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	05/26/2026

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 - Minimal harm or potential for 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 the resident's right to be free from verbal abuse for one (R9) resident by another resident (R6) out of five residents reviewed for Abuse in a sample list of nine residents.Findings include:R9's Electronic Medical Record (EMR) documents medical diagnoses of Spinal Stenosis, Chronic Obstructive Pulmonary Disease (COPD), Unsteadiness on Feet, Dementia, Scoliosis, Abnormalities of Gait and Mobility, Muscle Weakness, and Abnormal Posture.R9's Minimum Data Set (MDS), dated [DATE], documents R9 as moderately cognitively impaired. This same MDS documents R9 as dependent on staff for wheelchair mobility and requiring maximum assistance for transfers.R6's Electronic Medical Record (EMR) documents medical diagnoses of Dementia, Anxiety Disorder, Atrial Fibrillation, and Heart Failure.R6's Minimum Data Set (MDS), dated [DATE], documents R6 as moderately cognitively impaired.R6's Nurse Progress Note, dated 5/17/26 at 2:34 PM, documents that R6 was verbally aggressive toward R9. This same note documents that V32, Licensed Practical Nurse (LPN), instructed R6 not to use inappropriate language toward R9. The note further documents that R9 was moved to allow R6 to pass by, as R6 continued to make inappropriate comments toward R9.On 5/24/26 at 12:45 PM, V32, Licensed Practical Nurse (LPN), stated that on 5/17/26 at 7:00 AM, she was passing medications in the hallway. V32 LPN stated that R9 was sitting in his wheelchair in the middle of the hallway when R6 attempted to pass through. V32 LPN stated that R6 began yelling and cursing at R9, stating, Move your fat a** (expletive), Get the hell out of my way, stupid, and You are so dumb you don't know what to do. V32 LPN stated that R9 began moving out of R6's way so R6 could pass through, and R6 again stated to R9, You are so lazy and stupid. V32 stated that R6 had made multiple similar comments to other residents and that it was time someone documented it so that something can be done. V32 LPN stated that R6 was verbally abusive toward R9 on 5/17/26.On 5/24/26 at 2:30 PM, R9 and V33 (R9's family member) were present in R9's room. R9 was sitting in a wheelchair. V33 stated that V2, Director of Nursing (DON), had just informed her and R9 of R6 yelling at (R9). V33 stated, Of course we do not want anyone yelling at (R9), but I don't think (R9) would be distraught by it either. V33 stated that R9 has Dementia and has declined over the past two years, so R9 probably didn't know what was going on. V33 further stated that R9 would not have liked being yelled at but would not have responded to it either.On 5/26/26 at 11:30 AM, V1 Administrator stated that V32 LPN should have notified her immediately of the incident between R6 and R9. V1 Administrator confirmed that R6's use of derogatory language and insults toward R9 constituted verbal abuse.The facility policy titled Resident Care Policy and Procedure Regarding Abuse and Neglect, Involuntary Seclusion, Exploitation, Misappropriation of Resident Property, Injuries of Unknown Origin, and Social Media, revised January 29, 2026, states that all residents have the right to be free from verbal, sexual, physical, and mental abuse; corporal punishment; involuntary seclusion; neglect; misappropriation of property; and exploitation. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish. Abuse includes the deprivation by an individual, including a caregiver, of goods or services necessary to attain or (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	maintain physical, mental, or psychosocial well-being. Instances of abuse, regardless of a resident's mental or physical condition, can result in physical harm, pain, or mental anguish. Abuse may be verbal, sexual, physical, or mental, including abuse facilitated or enabled through the use of technology or social media. Verbal abuse is defined as the use by an employee or agent of oral, written, or gestured language that includes disparaging or derogatory terms directed toward a resident, or used within the resident's hearing or sight, regardless of the resident's age, ability to comprehend, or disability.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review the facility failed to report an allegation of physical abuse from a staff member to one (R8) resident to the State Agency and failed to report an allegation of resident (R6) to resident (R9) verbal abuse to the Abuse Coordinator out of five residents reviewed for Abuse in a sample list of nine residents. Findings include:1. R8's initial report to the State Agency dated 5/24/26 documents on 5/12/26 V26 Certified Nurse Aide (CNA) grabbed R8's wrist ?somewhat forcefully' causing a bruise. The facility is not able to provide documentation this incident was reported to the State Agency prior to 5/24/26. The facility daily staffing sheets dated 5/12/26 documents V26 CNA was assigned to R8 to provide cares. The facility staffing sheets did not show that V26 CNA worked any shift after 5/12/26. On 5/23/26 at 9:22 AM R8 stated V2 Director of Nurses (DON) asked me about my bruise the day after it happened. R8 stated V26 CNA had a ?bear grip' on my wrist. R8 stated she did not think V26 CNA meant to hurt R8 but was ?very rough' with R8. On 5/23/26 at 10:00 AM V2 Director of Nurses (DON) stated unknown staff told him that R8 had a bruise so he did speak with R8 on 5/13/26. V2 DON stated the incident occurred on 5/12/26 when an agency CNA (V26) improperly transferred R8 from her toilet to her wheelchair causing a bruise on R8's Right Forearm. V2 stated he did not report the bruise caused by V26 CNA and should have. V2 DON stated any time a staff member causes a bruise, that incident should be fully investigated and reported to the State Agency. On 5/24/26 at 8:30 AM V1 Administrator stated R8's bruise should have been reported as an allegation of physical abuse. V1 stated the incident should have been initially reported to the State Agency, then V26 CNA should have been removed from resident areas and suspended pending an investigation. V1 stated a full investigation should have been completed and then a Final report to the State Agency should have been completed with the findings. V1 Administrator stated she was not aware of this incident until 5/24/26. 2. R6 and R9's combined initial report to the State Agency dated 5/24/26 documents R6 was verbally aggressive to R9 on 5/17/26.The facility is not able to provide documentation this incident was reported to the State Agency prior to 5/24/26. On 5/24/26 at 12:50 PM V32 Licensed Practical Nurse (LPN) stated she witnessed R6 verbally abuse R9 on 5/17/26 at 7:00 AM but did not report it. V32 LPN stated she did write a nurse progress note about R6's behavior and thought management reviewed the progress notes and would see it. V32 LPN stated she should have reported R6's verbal abuse towards R9 directly to V1 Administrator right when it happened.On 5/24/26 at 2:05 PM V1 Administrator stated V32 LPN should have reported the incident between R6 and R9 on 5/17/26 immediately to V1 Abuse Coordinator or her Designee, V2 Director of Nurses (DON). V1 Administrator stated a resident does not have to use profanity to verbally abuse another resident. V1 stated she would expect staff to make a direct phone call to V1 and/or V2 to report an allegation of abuse instead of only making a progress note. V1 Administrator stated she was not aware of this incident until 5/24/26.The facility policy titled Resident Care Policy and Procedure regarding abuse and neglect, involuntary seclusion, exploitation, misappropriate of resident property, injuries of unknown origin and social media revised January 29, 2026. All residents have the right to be free of from verbal, sexual, physical, mental abuse, corporal punishment, involuntary seclusion, neglect, misappropriation of property, exploitation. If the incident involves alleged abuse, neglect, or incident of unknown origin, the incident will immediately be reported to the Administrator and the Administrator shall provide the Illinois Department of Public Health with initial notice of the alleged abuse, neglect, or incident of unknown origin via the OHCR Portal or by emailing or telefaxing to the Department a copy of a report of the incident completed immediately after the incident becomes known.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on interview and record review the facility failed to complete a thorough investigations for allegations of abuse for three (R5, R6, R8) residents out of five residents reviewed for Abuse in a sample list of nine residents.Findings include:1. R5 and R6's Final Report to the State Agency dated 4/14/26 documents R5 and R6 were involved in a physical altercation on 4/12/26. This same report and facility investigation file does not include any statements from other cognitively intact residents or any staff member with the exception of V8 CNA who witnessed a portion of the incident. On 5/23/26 at 11:40 AM V6 LPN stated she did not witness the incident between R5 and R6. V6 LPN stated V8 CNA was the one who reported this to V6 and as far as V6 knew, V8 CNA was the only person who actually witnessed anything. V6 LPN stated no one ever asked her what happened or asked her to complete a witness statement. V6 LPN stated she thought that was because she did not witness anything. V6 LPN stated she did document this incident in the progress notes so that if anyone had questions, they could refer to the note.On 5/24/26 at 8:35 AM V1 Administrator stated she only interviewed V8 Certified Nurse Aide (CNA). V1 stated she did not interview any residents other than R5 and R6 and/or staff regarding the R5 to R6 incident which occurred on 4/12/26. V1 Administrator stated a full investigation should have been completed due to R5 did have a history of behaviors with staff and other residents. V1 stated V8 CNA reported the R5 to R6 altercation to V6 LPN.On 5/24/26 at 8:55 AM V8 CNA stated she was exiting the public restroom on the South Hall when she saw R5 and R6 hitting each other at the opposite end of the hall. V8 stated she ran towards both R5 and R6 and separated the two residents. V8 stated she then called for V6 LPN who also then came to assist. V8 stated V6 could not have seen anything due to her location on another hall (between the long hall and the pod on south). V8 stated this happened about 12:15-12:30 right after lunch. V8 CNA stated R5 and R6 had already started fighting when they entered the hallway. V8 CNA stated other staff or residents may have seen R5 and/or R6 shortly before that since the residents were finishing their lunch time and there is supposed to be a staff member present for all meals. 2. R8's Initial report to the State Agency dated 5/24/26 documents V26 Certified Nurse Aide (CNA) ?somewhat forcefully' grabbed R8's wrist on 5/12/26.On 5/23/26 at 9:22 AM R8 stated a staff member (V26) Agency Certified Nurse Aide (CNA) was assisting her from the toilet back to her wheelchair. R8 stated V26 held onto her wrist with a ?bear grip'. R8 stated ?it really hurt' and left a bruise for days. On 5/23/26 at 9:30 AM V1 stated she did not know anything about R8's bruise caused by V26 CNA. On 5/23/26 at 10:00 AM V2 Director of Nurses (DON) stated unknown staff told him that R8 had a bruise, so he did speak with R8 on 5/13/26. V2 DON stated the incident occurred on 5/12/26 when an agency CNA (V26). V2 DON stated he did not speak with V26 CNA, any of the other staff or other cognitively intact residents. V2 DON stated any time a staff member causes a bruise, that incident should be fully investigated and reported to the State AgencyOn 5/24/26 at 8:30 AM V1 Administrator stated R8's bruise should have been reported as an allegation of physical abuse. V1 stated the incident should have been initially reported to the State Agency, then V26 CNA should have been removed from resident areas and suspended pending an investigation. V1 stated a full investigation should have been completed and then a Final report to the State Agency should have been completed with the findings. The facility policy titled Resident Care Policy and Procedure regarding abuse and neglect, involuntary seclusion, exploitation, misappropriate of resident property, injuries of unknown origin and social media revised January 29, 2026. After an initial report of suspected abuse or neglect is sent to IDPH, the Administrator or designee shall investigate all alleged incidents of abuse or neglect. This same policy documents the investigation shall include interviews with all involved parties and potential witnesses. If possible, at least two interviewers shall be present for each witness interview. At least one interviewer shall take notes.

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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** Based on observation, interview and record review the facility failed to provide a safe transfer for one (R8) resident causing a bruise out of five residents reviewed for Abuse in a sample list of nine residents.Findings include:R8's Electronic Medical Record (EMR) documents medical diagnoses as Heart Failure, Osteoporosis, Radiculopathy Cervical Region, Repeated Falls, Muscle Weakness, Atrophy, Difficulty in Walking, Anxiety, Unsteady on Feet, Abnormalities of Gait and Mobility, Abnormal Posture and Bone Density disorder. R8's Minimum Data Set (MDS) dated [DATE] documents R8 as moderately cognitively impaired. This same MDS documents R8 requires moderate assistance with transferring on and off of toilet and is dependent on staff for assistance with toileting personal hygiene, bathing, and dressing.R8's Care Plan intervention dated 3/11/25 instructs staff to utilize gait belt for one assist transfers. This same care plan documents an intervention dated 7/1/2025 instruct staff to encourage R8 to wear protective sleeves for skin protection.On 5/23/26 at 9:20 AM R8 was sitting in her wheelchair in her room. R8 was not wearing protective sleeves on her arms. On 5/23/26 at 9:22 AM R8 stated a staff member (V26) Agency Certified Nurse Aide (CNA) was assisting her from the toilet back to her wheelchair. R8 stated V26 CNA did not use a gait belt during the transfer. R8 stated all the other girls use one so I don't know why (V26) didn't. R8 stated V26 CNA had a ?bear grip' on her wrist. R8 stated she did not think V26 CNA meant to hurt R8 but was ?very rough' with R8. R8 stated since V26 did not use a gait belt, V26 held onto her wrist with a ?bear grip'. R8 stated ?it really hurt' and left a bruise for days. On 5/23/26 at 10:00 AM V2 Director of Nurses (DON) stated unknown staff told him that R8 had a bruise so he did speak with R8 on 5/13/26. V2 DON stated the incident occurred on 5/12/26 when an agency CNA (V26) improperly transferred R8 from her toilet to her wheelchair causing a bruise on R8's Right Forearm. V2 stated V26 CNA did not use a gait belt when transferring R8 and did not ensure R8 had her protective sleeves on to help reduce the risk of injury to R8's skin. On 5/24/26 at 9:54 AM attempted to contact V26 Agency CNA with no success. The facility policy titled Safe Resident Handling Program Policy revised March 18, 2018 documents gait belt usage is mandatory for all resident handling with the exception of mechanical lift use, bed mobility & medical contraindications. The gait belt will be considered a part of the certified nursing assistant's uniform.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide timely incontinence care and failed to prevent cross contamination during incontinence care for one (R2) resident out of three residents reviewed for Activities of Daily Living (ADL) in a sample list of nine residents. Findings include:R2's Electronic Medical Record (EMR) documents medical diagnoses as Unsteady on Feet, Recurrent dislocation of Right Shoulder, Congestive Heart Failure, Dementia, Atrial Fibrillation, Type II Diabetes mellitus, Muscle Wasting and Atrophy and Generalized Weakness.R2's Minimum Data Set (MDS) dated [DATE] documents R2 as severely cognitively impaired. This same MDS documents R2 is dependent on staff for personal hygiene, toileting and requires maximum assistance for transfers. On 5/23/26 continual observations were made from 8:45 AM to 10:53 AM of R2 when V14 and V23 Certified Nurse Aide (CNA) assisted R2 to her room. R2 was sitting in her wheelchair facing the wall sized window in the resident common area across from the nurses station the entire time with no staff assistance of any kind.On 5/23/26 at 10:53 AM V14 and V23 Certified Nurse Aide (CNA) transferred R2 into her bed using a total body mechanical lift and then provided incontinence care. V14 and V23 CNA's did not change their gloves or perform hand hygiene throughout the entire process. R2 was incontinent of urine and bowel. R2's bilateral Ischial Tuberosities and Coccyx had baseball sized dark reddened areas. R2's buttocks showed multiple red lines/wrinkled areas from sitting on the total body mechanical lift sling for an extended period of time. R2's odor has an extremely foul odor that permeated the room. On 5/23/26 at 11:10 AM V14 Certified Nurse Aide (CNA) stated she provided incontinence care at 7:30 AM and then assisted R2 to the dining room for breakfast. V14 stated R2 had not been assisted with any cares since 7:30 AM. V14 CNA stated she should have provided incontinence care every two hours but got busy and did not have time to check on R2. V14 CNA stated R2's urine has had a strong foul odor for a long time. On 5/24/26 at 3:20 PM V2 Director of Nurses (DON) stated the facility expectation is to follow the standard of practice for incontinence care. V2 DON stated all residents who are not able to voice their toileting needs and who are incontinent of bladder and bowel should be provided incontinence care every two hours and as needed. V2 DON stated the staff would not know if the resident is incontinent or not if the staff are not checking them. V2 DON stated even if the resident is continent at the two hour mark the staff would still need to reposition those residents to help reduce the risk of pressure ulcers from sitting in the same place too long.