6 had diagnoses including Dementia, Anxiety Disorder, Major Depressive Disorder, and multiple chronic medical conditions affecting overall health status.Both residents had documented behavioral concerns requiring monitoring and intervention.R4's care plan, initiated 01/20/2026, identified behaviors including agitation, hallucinations, exit-seeking, and intrusive behaviors toward other residents. Interventions included monitoring behaviors and administering psychotropic medications; however, the care plan did not include an effective, individualized behavioral health treatment plan or structured behavioral health services.Record review revealed a pattern of escalating behaviors:On 02/01/2026, R4 hit another resident in the dining room.On 03/26/2026, R4 displayed aggressive behavior toward staff.On 04/20/2026, R4 made verbal threats toward staff.On 04/12/2026, R4 engaged in a physical altercation with R6.On 04/12/2026 at 12:25 PM, R4 was observed swatting at R6 in the hallway, with both residents actively striking one another. R6 sustained a skin tear to the right wrist, resulting in actual harm.Record review indicated R4 was undergoing a gradual dose reduction (GDR) of psychotropic medications. Interview with the V10 (R4's) Power of Attorney (POA) revealed V10 did not understand why medications were being reduced and stated the facility told V10 it was due to state law, without further clinical explanation or education. There was no evidence that the facility provided adequate education or individualized clinical justification to V10 POA regarding medication changes in relation to behavioral symptoms.R6 had documented behaviors including agitation, yelling, resistiveness to care, and emotional instability. The care plan included general interventions such as monitoring behaviors, identifying triggers, and redirection.However, record review failed to show evidence of effective behavioral health services, such as psychiatric consultation follow-up, structured behavioral intervention planning, or individualized behavioral support beyond routine care measures.There was no evidence that R6 received behavioral health services to address risk factors related to repeated exposure to aggressive residents or to reduce vulnerability in shared environments.On 04/21/2026 at 1:00PM, V11 Clinical Director of Operations confirmed the facility does not provide behavioral health services on-site and relies on hospital transfers when behaviors escalate. No evidence was provided of ongoing behavioral health specialist involvement, behavioral programming, or structured interdisciplinary behavioral care planning.On 04/20/2026 at 9:05 AM, R4 was moving rapidly through hallways in a wheelchair and reaching toward others, demonstrating ongoing behavioral instability without effective intervention.The facility failed to:Provide or coordinate behavioral health services for residents with known behavioral symptoms.Develop and implement effective, individualized behavioral intervention plans.Ensure ongoing behavioral assessment and monitoring for both residents.Provide appropriate education and clinical justification to the POA regarding psychotropic medication reductions.Implement protective behavioral strategies to prevent resident-to-resident altercations.The lack of behavioral health services, ineffective behavioral interventions, and inadequate psychotropic medication management resulted in continued unsafe behaviors by R4 and increased vulnerability for R6. These failures contributed to a (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	resident-to-resident physical altercation that caused actual harm (skin tear) to R6 and placed other residents at risk for harm.