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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>145945 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                               | (X3) DATE SURVEY COMPLETED<br><br>08/01/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Imboden Creek Senior Living |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>180 West Imboden<br>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.

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| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>(continued on next page)</p>    |

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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| <p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to provide a dependent resident, at risk for pressure ulcers, timely repositioning and incontinence care to prevent pressure ulcers. R9 is one of 13 residents reviewed for pressure ulcers on the sample list of 16. Findings include:R9's current Diagnoses list documents the following: Dementia in Other Disease Classified Elsewhere, Mild with Other Behavioral Disturbance, and Alzheimer's Disease, Unspecified. R9's Minimum Data Set (MDS), dated [DATE], documents R9 has severe cognitive impairment, is totally dependent on staff for activities of daily living, and is always incontinent of bowel and bladder.R9's same MDS documents R9 is at risk for pressure ulcers, and has the following interventions in place to prevention of skin impairment: Section M - Skin Conditions M1200. Skin and Ulcer/Injury Treatments Check all that apply (the following were marked): A. Pressure reducing device for chair.B. Pressure reducing device for bed.C. Turning/repositioning program.H. Applications of ointments/medications other than to feet. R9's Shower sheet, dated 7/24/25, documents R9 had reddened skin on her coccyx and upper buttocks and required barrier zinc cream, which was applied. On 7/31/25 at 2:15 PM, V15, Certified Nursing Assistant (CNA), stated, I was (R9's) CNA today. (R9) was up for meals and I gave her a shower before breakfast today. I have not done a shower sheet yet, but I gave her a shower. She did not have any skin breakdown. She is scheduled Mondays and Thursday on day shift (for showers). She does not have any new skin issues, or I would have reported it to the nurse after the shower. Her bottom is clear. She lays back down after meals and sleeps. I don't remember what time I checked her last. It was right before lunch, before noon, I think. I did not think she was wet at the time. I did not check her after lunch or reposition her because she was sleeping so well. I am off work now, and need to leave, I can't do her incontinence care before I leave. Next shift will have to do her.On 7/31/25 at 2:20 PM, R9 was lying in bed, asleep, in a back lying position. On 7/31/25 at 3:20 PM, R9 remained in the same back lying position as noted at 2:20 PM. V16 and V28, Certified Nursing Assistants, entered R9's room. V16 approached bedside and asked R9 if she could change her incontinence brief. R9 opened her eyes and smiled. V16 and V28, CNAs, washed their hands and donned gloves. V16 and V28, CNAs, stood on opposite sides of the bed, pulled R9's pants down, and unfastened the tape closure of R9's incontinence brief. R28 tucked R9's brief down between R9's legs. R9s incontinence brief was moderately wet with urine. R9's anterior peri-care was completed using disposable wipes. V28, CNA, stated, She did not flinch, though these wipes are cold. V28 and V16 turned R9 over to a right-side lying position, changing gloves after performing hand hygiene. R9 had deep indentations on her skin from mid-back down to her knees. R9 also had a deep red colored, moist, raw area of skin over her upper inner, right buttock, medial aspect, just distal to the coccyx. The right buttock skin impairment measured approximately one-inch long by two-inches wide. R9 also had skin impairment directly on her protruding coccyx bone, that was deep red in color, un-opened skin, which measured approximately one-inch long by three-inches long. V16 stated, It is obvious (R9) had not been repositioned as often as she should be. V28 agreed and stated, We haven't turned her in the hour and a half we've been here (second shift starts at 2:00 PM). I am guessing, it was quite a while before our shift that she got turned last. These deep indentations in the skin don't come up like that unless a resident has not been moved (repositioned) for several hours. It's been lot more than two hours like we are supposed to. The raw skin areas over the bones weren't there before. That one is even open (points to inner right buttock raw, red skin). This did not happen in two or three hours. We will tell the nurse. V16 and V28 completed peri-care and did not apply barrier protective ointment or cream. R10's (R9's roommate) MDS, dated [DATE],5 documents R10's Brief Interview of Mental Status score as 15 out of a possible 15, indicating no cognitive impairment.On 7/31/25 at 3:45 PM, R10, stated (R9) had a shower this morning, early, before breakfast. I am not sure how often she gets one. We are supposed to get one twice weekly. I get mine, unless I choose not to. I think the staff give (R9) a lot of attention, lately, even by the administrative staff. (R9) has been in with me (roommate) for about two and a half months. I have seen some CNA's (Certified Nursing Assistants) come in and change (R9) often. Those CNAs are the same ones that reposition her frequently. Not all CNA's change or reposition (R9) like they should. She (R9) can't move herself at all. Some days she is in bed all day. I have not smelled any lingering odors in our room. I can't say it's because it doesn't have bad odors, but part of that is me. My nose (smelling ability) doesn't work as good as it used to. On 7/31/25 at 3:50 PM, V13, Licensed Practical Nurse (LPN), stated she has been informed by the CNA's that R9 has new open areas on her buttocks. V13 LPN stated</p> |  |  |

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| <p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>(continued on next page)</p> |

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| <p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to provide timely incontinence care, free of cross contamination for a one (R9) of thirteen-resident reviewed for hygiene needs on the sample list of 16. Findings include: R9's Minimum Data Set, dated [DATE], documents R9 has severe cognitive impairment, is totally dependent on staff for all activities of daily living and is always incontinent of bowel and bladder. R9's Current Physician Order Sheet (POS) and Medication Administration Records (MAR) documents R9 was started on an antibiotic and probiotic for an infection. On 7/23/25 order was received for: Cephalexin Capsule (antibiotic) 500 MG, give 1 capsule by mouth, three times a day every 7 day (s), for infection and Probiotic Oral Tablet (live microorganisms that prevent antibiotic -associated diarrheas), Give 1 unit, by mouth, two times a day every 7 day (s) for infection. R9's Progress Note, dated 7/24/25 at 12:27 PM, documents: Note Text: Urine culture results from 7/21/25: Final equal or &gt;100,000 CFU/ML (Colony-Forming Units per milliliter) Gamma Streptococcus (specific bacteria). Resident already started on Keflex (Cephalexin) 500 mg BID (twice a day) (order on POS documents three times a day) x 7 days. Faxed to MD (Medical Doctor). R9's Nurses Notes, dated 7/24/25 at 2:55 PM, documents the following: Note Text: (V3) NP (Nurse Practitioner) here to see resident. N.O. (New Order) Continue to monitor and treat for UTI (Urinary Tract Infection) at this time. If any other concerns, please notify provider. POA (V11, R9's Power of Attorney/Family Member) Aware. On 8/1/25 at 9:45 AM, V20, Certified Nursing Assistant (CNA), and V19, CNA, gathered supplies and took the full-body mechanical lift down to R9's room. V20, CNA, stated, I am running late with (R9's) care, and her breakfast this morning. V20 stated she came in at 6:00 AM to work and has not changed or repositioned R9. V20 stated V20, CNA, was running late because The guy (R5) across the hall needed me about 50 times. He is the sweetest. I think he is just not feeling good. I was busy and she (R9) was asleep, so I did not wake her up to reposition or check her to see if she was wet. V19 and V20, CNA's, performed hand hygiene and donned gloves. V19 and V20 were standing on opposite sides of R9's bed. Both V19 and V20 unfastened the side adhesive tape of R9's wet incontinence brief and tucked it down between R9's legs. R19 and R20 continued with the same soiled gloves. V19 held R9's hand and talked to R9 while V20 picked up a washcloth with her contaminated gloves and wiped R9's bilateral eyes repeatedly, to remove the crusted debris from R9's eye lashes. V20, CNA, then using the same contaminated gloves and area of the washcloth, cleansed the sides of R9's dried green debris from the sides of R9's mouth. V20, CNA, left the bedside with the same contaminated gloves and went over to the bathroom, opened the door with the contaminated gloves and looked into the bathroom for an additional washcloth. V20 then went to the dresser under the TV and opened the top drawer and removed a washcloth with the same contaminated gloves. V20 returned to the bedside and completed anterior peri-care with the same contaminated gloves. V19 and V20 positioned R9 in a right-side lying position. R9's incontinence brief was soiled with a large amount of urine. R9's brief had dark yellow and brown edged urine-like rings, and light-yellow urine-like ring, surrounding the darker yellow dried like urine. V19 and V20 stated they did not hear anything from night CNA's about when R9 was last changed. Often night staff just leaves when they see day shift come in, and don't give report. R9 had a waterproof-like wound dressings on her coccyx. R9's back, upper thighs, and bilateral buttocks had deep indentations in the skin. V20 completed R9's incontinence care and removed the soiled gloves and washed her hands. V19 also removed her gloves and washed her hands after re-dressing R9. On 8/01/25 at 10:05 AM, V20, CNA, stated, I know what I am doing. I give incontinence care all day long. I was just nervous being watched by you. I always wash my hands and use clean gloves when I do all my care. That is all I can really say. I was nervous. On 08/01/25 at 1:45 PM, V2, Regional RN, stated, The cross contamination during (R9's) incontinence care should have never happened. The CNAs are expected to use proper technique, hand hygiene and universal precautions when performing anyone's hygiene and incontinence care.</p> |  |  |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on observation, interview, and record review, the facility failed to supervise medication administration for one resident (R11) of two residents reviewed for supervision of medication administration in the sample list of 15. Findings:On 7/24/25 at 10:51 AM, surveyor went into R11's room to interview the roommate, R3, who was not present. A medication cup with medications in it was observed at R11's bedside full of 17 medications. R11 would not wake up when spoke R11's name. V1, Administrator, immediately came into R11's room to see the medication cup with medications at R11's bedside. At 10:58 AM, V1 stated the medications should have been taken by R11 with the nurse present and if the resident was asleep, V3, Licensed Practical Nurse (LPN), should not have left the medications at bedside.On 7/24/25 at 10:59 AM, V3, LPN, came to R11's room and woke R11 up to take the medications setting at bedside. V3 stated normally R3 takes the medications on his own but does not have an order stating that medications may be left at bedside. V3 stated, We're not supposed to leave medications at bedside per our policy, and we are to watch the resident take the medications.On 7/24/25 at 11:10 AM, R11 stated this nurse, V3, LPN, has left his medications at bedside for him to take without V3 being present.Medications in the medication cup include: Amiodarone Hydrogen Chloride tablet 200 milligrams, one tablet by mouth one time a day; Amlodipine Besylate tablet five milligrams one tablet one time a day; Aspirin 81 milligrams one tablet delayed release give one tablet by mouth one time a day; B-Complex oral tablet 600 micrograms by mouth one time a day; Biotin oral tablet three milligrams one tablet by mouth one time a day; Duloxetine Hydrogen Chloride capsule delayed release particles 30 milligrams give one capsule by mouth one time a day; Ferrous Sulfate tablet 324 milligrams give one tablet by mouth one time a day; Folic Acid one milligram oral tablet one time a day; Losartan Potassium oral tablet 25 milligrams give one tablet by mouth one time a day; Multivitamin adults 50+ tablet one tablet by mouth one time a day; Protonix tablet delayed release 40 milligrams one tablet by mouth one time a day; Torsemide oral tablet 100 milligrams one tablet by mouth one time a day; Vitamin D3 oral tablet 125 micrograms one tablet by mouth one time a day; Apixaban oral tablet five milligrams one tablet by mouth two times a day; Carvedilol oral tablet 25 milligrams one tablet by mouth two times a day; Doxycycline Hyclate oral tablet 100 milligrams one tablet by mouth two times a day; and Lubiprostone oral capsule eight micrograms one capsule by mouth two times a day.The facility's Administering Medications Policy, dated Revised April 2019, documents medications are administered in a safe and timely manner; medications are administered within one hour of their prescribed times; if a drug is given at a time other than scheduled, the person administering the medication shall document such in the space provided for that drug and dose; and a resident may self-administer their own medications only if the Attending Physician has determined that the resident has the decision-making ability to do so safely.</p> |  |  |

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| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interviews, the facility failed to maintain complete and accurate medical records for one (R9) of 14 residents reviewed for medical records on the sample list of 16. Findings include: R9's current Diagnoses list documents the following: Dementia in Other Disease Classified Elsewhere, Mild with Other Behavioral Disturbance, and Alzheimer's Disease, Unspecified. R9's Diagnosis list does not document a diagnosis of Psychosis. R9's historic Psychiatric Evaluation, dated 9/7/23, documents R9 had Psychosis, and Irritable/Frequent Anger when Risperdal Antipsychotic medication was originally ordered. R9's Minimum Data Set, dated [DATE], documents: Did the resident receive antipsychotic medications since admission/entry or reentry or the prior OBRA assessment, whichever is more recent? Yes - Antipsychotics were received on a routine basis only. R9's current Physician Order documents the following: Risperdal (anti-psychotic medication) oral tablet, give 0.25 mg (milligrams) by mouth in the morning for Prophylaxis (to prevent a disease process), (inaccurate diagnosis documented). Start date 9/19/24. R9's current Medication Administration Record (MAR) documents the following: Monitor for the following behaviors: itching, picking at skin, restlessness, agitation, hitting, increase in complaints, biting, kicking, spitting, foul language, elopement, stealing, delusions, hallucinations, psychosis, aggression, refusal of care every shift. Document: 'Y' if monitored and none of the above observed. 'N' if monitored and any of the above was observed, select 'N' if monitored and any of the above was observed, select chart code 'Other/ See Nurses Notes' and progress note findings. -Start Date 1/22/2024. R9's same MAR documents nurses initial to indicate the monitoring occurred the full month of July 2025 (31 days at three shifts per day, 93 incomplete documentation errors). The nurses did not document Y or N and did not document any behaviors in the corresponding nurses note. On 7/31/25 at 12:10 PM, V2, Regional Registered Nurse, confirmed R9's medical records were inaccurate and incomplete as documented above. V2 also stated she will be educating the nurses on accurate and complete documentation in residents medical records. The facility policy Charting and documentations revised July 2017 documents the following 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.</p> |