

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  09/05/2025
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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>Based on interview and record review, the facility failed to notify a family member of an accident for one of three residents (R1) reviewed for resident injury in the sample list of 12. Findings include:R1's undated Diagnoses list includes fracture of other parts of the pelvis, subsequent encounter for fracture with routine healing, Chronic Pain due to trauma, other reduced mobility, unspecified abnormalities of Gait and Mobility, and unsteadiness on feet.R1's Care Plan dated 10/15/24, documents impaired cognitive function or impaired thought processes, impaired decision-making, long-term memory loss, short term memory loss related to age, history of falling, and decreased mobility with an intervention for an alarm when R1 is in the chair related to impulsivity. R1's Fall Risk Evaluation dated 6/13/25, documents R1 is at risk for falls due to intermittent confusion, being chair bound, and requiring use of assistive devices.On 9/3/25 at 9:30 AM V1 Administrator stated on 8/26/25 R1 was observed on the floor on R1's buttocks. V1 stated V3 Licensed Practical Nurse (LPN) found R1 as V3 was walking by and heard yelling so V3 told V4 LPN and V5 Certified Nursing Assistant (CNA). V1 stated R1 had a bruise to her right temple and right arm and a small bruise on her left forearm. V1 stated the family was not notified at that time. On 9/4/25 at 11:15 AM, V4 LPN stated V4 got to the facility around 2:15 PM. V4 stated when V4 walked in she punched the time clock, and another nurse V3 LPN was yelling that R1 was on the floor. V4 stated V4 told another nurse V7 LPN that V4 would go check on R1 for V7. V4 stated V5 CNA came in the room also and R1 was sitting on her buttocks right in front of her wheelchair. V4 stated R1 likes to transfer herself and it looked like that's what R1 was trying to do. V4 stated R1 did not remember what happened when asked. V4 stated V4 did an assessment on R1 and took R1's vital signs. V4 stated she gave R1's vital signs to V7 on a piece of paper but was unsure if V7 actually got the vital signs. V4 stated she did not document any assessment, vital signs, or any information about R1's fall and did not contact R1's family, V1 Administrator or V2 Director of Nurses. V4 stated V4 knows she is supposed to call the family and tell V1 Administrator. V4 stated V4 thought V7 was doing to do all that. V4 stated V7 did not go down to the room where R1 was found.The facility's Accidents and Incidents (WLC) - Investigation and Reporting policy dated Revised July 2017, directs staff to document the date and time resident's family member is notified of an accident.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 145945
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to protect the resident's right to be free from physical abuse for one (R3) resident of three residents reviewed for abuse in a sample list of 12. Findings include: The facility's Initial Report, dated 8/2/25, documents R2 and R3 made unwanted contact with one another. R2 yelled at R3 stating she stole my fan, I'm going to knock her head off as the reason for R2 making the unwanted contact with R3. This report also documents the resident (R3) was struck with an open hand in a smacking motion by R2. R2's undated Diagnoses include anxiety disorder, unspecified; Restlessness and Agitation; and Mild Cognitive Impairment of uncertain or unknown etiology. R2's Care Plan, dated 8/10/24, documents R2 has the potential to demonstrate verbally abusive behaviors Poor impulse control Verbal aggression towards staff and roommate, behavior problem with roommate and potential to demonstrate physical behaviors, Dementia, poor impulse control, and anger. R2's Minimum Data Set (MDS), dated [DATE], documents R2 is cognitively intact. R3's undated diagnoses list documents R3's diagnoses as Cognitive Communication Deficit, general anxiety disorder, unspecified Dementia with unspecified severity without Behavioral Disturbances, Psychotic Disturbances, Mood Disturbances, and Major Depressive Disorder. R3's Care Plan, dated 12/15/24, documents R3 as having Impaired Cognitive function related to Dementia, Communication Problem related to Dementia, Impaired Visual Function, Behavior problems, and Major Depression. On 9/3/25 at 2:53 PM, V6, Certified Nursing Assistant/CNA, stated both R2 and R3 were sitting in their wheelchairs at the nurse's station and R2 started yelling at R3 that R3 took R2's fan. V6 stated, As we were backing (R3) up away from (R2), (R2) reached over and hit (R3) on the shoulder two times with an open hand. On 9/4/25 at 11:43 AM, V3, Licensed Practical Nurse/LPN, stated the incident between R2 and R3 happened after dinner. V3 stated R2 was having a bad day. V3 stated she heard R2 say you stole my fan to R3. V3 stated a CNA (unknown) went to pull R2 away from R3 (both in wheelchairs), and R2 made a motion with her arm/hand like R2 was going hit R3 and R2's fingertips grazed R3's shoulder. V3 stated R2 had an open hand, but only her fingertips grazed R3. V3 stated R3 asked what happened because R2 was yelling at R3 and R3 said what did I do wrong? V3 stated R2 can get agitated and yell. V3 stated R2 and R3 were once in a room together but R3 was moved to another room because R2 would yell at R3. The facility's Abuse Policy, dated 8/16/19, documents the facility affirms the right of the residents to be free from abuse and therefore prohibits abuse of the residents and has attempted to establish a resident sensitive and resident secure environment. This same policy also documents the facility is committed to protecting the residents from abuse by anyone including other residents.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>Based on interview and record review, the facility failed to timely review and revise comprehensive care plans. This failure affects three residents (R1, R2, R3) of three residents reviewed for care plans in the sample list of 12 residents. Findings include: R1's most current Care Plan is dated 11/9/24. R2's most current Care Plan is dated 9/16/24, and R3's most current Care Plan is dated 12/15/24. On 9/4/24 at 10:49 AM, V1 Administrator stated, we don't have anyone at this facility doing care plans, it's all done at the corporate level. The facility's policy Care Plans, Comprehensive Person-Centered dated Revised December 2016, documents their policy is a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each of the residents. This same policy documents the care plan will identify problem areas and their causes and develop interventions that are targeted and meaningful to the residents. This same policy documents the Interdisciplinary Team must review and update the care plan when there has been a significant change, when the desired outcome is not met, and at least quarterly in conjunction with the required quarterly Minimum Data Set (MDS) assessment.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to implement a fall intervention for one resident (R1) of three residents reviewed for resident injury in the sample list of 12. Findings include: R1's undated Diagnoses list includes fracture of other parts of the pelvis, subsequent encounter for fracture with routine healing, Chronic Pain due to trauma, other reduced mobility, unspecified abnormalities of Gait and Mobility, and unsteadiness on feet. R1's Care Plan, dated 10/15/24, documents impaired cognitive function or impaired thought processes, impaired decision-making, long-term memory loss, short term memory loss related to age, history of falling, and decreased mobility with an intervention for an alarm when in the chair related to impulsivity. R1's Fall Risk Evaluation, dated 6/13/25, documents R1 is at risk for falls due to intermittent confusion, being chair bound, and requiring use of assistive devices. Throughout the survey, on 9/3/24, 9/4/25, and 9/5/25, there was no alarm present in R1's wheelchair while R1 was present in the wheelchair. On 9/3/25 at 10:30 AM, R1 stated once in a great while, she will try to transfer by herself. R1 stated she has lost count of how many times she has fallen recently. At this same time, R1 was observed to have faded bruising on right and left arms and right temple, and no alarm was present in R1's wheelchair. On 9/5/25 at 10:45 AM, V3, Licensed Practical Nurse, stated R1's Care Plan documents R1 should have a chair alarm. V3 stated, I need to get an alarm. On 9/3/25 at 11:22 AM, V5, Certified Nurse Aide, stated R1 uses a bed alarm and chair alarm, and everyone tries to look out for R1 because she goes all over the place in her wheelchair, and she tries to transfer herself all day, every day.</p>