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	09/17/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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

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	09/17/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to assess wounds/skin and complete wound treatments for two of three residents (R1, R2) reviewed for pressure sores in the sample of five residents. Findings include: The Prevention of Pressure Ulcers/Injuries policy, revision date July 2017, documents, Assess the resident on admission (within eight hours) for existing pressure ulcer/injury risk factors. Repeat the risk assessment weekly and upon any changes in condition. Conduct a comprehensive skin assessment upon admission, including: a. Skin integrity - any evidence of existing or developing pressure ulcers or injuries; Tissue tolerance -the ability of the skin (and supporting structures) to endure the effects of pressure. Treatments/Wound Care policy, dated October 2010, documents treatment/wound care is to be done according to the physician order. On 09/16/25 at 2:30pm, R1's posterior right upper buttock unstageable deep tissue injury (pressure ulcer) wound care was completed by V3, Corporate Nurse, and V7, Licensed Practical Nurse (LPN). The wound had full-thickness tissue loss with muscle and bone exposed and can be directly seen. The wound bed contained a large amount of slough and undermining. R1 complained of pain while V7 was packing the undermining with gauze. R1's undated care plan documents an admission date of 8/8/25, with diagnoses of Fracture of Lower End Of Right Femur, Presence Of Right Artificial Hip Joint, Spondylosis With Radiculopathy, Cervical Region, and Wedge Compression Fracture Of Third Lumbar Vertebra. On 09/11/25, R1's record review does not contain an admission skin or wound assessment, nor any weekly skin or wound assessments conducted by facility staff. Hospice admission Documents, dated 09/11/25 at 12:10pm, contain an admission note written on 8/9/25 documenting a surgical wound to the right hip as R1's only wound. Hospice Wound Record Report, dated 09/11/25 at 12:10pm, by V6, Hospice Nurse, documents on 8/9/25 at 5:26pm there is only a closed surgical wound to R1's right thigh. R1's Hospice Wound Record Report, dated 09/11/25 at 12:10pm, documents on 8/8/25 a proximal right thigh surgical incision. The same report documents on 8/23/25 a posterior right upper buttock unstageable deep tissue injury (pressure ulcer) for R1. R1's Hospice Wound Record Report, dated 09/11/25 at 12:10pm, by V6, Hospice Nurse, documents on 8/25/25 at 1:37pm the Right buttock deep tissue injury measures 10cm (centimeters) length, 11cm wide and 2cm deep and on 09/02/25 R1's wound measures 12cmx10.5cmx2cm indicating a change in size. R1's September 2025 Treatment Administration Record documents treatments to the posterior right buttock deep tissue injury were not completed on September 4,8,9,11, and 13.On 09/16/25 at 09:43am V4, R1's family, stated R1 was sent to the hospital after a fall at the assisted living facility and when R1 admitted to the facility R1 only had a surgical wound on the right hip. V4 stated R1 has a large open wound on the back of R1's leg/buttocks, and the facility is not completing wound care very well. V4 stated during visits the dressing on R1's wound would have an old dressing. V4 stated the dressing would be dated a day or two before the visit. On 9/16/25 at 2:30pm, V2, Director of Nursing/DON confirmed there is no admission assessment performed by facility nurses on admission for R1, and the treatment administration record for September 2025 documents the treatments were not completed as ordered by the physician. V2 stated nurses are to perform the wound treatments according to physician orders, and if wound treatments are not completed as ordered, the wound would worsen and likely become infected causing the wound to take longer to heal. On 9/17/25 at 11:30am V6, Hospice Nurse, confirmed the hospice documentation does not document a pressure ulcer wound on R1 at time of admission. 2.R2's undated care plan documents an admission date of 12/20/2024, with diagnoses of Parkinson's Disease Without Dyskinesia, Unsteadiness On Feet, Other Symptoms and Signs Involving the Musculoskeletal System, History Of Malignant Neoplasm Of Ovary, Acute Kidney Failure and Dementia. R2's September 2025 Treatment Administration Record documents a physician order for wound/pressure ulcer treatment dated 08/26/2025. The same document documents the physician order of cleanse sacral wound with normal saline. Pack gauze soaked in quarter strength bleach water into wound with cotton tipped applicator. Cover with ABD (gauze) pad. Change dressing two times a day (8am and 8pm) for Wound Care for 24 days. This same document documents on September 2,3,4,5,8,9,11,13,14 the 8am treatment was not completed and September 12 the 8pm treatment was not completed. On 09/15/25, R2's medical record documents R2's last skin/wound assessment as completed on 7/28/25. On 09/16/25 at 11:30am, R2's sacral unstageable deep tissue injury (pressure ulcer) wound care was performed by V3, Corporate Nurse, and V7, Licensed Practical Nurse (LPN). The wound had full-thickness tissue loss with muscle exposed and can be directly seen. The wound bed and edges are red and inflamed. V7 used bleach solution soaked gauze to pack the undermining around the wound edges