

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145945	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2025
NAME OF PROVIDER OR SUPPLIER Imboden Creek Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 41970 Based on observation, interview, and record review, the facility failed to offer timely toileting assistance, implement fall interventions, and complete thorough fall investigations for three of three residents (R1, R2, R3) reviewed for falls in the sample list of three. Failing to provide R1 with timely toileting assistance resulted in R1 falling, after attempting to toilet independently, and suffering a hematoma to R1's head and a femur fracture requiring surgery and hospitalization . Findings include: 1. R1's undated Face Sheet documents Obstructive and Reflux Uropathy, Adult Failure to Thrive, Parkinson's Disease, Disorder of the Muscles, Lack of Coordination, Atrial Fibrillation, Dementia, Weakness, and History of Falling. R1's Minimum Data Set (MDS), dated [DATE], documents R1 as cognitively intact. This same MDS documents R1 as requiring moderate assistance with toileting, maximum assistance with transfers, and is dependent on staff for bathing and dressing. R1's Physician Order Sheet (POS), dated January 2025, documents a physician order for Warfarin Sodium (anticoagulant) 4 milligrams (MG) every Friday starting 12/20/24 and ending 1/19/25. R1's Fall Risk Evaluation, dated 12/12/24, documents R1 is at risk for falls. (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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R1's fall investigation, dated 1/18/25, documents V6 and V7, Certified Nurse Aides (CNA), notified V8, Licensed Practical Nurse (LPN) of R1's fall. The fall investigation documents R1 had an unwitnessed fall that included hitting her head against the wall near the restroom. R1's Left side of Head had a small 2 centimeter (cm) length laceration that had moderate bleeding that had stopped on it's own before paramedics arrived. R1 was found laying on her back with legs out in front of her, complaining of pain. R1's wheelchair was near her as she appeared to have used it to get to the restroom and then tried to walk into bathroom trying to take herself to the restroom. This same fall investigation documents R1 was incontinent of urine at the time of fall, was ambulating without assistance, and was wearing improper footwear. This same fall investigation documents Interdisciplinary Team (IDT) met to discuss incident: R1 had breakfast at approximately 7:15 AM and was observed shortly after. R1 was observed on the floor near the bathroom/hallway. R1 stated to staff that she was trying to go the the bathroom. R1 reported to emergency room staff she had rolled out of bed and attempted to crawl to the door where she had been observed by facility staff. Intervention: offer/encourage R1 to toilet after breakfast and gripper socks when shoes are off. This same fall investigation documents R1 did not have on socks yet. R1 was trying to take herself to the restroom. V8, LPN, reminded R1 that she has incontinence briefs on so it is ok for R1 to urinate in her briefs with such urgency that she can't wait for assistance. R1's Final Report to the State Agency, dated 1/20/25, documents R1 had an unwitnessed fall on 1/18/25. This same report documents R1 is cognitively intact, has times of forgetfulness, and is impatient at times. This same investigation documents R1 ate breakfast at 7:15 AM and was found on the floor in her room at 9:45 AM. R1 was not wearing shoes or socks when found by staff. R1's Nurse Progress Note, dated 1/18/25 at 2:30 PM, documents, (R1) had an unwitnessed fall at 9:45 AM. Emergency services called and (R1) taken to the hospital by ambulance about 10:15 AM. Called hospital, (R1) has a Left Hip Fracture and is being admitted to the hospital. R1's Hospital Record, dated 1/20/25, documents R1 is an elderly frail patient, with a history of recurrent falls and Dementia, who presented to the emergency room from the facility after an unwitnessed fall. R1 stated to emergency room staff that she fell out of bed and was attempting to crawl to the door. R1's hospital record documents R1 has a past medical history significant for Atrial Fibrillation on Coumadin due to previous Deep Vein Thrombosis (DVT), Hypertension, Parkinson's Disease, Dementia, Stage IV Sacral Ulcer, as well as ulcers on both heels. This same report documents R1 presented to the emergency department status post fall at the facility. R1 was found to have Traumatic Hematoma of Forehead and Closed Intertrochanteric Fracture of Left Hip. R1's X-Ray report, dated 1/20/25, documents, Indications: Fall, pain. (R1) was found on floor, laceration and Hematoma to the Left side of her head, Altered Mental Status (AMS), Left Hip pain and Coumadin use. Impression: Comminuted Intertrochanteric Fracture of the Left Hip at its articulation of the Femoral Neck. R1's Computerized Tomography (CT) scan, dated 1/20/25, documents impression of Open Reduction Internal Fixation (ORIF) of Left Femur Fracture has been performed and Subcutaneous Hematoma on the Left side which measures 4.5 centimeters (cm) wide by 2.5 cm raised depth swelling by 10.5 cm long. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 1/28/25 at 12:05 PM, R1's Left Parietal area showed dark purple bruising, approximately 3 inches long by 4 inches wide. R1 stated her head hurt from where she fell and hit it. R1 stated she tells the staff when she needs to use the restroom. R1 stated, If the girls take too long, then I will try it myself. I don't want to wet myself. R1 stated she had to wait 'hours' that morning (1/18/25) to get any help to use the bathroom, and then after she fell , she yelled 'for a long time' to get anyone to come help her. R1 stated she broke her hip the day she fell because no one would help her use the bathroom. On 1/29/25 at 11:15 AM, R1 was laying in bed on her back. R1 stated, Oh! My hip hurts! I can't even move without it hurting. On 1/29/25 at 9:50 AM, V9, Certified Nurses Aide, stated V9 works on R1's hall regularly. V9 stated R1 is very good about asking for help. V9 stated R1 will attempt to take herself to the bathroom if no one helps her. On 1/28/25 at 12:00 PM, V3, Licensed Practical Nurse (LPN), stated R1 does complain of pain to her hip and head occasionally. V3, LPN, stated R1 is given as needed medication for her pain. 2. R2's undated Face Sheet documents medical diagnoses of Dementia, Syncope and Collapse, Overactive Bladder, Parkinson's Disease, Glaucoma, Unsteady on Feet, Abnormalities of Gait and Mobility, and Repeated Falls. R2's Minimum Data Set (MDS), dated [DATE], documents R2 as cognitively intact. This same MDS documents R2 as requiring moderate staff assistance with toileting and supervision with dressing and transfers. R2's Careplan intervention, dated 12/16/24, documents R2 is supposed to have a body pillow provided. R2's Fall Risk Evaluation, dated 12/13/24, documents R2 as a fall risk. R2's Nurse Progress Notes do not document R2's fall on 1/19/25. R2's Fall Investigation, dated 1/19/25, documents R1 had an unwitnessed fall in her room on 1/19/25 at 1:35 PM. This same fall investigation documents R2 obtained a skin tear to her Right Anterior Shin measuring 2.5 centimeters (cm) which produced scant bleeding which required three steri-strips. This same fall investigation documents (R2) must have fallen on her knees when sliding off of her bed. On 1/28/25 at 12:05 PM, R2 was laying in her bed. R2 had her head on the Right side of the bed with her torso pointed towards the left side of the bed and her feet were on the Left corner of the foot of the bed. R2 showed a large yellowing bruise approximately eight inches long and four inches wide just under her Right Knee. R2 had steri-strips just under her Right Knee at the top portion of the large bruise. R2 did not have a body pillow on her bed or within sight in R2's room. On 1/28/25 at 2:52 PM, R2 was laying in her bed with her head in the center of the bed, her knees were bent, and her feet were at the foot of the bed. R2 did not have a body pillow on her bed or within sight in R2's room. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 1/29/25 at 3:00 PM, R2 was laying in her bed, with her head in the center of the bed, with her torso positioned facing the Right side of her bed on the edge of her bed. R2's knees were bent with her feet hanging off the Left side of her bed. R2 did not have a body pillow on her bed or within sight in R2's room. On 1/28/25 at 1:50 PM, V3, Licensed Practical Nurse (LPN), stated R2 is able to answer simple questions, but is not oriented times four. V3, LPN, stated R2 is alert but not able to make complex decisions. 3. R3's undated Face Sheet documents medical diagnoses as Parkinson's Disease, Unsteady on Feet, Anxiety Disorder, and History of Falls. R3's Minimum Data Set (MDS), dated [DATE], documents R3 as moderately cognitively impaired. This same MDS documents R3 requires maximum assistance with bathing, dressing, personal hygiene, bed mobility and is dependent on staff for transfers. R3's Physician Order Sheet (POS), dated January 2025, documents a physician order starting 7/1/24 for Aspirin 325 milligrams (mg) daily with a medical history of Subarachnoid Hemorrhage. R3's Careplan intervention, dated 10/8/24, instructs staff to apply an overlay bolster to R3's bed. R3's careplan intervention, dated 1/20/25, instructs staff to exchange R3's overlay bolster. R3's Careplan intervention, dated 7/1/24, instructs staff R3 is supposed to wear slipper socks at all times. R3's Nurse Progress Note, dated 1/15/25 at 1:09 AM, documents, (R3) yelled 'HELP'. (R3) was found beside his bed, on the floor on his hands and knees. (R3) denied hitting his head. (R3) stated, I was trying to get something. (R3) could not tell what he was trying to get. On 1/29/25 at 9:45 AM, V12, Housekeeping and Laundry Supervisor, stated V12 removed R3's old overlay bolster after R3's fall on 1/15/25 and replaced it with a mattress with bolsters. V12 stated R3's old overlay bolsters were flat making them ineffective. V12 stated R3's overlay bolster should have been changed a long time ago. V13 stated he did not work during the night shift R3 fell , but that he changed the bolsters the next day. On 1/29/25 at 10:09 AM, V13, Licensed Practical Nurse (LPN), stated R3 fell out of his bed on the early morning of 1/15/25. V13 stated R3 has intermittent confusion and seemed to be confused that night. V13 stated she is aware of how to find R3's careplan, but did not look at R3's fall interventions. V13, LPN, stated R3 was not wearing any footwear, including slipper socks at the time of his fall. On 1/28/25 at 12:45 PM, V1, Administrator, stated residents should be offered toileting directly after each meal. V1, Administrator, stated prior to R1's fall on 1/18/25, R1 was able to propel herself in her wheelchair, and now she is not able to do that. V1, Administrator, stated R1 has had a general noticeable decline in her overall functioning since her fall on 1/18/25. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 1/29/25 at 11:30 AM, V2, Director of Nurses/DON, stated staff should offer complete toileting every two hours. V2, DON, stated complete toileting includes assisting the resident to the bathroom, making sure everything that is commonly used is within reach, making sure all of the fall interventions are in place, and ensuring the resident has the room set up to their preferences i.e. pulling the curtain, opening/closing the window, lights on/off, etc. V2, DON, stated R1's fall could have been prevented if staff would have offered toileting to R1 at least every two hours. V2, DON, stated it is the standard of care for residents to be assisted with morning cares including breakfast, and then offered to be toileted when the resident is done eating, not when the all the residents are finished eating. On 1/29/25 at 11:35 AM, V2, Director of Nurses (DON), stated the fall investigations for R1, R2, and R3 do not give enough information about the resident falls. V2, DON, stated there is no way to tell how exactly each resident (R1, R2, R3) fell , what interventions were in place or not. V2 stated R1, R2, and R3's fall interventions were not in place at the time of their falls. V2, DON, stated V2 will reeducate staff on fall interventions, accurate and complete charting, and how to prevent falls in general. The facility policy titled Routine Resident Checks, revised July 2013, documents the facility will provide scheduled toileting, offering repositioning and toileting every two hours, or other interventions to try to improve the individual's continence status.		