STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145945	A. Building B. Wing	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Imboden Creek Senior Living	180 West Imboden Decatur, IL 62521

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 31642 Based on observation, interview, and record review, the facility failed to ensure resident dignity was maintained by failing to provide timely bowel and bladder incontinence care, for one of three residents (R13) reviewed for incontinence care on the sample list of 24. Findings include: R13's Physician Order Sheet, dated 10/08/24, documents the following: Admit to (name of hospital) Hospice: dx (diagnosis) CHF (Congestive Heart Failure), and Aspiration Pneumonia. R13's Minimum Data Set (MDS), dated [DATE], documents R13 has a Brief Interview of Mental Status score of 12 out of a possible 15, indicating moderate cognitive impairment. The same MDS documents R13 is always incontinent of bladder, and bowel function was not rated on this MDS. R13's Care Plan, dated 08/07/24, documents the following: The resident has an ADL (Activity of Daily Living), Self - Care Performance Deficit r/t (related to) weakness and blindness. Self Care and TOILET USE: The resident is totally dependent on staff for toilet use. On 10/11/24 at 1:15 pm, V17, Certified Nursing Assistant (CNA), pushed R13's wheelchair down the hall to his room and parked his wheelchair bedside. V17, CNA, then walked out of R13's room. V16 (R13's family member) stated, I hope they (CNA's) are going to change him. He had a bowel movement while he was eating in the dining room. I asked one of the girls (unidentified, CNA), if they would change him then. She said after lunch, they were too busy feeding other residents right then. He finished lunch a half hour ago. We have been waiting, and they just now brought him to his room. I hate this for him. He shouldn't have to set in his own p***. V16 also stated, (R13) had a stroke, is paralyzed on one side of his body, and requires a (mechanical lift) to transfer. The CNA may be getting the (mechanical lift). On 10/11 24 at 1:30 pm, V17, CNA, did not return to provide R13's incontinence care. V3, Director of Clinical Operations, was in an office across from the nurse's station. V3 was informed V16, R13's Family Member, had asked staff to provide incontinence care during lunch, and R13 was still waiting for to be provided incontinence care. V3 stated that is too long to wait and staff should have taken care of R13's needs right away. (continued on next page)

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 - Few	On 10/11/24 at 1:35 pm, V18, Certified Nursing Assistant, and V11, Certified Nursing Assistant, transferred R13 to bed, via full mechanical lift. V11 and V18 both used hand sanitizer and donned gloves. V18, CNA, performed anterior incontinence care, while V11, CNA, provided R13 conversation during care. R13's incontinence brief was heavily wet, visibly saturated with urine and feces. V18 stated she and a (unidentified) CNA in training changed R13 around 11:30 am. V18 stated, He is a heavy wetter. V11 and V18, CNA's, repeated hand hygiene and re-gloved appropriately throughout incontinence care. R13 was repositioned to a side lying position. R13 had dried brown feces at the top of his buttocks, and up his buttocks crease to his low back. V18 cleansed, rinsed, and patted R13's buttocks dry, and applied a clean incontinence brief. On 10/15/25 at 1:50 pm, V3, Director of Clinical Operations/Registered Nurse, confirmed R13's delay in incontinence care was a dignity issue. On 10/15/24 at 4:00 pm, V31, [NAME] President of Clinical Operations/Registered Nurse, agreed the delay in R13's incontinence care was a dignity issue. V31 then stated, Residents that are heavy wetter are to receive more frequent incontinence care check. The facility policy Quality of Life -Dignity documents the following: Policy Statement Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. 1. Residents shall be always treated with dignity and respect. 2. 'Treated with dignity' means the resident will be assisted in maintaining and enhancing his or her self esteem and self-worth.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642 Based on observation, interview, and record review, the facility failed to accurately measure food portions during of meals service for residents in the dining room and residents that dine in their rooms. This failure affects three residents (R1, R4, R18) and has the potential to affect all 75 residents residing in the facility. Findings include: 1.) On 10/11/24 at 10:50 am, V24, Licensed Practical Nurse, stated, Portion sizes really depends on who is cooking. Some residents ask for seconds and have to wait until everybody has been served first. I think they should be able to get seconds when they ask. On 10/11/24 at 11:05 am, V11, Certified Nursing Assistants (CNA), stated, There are a lot of dietary problems in the facility. V11 also stated, The portion sizes-- residents do complain about. One time they may get a lot, other times a spoonful. On 10/11/24 at 11:51 am, V14, CNA, stated, There are a lot of dietary concerns. It seems like everybody complains about the presentation. Some hungry people get a spoonful, and others get a great big scoop. The kitchen tell us not ask for seconds if the rest of the people have not gotten first (servings). Sometimes they just say 'no' we are out, so residents don't get anymore. Either way, people are not getting full portions most of the time. On 10/11/24 at 12:10 pm - 12:45 pm during observation of kitchen meal service, to the dining room and resident that dine in their rooms, V19, Cook, plated the food. V19, Cook, plated food for each resident according to their diet slips. Each resident plate had breaded chicken or broiled un-breaded fish served on a bun. The chicken breasts were uniform sized and covered the buns. The fish varied in size. Some covered the bun, most portions of fish were small and only covered the center of the bun, with approximately an inch of the bun with no fish present. Some of the fish, single filet of fish on the bun, was half the size of the full slice of fish. Each plate was served with a scoop of macaroni and cheese. Some plates of residents food, were large mounding portion approximately an overflowing cup size, and others were served with less then half of the amount. The smallest portions of macaroni and cheese observed measured approximately two tablespoons, but were scooped with the same four-ounce scoop. The difference in portion sizes were unrelated to the resident diet order slips. None of the diet order slips specified a deviation in food portion size. Mechanical textured fish and chicken was not served on buns, and were approximately two tablespoons in size. The mechanical textured meat portions were scooped onto the plates with a half full, three-ounce scoop. A small, teaspoon sized dollop of white gravy was put of the mechanical fish and chicken. The mechanical soft meals had a four-ounce scoop of cooked carrots. The portion of carrots onto each plate varied. The four-ounce scoop was overflowing with most of the portion of carrots plated. The scooped carrots were heaping full and encompassed more than a third of the plate. V9, Director of Culinary Services, V4, Dietary Manager, V27, Dietary Assistant, V28, Cook, V29, Dietary Assistant, each prepared for the delivery of residents meals in the dining room, and hall trays of resident's food. None of the staff participating in food service identified the discrepancy in food portions for any of the resident served. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/11/24 at 12:50 pm, R4 was seated in a bariatric wheelchair with R18 (R4's family member / co-resident). R4 stated he had eaten R18's food. R18's plate was empty. My (family member), (R18) doesn't eat much, and I can't get enough. The food here is pretty good. The portions are just too small sometimes. On 10/11/25 at 1:55 pm, V19, Dietary Assistant/Cook, confirmed the portion sizes of macaroni and cheese, carrots, and mechanical fish and chicken varied. V19 stated, The varying portions I served are based on how much I know they usually eat. I have worked here almost two years and know the residents real well. The scoop was the right size according to the menu. I know some portions were overflowing, and some were not. V19 also stated, The fish and chicken come already portioned. Some of the fish pieces today were small. I can't measure them. Each resident got one piece. That is all they are supposed to get. On 10/11/24 at 2:40 pm, V3, Regional Director of Clinical Services, stated food portions should be accurate and consistent. On 10/15/24 at 12:34 pm, V9, Regional Director of Culinary Services, stated, I saw the same things you (this surveyor) did Friday (10/11/24 meal service). I have addressed the portion size discrepancy with all the dietary staff working today. They know to measure appropriately. I will be doing an in-service of the scoop sizes with all the dietary staff not working today as well. The facility policy Resource: Dining Services, Employee Basic Skills Competency, dated 2016, documents the following: B. Area Two-Meal Service: 1. d. Cooks and aides should be able to demonstrate the ability to read the menu and select the correct serving utensil/scoop to serve the menu correctly. The Cooks and aides should point out how to locate the indication of size on the scoop, ladle or spoodle. The (facility name) Room Directory, dated 10/09/24, documents 75 residents reside in the facility. 49492 2.) On 10/10/24 at 1:45 pm, R1 stated the kitchen is serving small portions and on an unknown date, that R1 cannot remember, R1 only received about 10 Cheeto style chips on the plate, with a ground up meat sandwich with cottage cheese and a banana. R1 states his spouse went to the local fast-food restaurant and purchased R1 a hamburger to eat as the kitchen staff would not get R1 something different to eat. R1's undated clinical census page states admitted to the facility on [DATE] and discharged home on 10/11/2024. R1's undated Clinical Physician Orders states admitted to the facility, dated 9/22/2024, shows a diet order of Controlled Carb diet, Mechanical Soft texture, Regular Liquid Consistency. R1's undated Medical Diagnosis List shows a diagnosis of Type 2 Diabetes Mellitus With Diabetic Polyneuropathy was created on 6/24/2024. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Care Plan, dated initiated of 9/22/2024, states to monitor nutritional status and offer nutritional supplement as per physician orders.