

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145708	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/24/2025
NAME OF PROVIDER OR SUPPLIER Country Health		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a resident's right to dignity while dining for R20, and by staff talking on cell phones during resident care for R8, R43, and R58. These failures affected four out of 29 residents (R20, R8, R43, and R58) reviewed for dignified care on the sample list of 31. Findings include:1.) R20's current diagnosis list documents the following diagnoses: Pain in right shoulder; Poly-osteoarthritis, unspecified; Other injury of unspecified body region (unidentified-R20 does have a left-hand amputation noted on observation below); Alzheimer's disease, unspecified; Personal history of other diseases of the circulatory system; Weakness; and [NAME] syndrome (a rare neurological syndrome that affects the eye and surrounding area on one side of the face).R20's current Physician Order Sheet documents the following: regular diet, regular texture, thin-consistency liquids.R20's Minimum Data Set (MDS) dated [DATE] documents R20 has severe cognitive impairment and requires: Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident. Supervision or touching assistance - helper provides verbal cues and/or touching/steadying and/or contact guard assistance as the resident completes the activity. Assistance may be provided throughout the activity or intermittently.The same MDS documents R20 requires: Personal hygiene: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene). Partial/moderate assistance - helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.R20's Care Plan dated 6/27/25 documents R20 is at risk for altered nutrition and self-feeds with cueing in the assisted dining room for supervision with meals.On 9/21/25 between 12:10 p.m. and 12:20 p.m., R20 sat in the resident feeding-assistance dining room, in a wheelchair, feeding herself with her right hand. R20's left hand was amputated above the wrist. The wheelchair was locked. The armrests of the wheelchair were approximately one foot from the table. There were no staff members seated at the half-moon-shaped feeding-assistance table. Two cognitively impaired residents were seated at the same table eating.R20 had a regular plate and regular tableware, without any modification device to promote successful self-feeding. R20's plate contained a regular diet consisting of pork loin pieces, rice, and spinach greens, and there was an empty, regular, unlidded plastic beverage glass. R20's right hand and fingers were covered with rice and spinach. She did not receive physical or verbal assistance from staff, though several unidentified staff members intermittently walked by her.R20 had rice and spinach on her bilateral cheeks and multiple grains of rice stuck to and dangling from the tip of her nose. The tabletop surrounding her regular plate had copious amounts of food that extended approximately six inches around the outer edge of the plate. The plate was approximately seventy-five percent emptied.The thigh area of R20's slacks was smothered in rice pieces, greens, and pork pieces, which extended to the seat of her wheelchair. R20's clothing protector had a trail of food approximately eight inches wide, extending from the neckline over her chest and down to her abdomen and slacks. There was spilled clear fluid and food around and under her wheelchair on the floor.On 9/21/25 at 12:21 p.m., this surveyor asked (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	V4, Restorative/MDS Licensed Practical Nurse (LPN), if R20 was supposed to be provided assistance with dining. V4 stated, No, she can eat by herself. She is in the resident assistive dining room for supervision only. It doesn't look like she got much supervision today, by the way her clothes are covered in food. V4 then stated, (R20) does not use any assistive devices. It would probably benefit her to have a plate guard or something to prevent all the mess. I wouldn't want to sit like that. V4 then walked over to R20's chair and asked R20 if she could wipe her right hand off. R20 raised her hand but did not talk. V4 continued to clean R20's face and clothes, then assisted R20 out of the dining room. On 9/21/25 at 12:25 p.m., V5, Certified Nursing Assistant (CNA), stated R20 does not get assistance with dining and that She pushes our hand away. V5 also stated, Yes, that is a dignity issue-to be covered in food like that. On 9/21/25 at 12:40 p.m., V4, LPN/MDS/Restorative, stated, I think we can do better to accommodate (R20's) dining needs. I will find out what would work best for her. I would say by the amount of food on her clothes and face, it is a dignity issue. The right plate guard may make the difference so we can still foster her independence. 2.) The facility's Resident Council Minutes dated 08/21/25 document the following: Residents are tired of CNA's (Certified Nursing Assistants) on their phones while providing care. R8's MDS dated [DATE] documents a Brief Interview of Mental Status (BIMS) score of 15/15, indicating no cognitive impairment. R43's MDS dated [DATE] documents a BIMS score of 13/15, indicating no cognitive impairment. R58's MDS dated [DATE] documents a BIMS score of 15/15, indicating no cognitive impairment. R74's MDS dated [DATE] documents a BIMS score of 14/15, indicating no cognitive impairment. On 09/22/25 from 10:30 a.m. to 11:50 a.m., R8, R43, R58, and R74 all stated Agency Certified Nursing Assistants (CNAs) are still (since the Resident Council minutes dated 8/21/25) providing resident care in resident rooms while talking on their cell phones. On 9/22/25 at 12:32 p.m., V10, Registered Nurse, stated she has had to direct some Agency CNAs to stay off their phones when providing resident care. V10 stated, I have had it happen a couple times recently. This is a dignity issue. If the CNAs are talking on the phone during care, they are not talking to the residents. That is rude and unacceptable. This is supposed to be resident-centered care. I have interrupted care because of this situation a lot previously. Recently a couple times. It has gotten better but should not be happening at all. On 9/23/25 at 9:05 a.m., V9, Activity Director, confirmed the Resident Council group continues to report concerns about CNAs being on the phone while performing care. The facility provided the Illinois Long-Term Care Ombudsman Program Residents' Rights for People in Long-Term Care Facilities pamphlet, revised November 2018, which documents the following: As a long-term care resident in Illinois, you are guaranteed certain rights, protections and privileges according to state and federal law. As an individual living in a long-term care facility, you retain the same rights as every citizen of Illinois and of the United States. The following regulations provide clarity on specific rights granted to residents living in long-term care facilities. Your rights to dignity and respect: You have a right to make your own choices. Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Your facility must provide equal access to quality care regardless of diagnosis, condition, or payment source.		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure a resident's right to choose their own wake -up time. This failure affected four of 29 residents (R8, R43, R58 and R74) reviewed for resident rights on the sample list of 31. Findings include: R8's Minimum Data Set (MDS) dated [DATE] documents R8's Brief Interview of Mental Status (BIMS) score of 15 out of a possible 15, indicating no cognitive impairment. R43's MDS dated [DATE] documents R43's BIMS Score of 13 out of a possible 15, indicating no cognitive impairment. R58's MDS dated [DATE] documents R58's BIMS Score of 15 out of a possible 15, indicating no cognitive impairment. R74's MDS dated [DATE] documents R74's BIMS Score of 14 out of a possible 15, indicating no cognitive impairment. On 09/22/2025 at 10:30 am - 11:50 am during a resident group meeting that R8, R43, R58 and R74 attended, R43 stated This morning at 3:00 am agency staff got me (R43) up, cleaned me up for the day, dressed me, then put me back to bed. R43 said R43 told them, R43 did not want to get up for the day, dressed for the day, and did not want to sleep in clothes. R58 stated that the agency people don't know the residents and don't realize this is the residents' home. They think we get up when they want us to. No matter what we say. I have to insist they let me stay in bed until at least 6:00 am. R8 and R74 both stated the agency staff get them up according to the agency staff schedule, not their desired time. R8 then added We hear all the time this is our home, it doesn't feel like it, when agency staff come in to get us up. On 9/22/25 at 1:25 pm V2, Director of Nursing confirmed residents have a right to determine their own sleep schedule. The facility provided Illinois Long-Term Care OMBUDSMAN PROGRAM RESIDENTS' RIGHTS or People in Long-Term Care Facilities pamphlet dated revised November 2018 which documents the following: As a long-term care resident in Illinois, you are guaranteed certain rights, protections and privileges according to state and federal law: As an individual living in a long-term care facility, you retain the same rights as every citizen of Illinois and of the United States. The following regulations provide clarity on specific rights granted to residents living in long-term care facilities. Your rights to dignity and respect, You have a right to make your own choices. Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Your facility must provide equal access to quality care regardless of diagnosis, condition, or payment source.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure care plans were comprehensive to include medications, diagnoses, behaviors, accidents/injuries, and incontinence for three of 18 residents (R6, R8, R45) reviewed for care plans in the sample list of 31. The facility's Care Plan policy dated November 2017 documents A Comprehensive person-centered care plan shall be developed and implemented to meet the resident's preferences and goals, and address the resident's medical, physical, mental and psychosocial needs, while honoring resident rights to choice. This care plan shall include goals, measurable objectives, and interventions to meet identified resident needs. 1.) On 09/21/2025 at 10:32 AM R6 stated R6 used an electric wheelchair up until about three weeks ago when she hit her right leg on the bed frame causing a hematoma that ended up having to be lanced at the hospital. On 9/22/25 at 10:20 AM R6 stated R6 was given enemas while in the hospital and the staff there rubbed R6's buttocks very hard which made the wounds worse/raw. R6 confirmed R6 requires staff to provide R6's incontinence care. On 9/21/25 at 11:51 AM V19 Wound Nurse and V7 Licensed Practical Nurse administered R6's right lower leg wound treatment. R6's wound was superficial, wound bed was pink/red and moist, and was almost the entire length of R6's calf. On 9/22/25 at 10:00AM V16 Registered Nurse administered wound treatment to R6's buttocks and reapplied R6's incontinence brief. R6 had raw areas to inner buttocks, with two small areas that were bleeding. R6's Minimum Data Set (MDS) dated [DATE] documents R6 is cognitively intact, always incontinent of bowel and bladder, and requires dependence on staff for toileting. R6's Physician Order dated 9/20/25 documents to clean Moisture Associated Skin Damage (MASD) to bilateral buttocks with soap and water, pat area dry, skin protectant to peri wound, apply calcium alginate to wound and cover with hydrocolloid dressing. R6's Nursing Note dated 8/3/2025 documents at 7:00 PM R6 somehow managed to pinch her leg between the wheelchair and her bed while alone in her room. At 7:30 PM there was a large bump, similar to a blood blister, that measured approximately 3 inches by 2 inches. At 9:00 PM the bump on R6's leg was slightly larger and measured 9 centimeters by 5.5 centimeters. R6's active care plan does not include problem, goals, and interventions to address R6's incontinence and R6's accident/injury with the electric wheelchair. On 9/23/25 at 2:20 PM V19 stated V19 entered MASD and surgical wound on R6's care plan. V19 and V4 MDS Coordinator confirmed R6's care plan does not include problem, goals, and interventions for R6's incontinence and accident/injury. 2.) R8's September 2025 Medication Administration Record documents R8 takes Tramadol (opioid) 50 milligrams by mouth twice daily since 2/5/25, MiraLAX 17 grams every other day, and R8 was given Milk of Magnesia on 9/11/25. R8's active care plan does not include problem, goal, and intervention for opioid use, including risk for constipation. On 9/23/25 at 2:20 PM V4 confirmed R8's care plan does not address opioid use and risk for constipation. 3.) R45's active diagnosis list includes Dementia with Agitation as of 8/15/25. R45's Nursing Notes document between 2/5/25 and 9/21/25 R45 had episodes of behaviors including refusing medications and meals, wandering the facility, forgetting the location of her room, and being aggressive and angry towards staff. R45's active care plan does not include problem, goals, and interventions to address R45's Dementia and related behaviors. On 9/23/25 at 2:15 PM V15 Social Services Director stated V15 is responsible for updating behaviors on the care plan. V15 Confirmed R45's care plan did not address Dementia and related behaviors. V15 stated V15 just updated R45's care plan to include this.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility repeatedly failed to follow a physician order to discontinue the administration of a medication, for one of five residents (R69) reviewed for unnecessary medications on the sample list of 31. Findings include: R69's Minimum Data Set, dated [DATE] documents R69's Brief Interview of Mental Status score as three out of a possible 15, indicating severe cognitive impairment. R69's Medication Administration Sheet (MAR) dated 9/1/25-9/30/25 documents: Nuedexta (can cause excessive drowsiness), Oral Capsule 20-10 MG (Dextromethorphan HBr-Quinidine Sulfate), Give 1 capsule by mouth every morning, and at bedtime for the diagnoses of Pseudobulbar Disease (neurological disorder, uncontrolled laughter, crying and involuntary movements). This Physician order documents to start R69's Nuedexta 11/19/2024. R69's MARs for May, June, July, and August also documents R69 received Nuedexta every morning and at bedtime. R69's Quarterly Medication assessment dated [DATE] documents no involuntary movements, excessive drowsiness, crying, or laughing outburst. The facility pharmacy sent a request dated 05/20/25, to R69 providers to consider discontinuing R69 Nuedexta medication. The pharmacy request documented Resident that has been taking the medication above since November 2024. CMS is not specific regarding a GDR (Gradual dose reduction) for Nuedexta (neurological medication), but since the medication is being utilized for psychotropic reasons (outburst of crying, and laughing), please reassess for continued use. V20, Nurse Practitioner response I have documented that assessment. No Pseudobulbar Affect Behaviors. I have No plans to resume Nuedexta. On 9/21/25 during initial tour 8:30 am -9:30 am, and throughout the survey 9/21-9/24/25, R69 sat in a geriatric chair, alert and pleasantly conversing with staff, surveyor, and other residents in the main common areas on the north pod of the facility. R69 did not show any signs of excessive tearfulness, uncontrolled laughter, sedation, or neurological involuntary movements, for which Nuedexta was ordered. On 9/24/25 at 12:00 pm V18, Nurse Practitioner (NP) stated (R69's) Nuedexta order should have been discontinued 5/20/25 or at least clarified by the facility nurses. I do not feel there was any harm or a potential for harm. I have known (R69) in the past. Her Pseudobulbar symptoms were present for a long time. She had been on Nuedexta for a long time before she admitted to the facility. There has not been any negative outcome, she has no indication of sedation. If anything, this medication, together with her other medications have been a benefit. I am not going to make any changes to the Nuedexta order, at this time. (V20, Nurse Practitioner) will be back in the facility Monday (9/29/25). She is off right now related to a family members health issue. She (V20, NP) and I (V18, NP), together will review this. I believe (R69) would benefit from continuing Nuedexta, just knowing (R69) and her, current status. She is doing great. I remember in the past when she was not. It shouldn't have happened (Nuedexta been administered since 5/20/25). Pharmacy has reviewed her (R69) meds (medication) monthly since. (V20, NP) has also seen (R69) since 5/20/25. I know it was not discontinued (5/20/25), I can see that in (R69's) medical records. I just could not see anywhere that Nuedexta, may have been re-instated. These are questions I have for (V20, NP).		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to follow pharmacy instruction for the safe administration of physician ordered medication, for two of eight residents (R66 and R78) reviewed during medication observation. These failures resulted in three errors out of 29 opportunities for a 10.39 percent medication administration error rate. Findings include:R66's Minimum Data Set (MDS) dated [DATE] documents R66's Brief Interview of Mental Status (BIMS) score as 10 out of a possible 15, indicating moderate cognitive impairment.R66's current Physician Order Sheet (POS) documents the following: R66 is on a regular diet with regular-texture food and thin-consistency liquids, which indicates R66 does not have difficulty chewing.The same POS documents 15 oral medications scheduled for administration during the morning medication pass. The oral medications include:Potassium Chloride Crystal, ER (Extended Release) 20 mEq tablet, give three tablets by mouth each morning, andAspirin EC (Extended Release), Low Dose Oral Tablet Delayed Release, 81 mg, one tablet by mouth each morning.R66's Potassium Chloride [NAME] tablet pharmacy-labeled card documents: May be broken or allowed to disintegrate in water (stir well) before swallowing. Rinse down with water, but do not chew all of the remaining particles.The pharmacy instruction pamphlet inserts for the facility's stock bottle of Aspirin Enteric-Coated tablets document the following: DIRECTIONS: do not exceed recommended dose - drink a full glass of water with each dose - swallow whole, do not chew or crush.On 9/22/25 at 8:10 a.m., V8, Agency Registered Nurse (RN), prepared 17 oral medications in a 30 cubic centimeter (cc) medication cup. The 17 pills included:three 3/4-inch Potassium tablets (with pharmacy directions to swallow whole and drink adequate water),R66's enteric-coated aspirin (with directions to swallow whole), andthirteen other oral medications.The medication cup was more than half full of R66's oral medications. V8, RN, filled the medication cup with applesauce to approximately 25 cc in the 30-cc cup. R66's medications were firmly compacted as V8 stirred the medications into the applesauce.V8 spooned four bites of the compacted oral tablets (mixed with applesauce) into R66's mouth. R66 had multiple missing front teeth and chewed the medications with his side and back teeth.As V8 spooned the four spoonfuls of compacted medications in applesauce, V8 did not provide water for R66 to drink between bites. R66 paused after the third spoonful and asked V8 to wait before the next spoonful of pills. R66 coughed momentarily and swallowed. V8 did not offer water and continued to give R66 the fourth spoonful of medication. V8 did not direct R66 to swallow the medications whole without chewing.R66 took one small sip (approximately 5 cc) of water after V8 administered the 17 oral medications. V8 again failed to encourage R66 to drink more water.On 9/22/25 at 8:15 a.m., V8, RN, stated, I don't think (R66) really chewed that much. He doesn't like the taste of the potassium. As far as the aspirin, it is small, it likely went down whole.V8, RN, removed the medication card from the medication cart and read it. V8 stated, The potassium alert on the card says 'may,' not 'have to,' dissolve in water. The card doesn't say any certain amount of water after. He had a small (surveyor observed approximately 5 cc) amount after.2.) R78's MDS dated [DATE] documents R78 has moderate cognitive impairment.R78's Current Diagnoses Sheet documents the following diagnosis: Gastrostomy Status (has a surgically inserted abdominal feeding tube).R78's current POS documents the following:Cyanocobalamin Oral Tablet Disintegrating 500 mcg (micrograms) - Give 1 tablet by mouth one time a day for healthcare maintenance; Give 1 tablet under the tongue every day.On 9/22/25 at 11:35 a.m., V10, Registered Nurse, crushed and mixed together four other medications with R78's sublingual (under the tongue) Cyanocobalamin oral tablet. V10 administered the medications via R78's G-tube.On 9/23/25 at 8:25 a.m., V2, Director of Nursing, confirmed she has completed medication error reports regarding R66's medications and R78's medication error. She has notified physicians and family and educated the nurses.On 9/23/25 at 12:35 p.m., V17, Registered Nurse, who stated she most often takes care of R78 and administers R78's medication, opened the medication cart and confirmed R78's Cyanocobalamin (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Oral Tablet Disintegrating 500 mcg tablet is supposed to be administered sublingually, as the pharmacy label and physician order indicate. V17, RN, then stated, I have always given it wrong. I thought it was crushed and by G-tube with her other meds.Facility PolicyThe facility policy Medication Administration dated January 11, 2010 documents the following:Objective: To provide accuracy during medication pass to assure quality care for residents.Policy: It is the policy of this facility to accurately administer medication following the physician's orders.Procedure:6. Compare label with MAR.7. Crush only meds that can be crushed or for which a physician has given orders to crush.9. Administer meds with adequate fluids. Dilute medications, if needed, in juice or water according to pharmacy guidelines and the resident's dietary restrictions.16. Report known medication errors as soon as possible. Notify physician of known medication error and follow orders received. Monitor resident and document interventions. Complete Medication Error Report and counsel and/or in-service staff as needed.		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, interview and record review the facility failed to respond to a resident grievance in a timely manner, for one of four residents (R58) reviewed for grievances in the group meeting, on the sample list of 31. Findings include: On 09/22/2025 at 10:30 am - 11:50 am during the resident group meeting. R58 sat in a wheelchair without a shoe on her left foot. R58 stated she had filed a grievance by sending a letter to V1, Administrator within the last month. R58 stated I haven't been able to wear a shoe, because of a toe ulcer, I have had for about a year. I saw a podiatrist, at an outside the facility four to six months ago. The corn was removed, and my pinky toe never healed. I still can't wear a shoe and the Administrator never responded to the letter. On 9/24/25 at 3:25 pm V1, Administrator provided an undated, handwritten grievance letter from R58. V1 confirmed the letter had been written by R58, and was given to V1, Administrator within the last several weeks. V1 also confirmed she had not put this grievance on her grievance log and therefore had not followed up with Nursing to figure out a resolution to R58's pains and inability to wear a shoe on her left foot. R58's undated, handwritten letter documented the grievance and explained that R58 has not been able to wear a shoe on her left foot because of pain in her left, pinky toe. R58 further explained in the letter that she had pain when standing on the mechanical stand lift and does not want to be downgraded to the use of a full mechanical lift for transfers. R58 letter documents that on 5/8/25, R58 was seen by a podiatrist outside the facility, who diagnosed the pinky toe as an ulcer, in the location a previous corn that had been removed. After seeing podiatrist regarding her ulcer on left, pinky toe- she continued to suffer from pain from the toe. R58 documented the ulcer has not healed. The facility provided Illinois Long-Term Care OMBUDSMAN PROGRAM RESIDENTS' RIGHTS or People in Long-Term Care Facilities pamphlet dated revised November 2018 which documents the following: As a long-term care resident in Illinois, you are guaranteed certain rights, protections and privileges according to state and federal law: As an individual living in a long-term care facility, you retain the same rights as every citizen of Illinois and of the United States. The following regulations provide clarity on specific rights granted to residents living in long-term care facilities. You have the right to complain to your facility and to get a prompt response.		

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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. Based on interview and record review the facility failed to report an injury of unknown origin to the administrator and the state survey agency for one of one resident (R6) reviewed for abuse in the sample list of 31. Findings include: The facility's Abuse Prohibition Policy dated 8/25/25 documents injuries of unknown origin will be immediately reported to the administrator and the administrator will notify the Illinois Department of Public Health (IDPH). R6's Emergency Department Note dated 8/15/25 at 5:27 PM documents R6 presented with shortness of breath and chest discomfort described as constant pressure that worsens with inspiration. R6's Chest Computed Tomography (CT) dated 8/5/25 at 7:18 PM documents Likely acute/recent T10 compression fracture with approximately 25% central vertebral body height loss. Other chronic compression fractures are demonstrating similar height loss relative to the CT from 10/20/2022. R6's Hospital admission History and Physical dated 8/5/25 documents R6's hospital admission diagnoses included Acute/recent T10 fracture and neurosurgery was consulted for further evaluation. R6's Neurosurgery Note dated 8/5/25 documents R6 has a T10 compression fracture thought to be newer. R6 is alert and oriented to person, place, time and situation; and R6 reported having chronic back pain that increased over the last few months. R6 denied any recent trauma other than a hematoma to her right lower leg caused from getting her leg caught between her dresser and bed. R6's Thoracic Spine X-ray dated 9/11/25 documents compression deformity of endplate of T11 (previously reported as T10), which has not significantly changed from prior radiographs and CT. Chronic compression deformity of T8 also noted. R6's Neuroscience Progress Note dated 9/11/25 documents R6 was evaluated for T11 fracture identified on R6's x-ray, and there is another old fracture higher up. This note documents that sometimes cement injection is done, but R6 is too far down the line for that and R6 isn't a surgical candidate. Recommendation made for R6 to return in four weeks with a follow up x-ray. R6's ongoing diagnoses log documents the facility added WEDGE COMPRESSION FRACTURE OF UNSPECIFIED THORACIC VERTEBRA, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING on 8/14/25. The facility's abuse log does not document any allegations of abuse or injury of unknown origin after 7/18/25. On 9/22/25 at 10:20 AM R6 confirmed compression fracture of vertebrae identified at hospital in August 2025. R6 stated R6 was unsure what caused the fracture and denied that she had any recent falls or incidents that could have caused this type of injury. On 9/22/25 at 2:46 PM V2 Director of Nursing confirmed R6's acute compression fracture was not reported to IDPH. On 9/23/25 at 4:00 PM V2 stated V2 thought R6's compression fracture was previously noted and was not new, she will look for documentation to provide for this. On 9/24/25 at 8:30 AM V2 stated she was not able to find any other documentation to show that R6's compression fractures were old and previously documented. At 11:10 AM V2 stated V1 Administrator was not aware of R6's acute compression fracture either, V1 and V2 both thought the fracture noted in September was old, due to the report. V2 stated we weren't aware of the acute fracture found during R6's August 2025 hospitalization. On 9/24/25 at 11:15 AM V1 confirmed V1 was not aware of R6's compression fracture identified during R6's August 2025 hospitalization. V1 stated V1 and V2 were only aware of R6's compression fracture identified when R6 was transferred to the hospital in September for low back pain, but the report identified it as being an old fracture. V1 confirmed the acute fracture noted in R6's 8/5/25 hospital records should have been considered an injury of unknown origin and should have been reported to V1 and IDPH.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review the facility failed to investigate an injury of unknown origin for one of one resident (R6) reviewed for abuse in the sample list of 31. Findings include: The facility's Abuse Prohibition Policy dated 8/25/25 documents injuries of unknown origin will be immediately reported to the administrator and will be investigated. R6's Emergency Department Note dated 8/15/25 at 5:27 PM documents R6 presented with shortness of breath and chest discomfort described as constant pressure that worsens with inspiration. R6's Chest Computed Tomography (CT) dated 8/5/25 at 7:18 PM documents Likely acute/recent T10 compression fracture with approximately 25% central vertebral body height loss. Other chronic compression fractures are demonstrating similar height loss relative to the CT from 10/20/2022. R6's Hospital admission History and Physical dated 8/5/25 documents R6's hospital admission diagnoses included Acute/recent T10 fracture and neurosurgery was consulted for further evaluation. R6's Neurosurgery Note dated 8/5/25 documents R6 has a T10 compression fracture thought to be newer. R6 is alert and oriented to person, place, time and situation; and R6 reported having chronic back pain that increased over the last few months. R6 denied any recent trauma other than a hematoma to her right lower leg caused from getting her leg caught between her dresser and bed. R6's Thoracic Spine X-ray dated 9/11/25 documents compression deformity of endplate of T11 (previously reported as T10), which has not significantly changed from prior radiographs and CT. Chronic compression deformity of T8 also noted. R6's Neuroscience Progress Note dated 9/11/25 documents R6 was evaluated for T11 fracture identified on R6's x-ray, and there is another old fracture higher up. This note documents that sometimes cement injection is done, but R6 is too far down the line for that and R6 isn't a surgical candidate. Recommendation made for R6 to return in four weeks with a follow up x-ray. R6's ongoing diagnoses log documents the facility added WEDGE COMPRESSION FRACTURE OF UNSPECIFIED THORACIC VERTEBRA, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING on 8/14/25. The facility's abuse log does not document any allegations of abuse or injury of unknown origin after 7/18/25. On 9/22/25 at 10:20 AM R6 confirmed compression fracture of vertebrae identified at hospital in August 2025. R6 stated R6 was unsure what caused the fracture and denied that she had any recent falls or incidents that could have caused this type of injury. On 9/22/25 at 2:46 PM V2 Director of Nursing confirmed R6's acute compression fracture was not investigated. On 9/23/25 at 4:00 PM V2 stated V2 thought R6's compression fracture was previously noted and was not new, she will look for documentation to provide for this. On 9/24/25 at 8:30 AM V2 stated she was not able to find any other documentation to show that R6's compression fractures were old and previously documented. At 11:10 AM V2 stated we weren't aware of the acute fracture found during R6's August 2025 hospitalization. On 9/24/25 at 11:15 AM V1 confirmed the acute fracture noted in R6's 8/5/25 hospital records should have been considered an injury of unknown origin and investigated.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to revise a care plan with fall interventions for one of 18 residents (R4) reviewed for care plans in the sample list of 31. Findings include: The facility's policy titled Care Plan Process with the revision date of 11/2017 documents a comprehensive person-centered care plan shall be developed and implemented to meet the resident's preferences and goals., and address the resident's medical, physical, mental and psychosocial needs, while honoring resident rights to choice All plans of care must be reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly assessment. Review of incident report reported to Illinois Department of Public Health on 5/30/25 at 7:50 AM documents R4 sustained a fall on May 30, 2025 at 7:50 AM. R4 was observed sitting in front of her recliner chair, legs extended out, and head resting on the foot of the chair. R4 stated I fell out of this chair right here. R4 complained of hip pain so the facility sent R4 to be evaluated and treated to the local hospital on 5/30/25 at 8:08 AM. R4 was interviewed on 9/22/25 at 11:30 AM and R4 did not remember what happened. Minimum Data Set (MDS) dated [DATE] Section C documents R4 with a BIMS (Brief Interview for Mental Status) of 3 which is severe cognitively impaired. R4's care plan dated 5/20/25 states R4 has had previous falls with a list of interventions. The care plan does not list the fall of 5/30/25 at 7:50 AM. V2, Director of Nurses stated in interview on 9/24/25 at 9:45 AM Yes the care plan should of been updated with (R4's) most recent fall. My expectations are the care plan should be updated after each fall.		

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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 prevent cross-contamination during catheter care for one of two residents (R53) reviewed for urinary catheter care on the sample list of 31. Findings Include:R53's Medical Diagnoses List dated May 20, 2025 documents R53 is diagnosed with Infection and inflammatory reactions due to indwelling urethral catheter and Retention of urine.R53's Minimum Data Set (MDS) dated [DATE] documents R53 has severe cognitive impairment, uses a wheelchair, is always incontinent of bowel, and is dependent on staff for toileting, hygiene, and transfers.R53's Care Plan dated 7/29/25 documents R53 has an indwelling Foley catheter.On 9/22/25 at 11:15 a.m., V27, Certified Nursing Assistant (CNA), wearing a personal protective gown, donned gloves and placed a basin of water on the bedside table, which also contained washcloths and towels. V27 placed a washcloth in the water, wrung out the excess water, and proceeded to wash R53's inner right thigh with the washcloth. V27 then placed the same washcloth back into the basin of water and washed R53's inner left thigh using the same area of the washcloth.V27 then obtained a new washcloth, placed it into the water basin, and began to clean R53's penis shaft on the right and left sides. Afterward, using the same washcloth, V27 placed it back into the water basin and washed the catheter insertion site at the meatus. R53 made noises indicating discomfort. V27 apologized to R53, stating she would try to be gentler.V27 then cleaned R53's catheter tubing by holding the catheter at the insertion site and wiping downward on the catheter tubing. V27 again placed the washcloth into the water basin and repeated wiping the catheter tubing using the same area of the washcloth. V27 then retrieved a dry towel and dried R53's body.On 9/22/25 at 11:25 a.m., V27 was asked if there was soap in the water. She stated, No, it is just plain water. V27 then stated she was finished with the catheter care.V27 was asked about using the same area of the washcloth while cleaning R53. V27 stated, Yes, I forgot to turn the cloth to wash the new area I was cleaning.On 9/24/25 at 12:20 p.m., V2, Director of Nursing, stated her expectations for catheter care: I expect peri wash or soap to be used when catheter care is being done for the residents, and they are supposed to use a clean washcloth each time they complete one area and start a new area.The facility's policy titled Catheter Care - Male, dated 8/1/05, documents the following:Procedure:8. Pull back foreskin gently.9. Cleanse area of insertion of catheter into meatus using a clean washcloth prepared with soap and water or peri-care cleanser. Cleanse downward from top to bottom on one side, and then repeat on the other side using a clean washcloth.10. Cleanse catheter tubing 11/2 to 2 inches down from the insertion site.11. Rinse well with clean cloths, following same procedure as for washing.12. Dry with a clean towel.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to monitor and record weights and meal intakes for one of three residents (R45) reviewed for weight loss in the sample list of 31. Findings include: On 9/21/2025 12:34 PM R45 was in her room eating lunch which consisted of peanut butter and jelly sandwich, cheese puffs, root beer float pie, and high protein ice cream. At 12:59 PM R45 was finished eating and lying in bed. R45 ate one or two bites of the sandwich and cheese puffs, half of the pie, and all of the ice cream. On 9/22/2025 at 11:51 AM V23 R45's Family stated R45's weight loss began in the Spring and R45 also was very sick with Norovirus. V23 stated R45 was getting nutritional shakes, but had a hard time keeping anything down. V23 stated the facility has kept the physician informed and R45 has continued to lose more weight. V23 stated R45 has dementia related to a traumatic brain injury that occurred four years ago and eating is something that R45 doesn't remember. V23 stated R45 has been on comfort care and they are considering transitioning to hospice soon. R45's Minimum Data Set, dated [DATE] documents R45 has cognitive impairment and had a one or six month significant weight loss that was not prescribed. R45's ongoing weight log includes the following: 2/5/25 140 pounds (lbs)2/26/25 131.8 lbs (5.86% loss in one month)3/4/25 129.8 lbs 4/9/25 116.6 (10.17% loss one month)4/23/25 121.8 lbs5/3/25 115.4 lbs5/28/25 118.4 lbs6/2/25 121.8 lbs7/2/25 118 lbs8/6/25 112.6 lbs (19.57% loss in 6 months)8/27 109.6 lbs9/1 107.8 lbs (16.95% loss in 6 months) R45's February-April 2025 Treatment Administration Records document the following: R45's weekly weight was not obtained/recorded as ordered on 2/12/25 and 2/19/25. All of R45's March weekly weights and 4/2/25 were documented by V24 Agency Registered Nurse as the same exact weight of 129.8 lbs. R45's weekly weight on 4/9/25 was 116.6 lbs. V24 recorded the next weekly weight on 4/16/25 as the same weight noted on 4/9/25. R45's weekly weight on 4/23/25 was 121.8 lbs. V24 recorded the next weekly weight on 4/30/25 as the same weight noted on 4/23/25. There are no other weights between February 2025 and April 2025 documented in R45's medical record. R45's February 2025 Meal Intake Report documents 15 unrecorded meals and 34 entries of 50% or less of the meal. R45's March 2025 Meal Intake Report documents 33 unrecorded meals and 33 entries of 50% or less. R45's April 2025 Meal Intake Report documents 24 unrecorded meals and 53 entries of 50% or less. R45's Meal Intake Report with date range of 8/25/25-9/23/25, documents 10 unrecorded meals. R45's Nursing Notes dated 3/5/25, 3/7/25, and 3/9/2025 document R45 complained of gastrointestinal symptoms and was placed on isolation. R45's Dietary Note dated 3/4/2025 at 1:51 PM documents R45 has had a decline, is more confused, often leaves the dining room and is pocketing food (holding food in cheek). R45 has had a one month significant weight loss and R45's diet was downgraded to mechanical soft. R45's Nursing Note dated 3/26/2025 at 12:49 PM documents V25 Nurse Practitioner called and stated V25 and V26 Physician reviewed R45's medications, weights, vitals and blood sugars, orders given to keep everything the same, and it is related to R45's progression of dementia. Continue current order for nutritional supplement 90 milliliter three times daily. Family was notified and in agreement with comfort care at this time and hospice referral when needed. R45's Social Service Note dated 8/22/25 at 1:06 PM documents hospice was discussed with R45's family and they are not going forward with hospice at this time. On 9/22/25 at 2:20 PM V4 MDS Coordinator confirmed weights are only documented in the resident's electronic medical record (EMR) in the weight section or on the TAR. On 9/22/25 at 2:46 PM V2 Director of Nursing stated V24 was a contracted agency nurse and V2 chose not to renew V24's contract when it expired. V2 stated V2 had no specific concerns, just that V2 was not impressed with V24. V2 provided V2's February - April 2025 meal intakes and confirmed the Certified Nursing Assistants should record meal intake for each meal. V2 confirmed missing entries for meal intakes. On 9/23/25 at 12:05 PM V2 confirmed there were no other recorded weights for R45 between February and April 2025 and confirmed V24's documented weights as being identical to prior weights. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V2 stated V2 questions the accuracy of R45's weights during that time frame, due to staff observed obtaining unidentified resident weights while resident is holding onto the scale or with a foot on the floor, which alters the weight. V2 stated V2 had provided staff training on obtaining accurate weights, but has no documentation of this. V2 confirmed R45 should have been reweighed to verify the accuracy of R45's weights and weight loss. The facility's Recording Nutritional Intake/Calorie Counts policy dated August 2019 documents The intake of adequate nutrition is key to maintaining functional status and optimal nutritional health. In the elderly appetite can change suddenly with little warning, resulting in weight loss and compromised nutritional status. Therefore the nutritional intake should be documented in (EMR software) daily. The nutritional intake documentation is located in (EMR software), under the task tab for each resident. Intake for each resident is completed thru a kiosk or Point of Care device by designated staff members. The facility's Weight Management Policy and Procedure dated 2023 documents: Each resident will be weighed at least once a month on a predetermined schedule. All residents will be monitored for significant weight changes to assure maintenance of acceptable parameters of body weight. Weights may be obtained more frequently than monthly if warranted based on resident condition or physician order. Residents will be weighed using the same scale and in a consistent manner unless clinical condition warrants the use of a different scale or an altered manner. A change in scale or method will be noted if this occurs. A resident with a weight fluctuation of greater than five pounds(+ or-) will be re- weighed for accuracy. The new weight will be recorded in the medical record.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review the facility failed to change the oxygen tubing and humidifier bottle for one (R63) of three residents reviewed for respiratory care on the sample list of 31. Findings include:R63's Facility Census documents R63 was admitted to the facility 4/1/23 and has the following medical Diagnosis; Obstructive Sleep Apnea, and Symptoms and Signs Involving the Circulatory and Respiratory system. R63's Physicians Order Sheet dated 3/27/25 documents oxygen clean filter on concentrator, change the water bottle, nasal cannula and bag on concentrator weekly and as needed. When in use. The facility's Oxygen Administration policy dated 1/15/25 documents to change nasal cannulas, tubing, and humidifiers weekly and label with the date, and store oxygen cannula or mask in a plastic bag when not in use.On 9/21/25 at 9:17 AM R63's oxygen concentrator bottle was dated 8/27/25 and R63's oxygen tubing was not dated. R63's Continuous Positive Airway Pressure machine (CPAP) was connected to the oxygen concentrator and tubing. R63 was sitting in R63's recliner taking a nap with the CPAP on.On 9/21/25 at 9:30 AM V3 Agency Registered Nurse confirmed that the concentrator water bottle was dated 8/27/25 and that the oxygen tubing was not dated. V3 stated that the concentrator and oxygen should get changed weekly on night shift, and whoever changes it should be dating them both.On 9/21/25 at 10:15 AM R63 stated that R63 uses R63's Continuous Positive Airway Pressure machine (CPAP) when R63 takes a nap or goes to bed. R63 stated that R63 is not sure the last time the concentrator bottle or tubing were changed.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review the facility failed to accurately transcribe hospital discharge orders resulting in a significant medication error for one of five residents (R6) reviewed for unnecessary medications in the sample list of 31. Findings include: R6's Hospital Discharge Orders dated 8/13/25 document to administer Eliquis (blood thinner) 10 milligrams (mg) by mouth twice daily for two more days through 8/14/25, then give 5 mg by mouth twice daily starting on 8/15/25 at 9:00 AM. These orders include a hand written notation that these orders were reviewed with V20 Nurse Practitioner on 8/13/25 and V20 signed these orders 8/15/25. R6's August 2025 Medication Administration Record documents R6's Eliquis orders were incorrectly transcribed, with both the 10 mg and 5 mg orders implemented together, and R6 received 15 mg on the evening dose on 8/13/25 and 15 mg twice daily on 8/14/25. There is no documentation that the facility identified this medication error. On 9/22/25 at 2:46 PM V2 Director of Nursing confirmed R6's Eliquis order was transcribed incorrectly. On 9/23/25 at 1:40 PM V18 Nurse Practitioner stated Eliquis is generally prescribed 5 mg twice daily for the geriatric population, and it can be given in higher doses for a short duration. V18 stated 15 mg twice daily, a total of 30 mg daily, would be considered an excessive dose and would cause risk for bleeding complications if it was an extended duration. The Medication Error Report dated 9/22/25 documents R6's transcription error for Eliquis and R6 received both 10 mg and 5 mg doses on 8/13/25 and 8/14/25. The facility's Physician's Orders policy dated May 2022 documents All medications and treatments shall be given only upon the written order of the physician. All such orders shall be written in the medical record and shall be given as prescribed by the physician at the designated times.		