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	11/06/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to timely notify the physician of a resident fall for one of four residents (R9) reviewed for falls in the sample list of eleven residents. R9's Nurse Progress Note dated 10/18/25 at 5:10 AM documents R9 was found on the floor. This same note documents staff assessed R9 with no injuries and R9 denied pain. This same note documents staff assisted R9 back to bed and then informed V33 Licensed Practical Nurse (LPN), R9's nurse. This same note documents V33 LPN then assessed R9 in her room with no findings and no obvious injuries.R9's Progress Note dated 10/18/25 at 7:14 AM documents R9 had swelling to her Right Leg from Hip to Knee noted when staff assisted R9 to get dressed for the day. This same note documents R9 had swelling noted to Right Knee, Right Femur, pain noted when Right Leg/Right Hip moved, no redness or warmth noted to Right Leg, pain noted with touch as well.R9's Progress Note dated 10/18/25 at 5:53 PM documents R9 was sent to the emergency room to be evaluated for pain and swelling to her Right Leg.R9's Femur X-Ray report dated 10/18/25 documents impression of acute, displaced fracture of the distal Femoral shaft. This same report documents there is an acute oblique fracture of the distal Femoral Diaphysis.On 11/4/25 at 12:30 PM V17 Licensed Practical Nurse (LPN) stated she was R9's nurse on 10/18/25. V17 LPN stated she did not get a verbal report from V33 LPN (Night Shift Nurse) that morning because V33 LPN left early. V17 LPN stated V33 LPN had written down on a piece of paper her report to pass to V17 LPN. V17 LPN stated she had no idea that R9 had fallen earlier that morning. V17 LPN stated V29 CNA came to inform her around 7:15 AM that R9's Right Leg was swollen and R9 was complaining of pain. V17 LPN stated she assessed R9 to find that R9 was complaining of Right Leg/Right Knee pain. V17 LPN stated R9's Right Knee was slightly more pink and swollen than her Left Knee. V17 LPN stated there was no bruising or obvious deformity to R9's Right Leg. V17 LPN stated she administered Acetaminophen for pain and applied an ice pack to R9's Right Knee to reduce the swelling. V17 LPN stated she contacted V19 Physician. V17 LPN stated she tried to find out what had happened to R9's knee because she was never informed that R9 had an unwitnessed fall. On 11/4/25 at 2:10 PM a voicemail message was left for V33 LPN to call for interview. No response received. On 11/5/25 at 2:00 PM V2 Director of Nurses (DON) stated V33 LPN did not report R9's unwitnessed fall to the next shift, nursing management, V19 Physician nor V40 (R9's) Power of Attorney (POA). V2 DON stated R9's unwitnessed fall should have been reported to all of the necessary people and was not.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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Imboden Creek Senior Living	180 West Imboden Decatur, IL 62521

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an undisturbed environment following the death of a resident prior to the arrival of the coroner for one of six residents (R1) reviewed for death in the sample list of eleven residents.Findings include: R1's Electronic Medical Record (EMR) documents R1 passed away at the facility on [DATE]. The facility video camera footage of R1's room door showed V8, V10, V21, and V26, Certified Nurse Aides (CNAs), in R1's room following her death at 9:45 AM and prior to V6, Coroner, arriving at the facility. This same camera footage shows V6, Coroner, entering R1's room at 10:36 AM and exiting at 10:44 AM. On [DATE] at 11:30 AM during observation of facility camera footage, V1, Administrator, stated the staff (V8, V10, V21, V26) CNAs were providing post-mortem care and transferring R1's body from the floor back to her bed using a total body mechanical lift. On [DATE] at 12:00 PM, V8, Certified Nurse Aide (CNA), stated V8, V10, V21, and V26, CNAs, provided post-mortem care and transferred R1 from the floor back to her bed after her death. V8, CNA, stated no one told them (V8, V10, V21, V26) not to mess with R1's body or environment. On [DATE] at 12:10 PM, V21, Certified Nurse Aide, stated V8, V10, V21, and V26, CNAs, provided post-mortem care and transferred R1 from the floor back to her bed after her death. V21, CNA, stated all four CNAs (V8, V10, V21, V26) used a total body mechanical lift to move R1's body after she passed away from the floor to the bed. V21, CNA, stated V3, R1's family, asked the staff to get (R1) cleaned up, so the staff abided. V21, CNA, stated if they (V8, V10, V21, V26) had known to not touch R1's body or environment, they would not have messed with anything.On [DATE] at 12:15 PM, V14, Licensed Practical Nurse (LPN), stated V14 called Emergency Medical Services (EMS) and the Coroner's office for R1 on [DATE]. V14, LPN, stated she did not speak to V6, Coroner, directly, but did speak with the Coroner's office receptionist. V14, LPN, stated she did not remember if she was instructed not to touch R1's body/environment, but was told V6 would either call or come to the facility. V14, LPN, stated normally if V6, Coroner, has to release the resident's body to the funeral home, and if there is any question, then V6, Coroner, comes to the facility. V14, LPN, stated the staff should not touch the resident's body or environment until the Coroner says it is ok to do so. On [DATE] at 3:25 PM, V6, Coroner, stated he received a call from the facility on [DATE], informing him of R1's death. V6 stated V6 arrived at the facility and was able to view R1's body. V6 stated he took pictures of R1's body, which is part of the normal procedure. V6 Coroner stated R1 was laying on her bed with clean sheets. V6 stated the sheet was covering R1's body up to her shoulders with her head/neck area outside of the sheet. V6, Coroner, stated the room was clean with no medical supplies present. V6, Coroner, stated he was not told by the facility that emergency services were present, that Cardiopulmonary Resuscitation (CPR) was not provided by the facility or the EMS, or that R1 had chosen to be a Full Code. V6, Coroner, stated the facility was told by V6 on the phone that V6 would be out to investigate R1's death. V6 Coroner stated, In a case like this, (R1's) body and the environment (R1) expired in should be left untouched. It is considered a possible crime scene, and no one should tamper with any part of it. V6 stated the facility should not have tampered with R1's body after she expired on [DATE] at 9:45 AM. On [DATE] at 1:00 PM, V1 stated the facility does not have a policy for when staff provide post-mortem care when a resident is considered a Coroner case, but the expectation is for staff to abide by the standard of care. V1, Administrator, stated she will be in-servicing the staff on when to provide post-mortem care.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide emergency response resuscitative efforts timely, resulting in a ten-minute delay in life saving services for one (R1) resident out of six residents reviewed for Death in a sample list of eleven residents. On [DATE], R1 was confirmed to be without signs of life ten minutes prior to the initiation of Cardiopulmonary Resuscitation (CPR). R1 subsequently expired at the facility on [DATE] at 9:45 am.Findings include:The Immediate Jeopardy began on [DATE] when facility staff noted R1 to be without signs of life and did not initiate CPR (Cardiopulmonary Resuscitation). V1, Administrator,was notified of the Immediate Jeopardy on [DATE]/25 at 4:27 PM. The surveyor confirmed by observation, interview, and record review, the Immediate Jeopardy was removed on [DATE], but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. R1's Electronic Medical Record (EMR) documents R1 admitted to the facility on [DATE], with medical diagnoses of Sepsis, Chronic Obstructive Pulmonary Disease (COPD), Atrial Fibrillation, Acute on Chronic Diastolic Heart Failure, Chronic Respiratory Failure, Muscle Weakness, Unsteady on Feet, Hepatic Encephalopathy, Morbid Obesity, Cirrhosis of Liver, Diabetes Mellitus Type II, Depression, Gastroesophageal Reflux Disease (GERD), Chronic Fatigue, Lymphedema, Acute Kidney Failure, Hypertension and Acute Respiratory Failure with Hypoxia. This same EMR documents R1 chose to have full resuscitative efforts performed in case of emergency (Full Code) upon admission on [DATE]. R1's Brief Interview for Mental Status, dated [DATE], documents R1 as cognitively intact.R1's Minimum Data Set (MDS), dated [DATE], documents R1 requires maximum assistance from staff for personal hygiene, and R1 is dependent on staff for eating, oral hygiene, dressing, bathing, toileting, transfers, and bed mobility. R1's Care Plan, initiated [DATE], documents R1 chose to be resuscitated in case of emergency (Full Code). R1's Physician Order Sheet (POS), dated [DATE], documents a physician order starting [DATE], with no end date, for R1 to be a Full Code (be resuscitated in case of emergency). R1's POS, dated [DATE], documents an order, dated [DATE] with no end date, to obtain blood glucose levels before meals and at bedtime. R1's October Medication Administration Record (MAR) documents R1's blood glucose and sliding scale Insulin is scheduled at 7:00 AM, 11:00 AM, 4:00 PM and 9:00 PM. This same MAR documents R1's [DATE] 7:00 AM blood glucose result was '0'. R1's POS, dated [DATE], documents and order, dated [DATE] with no end date, to administer Humalog (Insulin) subcutaneously per sliding scale for blood glucose of 150 - 199 = 2 units; 200 - 249 = 4 units; 250 - 299 = 6 units; 300 - 349 = 8 units; 350 - 400 = 0 units Above 350 CALL PCP; 401 - 450 = 0 Above 400 call PCP, subcutaneously before meals and at bedtime for diabetes. R1's [DATE] MAR documents R1's [DATE] 7:00 AM sliding scale insulin administration was 'Not Applicable (NA).'R1's POS, dated [DATE], documents an order, dated [DATE] with no end date, to administer Tramadol 50 milligrams (mg) every six hours for pain. R1's [DATE] MAR documents R1's [DATE] 12:00 AM and 6:00 AM scheduled Tramadol was marked as refused.R1's Nurse Progress Notes, dated [DATE], documents at 9:05 AM, Upon entering (R1's) room to administer scheduled medications and check blood glucose, (R1) was found unresponsive. Staff (V8, V10, Certified Nursing Assistants (CNA)) were attempting to provide care on (R1). Immediate assessment revealed no pulse, no oxygen saturation, no blood sugar and no measurable blood pressure. According to (R1's) Electronic Health Record (EHR), (R1) is a full code. (V2) Director of Nurses (DON) and V4, Licensed Practical Nurse (LPN), were notified without delay. (V14) alerted Emergency Medical Service (EMS). CPR was initiated promptly by (V2) DON. EMS arrived and took over resuscitative efforts at approximately 9:20 AM. Despite continued efforts, EMS was unable to revive (R1). Time of death was confirmed by EMS at 9:45 AM.R1's Progress Note, dated [DATE] at 10:00 AM, documents Coroner's office notified of (R1's) death. V6, Coroner, stated V6 will call back or come out to the facility.R1's Progress Note, dated [DATE] at 10:29 AM, documents V6, Coroner, was at the facility and profile paperwork given to V6, Coroner.R1's Progress Note dated [DATE] at 12:23 PM, documents, (R1's) Funeral home here and (R1's) body was released to them.On [DATE] at 9:00 AM, V2, Director of Nurses (DON), stated R1 had not been 'feeling well' for two days prior to [DATE]. V2, DON, stated R1 was sent to the hospital on [DATE], and returned to the facility the same day with no new orders. R1 had previously chosen to be resuscitated in case of emergency. V2, DON, stated the evening of [DATE], R1 was asking staff to crawl on the floor to check on the kids. This was abnormal behavior for R1. The morning of [DATE], V5, Licensed Practical Nurse (LPN), asked V2, DON, to check on R1. V2, DON, stated she walked in R1's room at 9:10 AM to see that V8 and

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview, and record review, the facility failed to complete a thorough fall investigation, complete post fall neurological assessments, properly transfer a resident after a fall, and implement fall interventions for four of four residents (R2, R4, R5, R9) reviewed for accidents in the sample list of eleven. Findings include: 1.R9's Electronic Medical Record (EMR) documents medical diagnoses as Right Femur Fracture, Cerebral Ischemia, Dementia, Lack of Coordination, Dysphagia, Anxiety, Sleep Disorder, Cognitive Communication Deficit, Cerebral Infarction, Systolic and Diastolic Heart Failure, History of Falling, Scoliosis, Atrial Fibrillation, and Lymphedema. R9's Minimum Data Set (MDS), dated [DATE], documents R9 as severely cognitively impaired. This same MDS documents R9 was dependent on staff for assistance with eating, oral hygiene, toileting, bathing, dressing, personal hygiene, bed mobility and transfers. R9's Care Plan documents a fall intervention, dated 8/6/24, which instructs staff to complete Neurological Assessments after a fall per policy. R9's Fall Risk Assessment, dated 8/12/25, documents R9 as being at risk for falling. R9's Mobility Assessment, dated 10/20/25, documents R9 requires a total body mechanical lift for transfers. R9's Nurse Progress Note, dated 10/18/25 at 5:10 AM, documents R9 was found on the floor. This same note documents staff assessed R9 with no injuries and denied pain. This same note documents staff assisted R9 back to bed and then informed V33, Licensed Practical Nurse (LPN), R9's nurse. This same note documents V33, LPN, then assessed R9 in her room with no findings and no obvious injuries. R9's Neurological Assessment, dated 10/18/25 at 5:30 AM ,documents R9's initial Neurological Assessment. The facility is unable to provide any further Neurological Assessments for R9. R9's Nurse Progress Note, dated 10/18/25 at 7:14 AM, documents R9 had swelling to her Right Leg from Hip to Knee noted when staff assisted R9 to get dressed for the day. This same note documents R9 had swelling noted to Right Knee, Right Femur, pain noted when Right Leg/Right Hip moved, no redness or warmth noted to Right Leg, pain noted with touch as well. R9's Nurse Progress Note, dated 10/18/25 at 12:45 PM, documents R9 was administered Acetaminophen for pain, ice pack applied 15 minutes at a time. This same note documents R9's swelling continues and R9 had remained in bed. This same note documents pain controlled if staff doesn't move (R9) too much. The Progress Note, dated 10/18/25 at 5:53 PM, documents R9 was sent to the emergency room to be evaluated for pain and swelling to her Right Leg. (continued on next page)

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(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 - Minimal harm or potential for actual harm Residents Affected - Some	R9's Femur X-Ray report, dated 10/18/25, documents impression of acute, displaced fracture of the distal Femoral shaft. This same report documents there is an acute oblique fracture of the distal Femoral Diaphysis. On 11/4/25 at 12:15 PM, V29, Certified Nurse Aide (CNA), stated the morning of 10/18/25, she did not get a report from the night shift staff for R9. V29, CNA, stated she entered R9's room around 7:00 AM to find that R9's Right Leg was swollen and R9 was complaining of it hurting. V29 stated she notified V17, Licensed Practical Nurse (LPN), of R9's complaint of pain and swollen Right Leg. V29, CNA, stated R9 stayed in bed all day due to R9 complaining of pain in her Right Leg and not feeling well. On 11/4/25 at 12:30 PM, V17, Licensed Practical Nurse (LPN), stated she was R9's nurse on 10/18/25. V17, LPN, stated she did not get a verbal report from V33, LPN, that morning because V33, LPN, left early. V17, LPN, stated V33, LPN, had written down on a piece of paper her report to pass to V17, LPN. V17, LPN, stated she had no idea that R9 had fallen earlier that morning. V29, CNA, came to inform her around 7:15 AM that R9's Right Leg was swollen and R9 was complaining of pain. Dhe assessed R9 to find that R9 was complaining of Right Leg/Right Knee pain. V17, LPN, stated R9's Right Knee was slightly [NAME] and more swollen than her Left Knee. V17, LPN, stated there was no bruising or obvious deformity to R9's Right Leg. V17, LPN, stated she administered Acetaminophen for pain and applied an ice pack to R9's Right Knee to reduce the swelling. She contacted V19, Physician, who ordered a stat portable X-Ray. V17, LPN, stated the portable X-Ray company returned her call stating they would not be able to come to the facility on [DATE]. V17, LPN, stated she then called V19, Physician, back who then gave an order for R9 to be sent to the emergency room to be evaluated for pain. On 11/4/25 at 2:10 PM, a voicemail message was left for V33, LPN, to call for interview. No response received. On 11/4/25 at 2:15 PM, V35, Certified Nurse Aide (CNA), stated the night of 10/17/25 into the morning of 10/18/25, the facility did not have an assigned CNA to R9's hallway. V35 stated there are four resident halls in the facility and that night there were three CNAs, so each CNA was assigned a hall and R9's hall did not have any CNA, except for every two-hour rounding. V35, CNA, stated on 10/18/25 at about 5:10 AM, V12, CNA, yelled out for help due to V12, CNA, had seen that R9 was on the floor. V35, CNA, stated V35, CNA, and V34, LPN, entered R9's room to find that R9 was sitting on the floor next to her bed with R9's Left Elbow resting on her bed. V35, CNA, stated V34, LPN, did a quick assessment on R9, and then V35, CNA, and V34, LPN, arm and legged (R9) back to bed. V35, CNA, described 'arm and legged' as V34, LPN, was behind R9 with V34's arms under R9's shoulders/armpits and V35 faced R9 as she picked up R9's legs. V35, CNA, stated V34, LPN, and V35, CNA ,then proceeded to pick up R9 and place her back in her bed. V35, CNA, stated normally staff would transfer a resident from the floor to their bed using a total body mechanical lift. V35, CNA, stated, I just followed (V34) LPN. We (V34, LPN, V35, CNA) should have used a total body mechanical lift. V35, CNA, stated a resident could get hurt if not transferred properly. V35, CNA, stated R9 was not complaining of pain after her fall but sometimes injuries don't show up for a while. V35, CNA, stated she saw V34, LPN, tell V33, LPN, (R9's) assigned nurse, that R9 had fallen and was put back in bed. V35, CNA, stated she did not realize R9 could get up by herself. V35, CNA, stated she was not very familiar with R9 and had only seen R9 in bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/6/25 at 4:30 AM, V12, Certified Nurse Aide (CNA), stated V12, CNA, was assisting another resident on R9's hall when she heard someone yelling 'Help!' and 'Help me!'. V12, CNA, stated she went to investigate where the yelling was coming from and found R9 sitting on the floor next to her bed with her back leaning against the bed, facing the window and her Left Foot tucked underneath her Right Leg. V12, CNA, stated she was the first person to know R9 had fallen out of bed and then she hollered out for help. V12, CNA, stated no one asked her what happened or asked her to fill out a witness statement for R9's fall. On 11/4/25 at 2:45 PM, V1, Administrator, stated staff should use a total body mechanical lift when transferring a resident from the floor to the bed after a fall. V1 stated the staff should complete neurological assessments after a resident sustains an unwitnessed fall. V1 stated R9's neurological assessment was not completed per the facility policy. V1, Administrator, stated she was not aware V12, CNA, was involved in R9's fall. V1, Administrator, confirmed R9's fall investigation did not have a root cause and fall investigation was not complete. On 11/6/25 at 11:45 AM, V41, Nurse Practitioner (NP), stated V41 was notified of a change in condition on 10/18/25 due to R9's Right Leg/Right Knee being swollen and red. V41 stated V41, NP, was not provided information of a fall until 10/19/25. V41, NP, stated she was aware R9's X-Ray results of a Right Femur fracture, but there was no indication of a fall at that point. V41, NP, stated the facility staff improperly transferred R9 after her fall. V41, NP, stated the facility did not do a thorough fall investigation by not interviewing all of the staff involved in R9's fall and not attempting to determine a root cause for R9's fall. The facility policy titled Neurological Assessment, revised October 2010, documents neurological assessments are indicated after an unwitnessed fall. When assessing neurological status include vital signs. The following information should be recorded in the resident medical record: date and time of neurological assessments. Neurological assessments should be completed every 15 minutes for the first hour, then every one hour for four hours, then every four hours for times four assessments, then every eight hours times four assessments. The facility policy titled Safe Lifting, Transferring and Movement of Residents, revised July 2017, documents Manual lifting of residents shall be eliminated when feasible. In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. Mechanical lifting devices shall be used for heavy lifting, including lifting and moving residents when necessary. 2. R2's Minimum Data Set (MDS), dated [DATE], documents R2 is cognitively intact. R2's Fall Risk Evaluation, dated 10/18/25, documents R2 is a fall risk. R2's Fall Reports document R2 has fallen on 9/6/25, 9/8/25, 10/18/25, and 10/21/25. R2's Care Plan, dated 9/6/25, documents R2 is at risk for falls related to decreased mobility and requires a non-slip mat added to the seat of the wheelchair. On 10/24/25 at both 11:30 AM and 3:30 PM, no non-slip mat was observed in R2's wheelchair. On 10/24/25 at 11:30 AM, R2 was observed with a bruised left eye and surrounding eye area bruised. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/24/25 at 11:30 AM, R2 stated she has fallen at the facility. On 10/28/25 at 11:47 AM, V2, Director of Nursing (DON), stated no non-slip mat was present in R2's wheelchair. On 10/28/25 at 12:15 PM, V2, DON, stated a non-slip mat was present in R2's wheelchair, but the mat was all curled up in the back of the wheelchair and not properly placed. 3. R4's MDS, dated [DATE], documents R4 as not cognitively intact. R4's Fall Risk Evaluation, dated 7/24/25, documents R4 is a fall risk. R4's medical record documents R4 has fallen on 6/29/25, 7/11/25, 7/24/25, 8/27/25, 9/1/25, 9/15/25, 10/12/25, 10/19/25, and 10/21/25. R4's Care Plan, dated 7/24/25, documents R4 is to have a body pillow on each side of the bed to prevent R4 from rolling out of bed, a bed pad alarm placed when in bed, and an overlay of bolster pad onto standard mattress. On 10/24/25 at 2:42 PM, R4 did not have body pillows on each of her sides, no bed alarm was present, no overlay bolster to mattress was present, and the call light was on the floor under the bed, not within R4's reach, with R4 stating R4 does not know where the call light is located. On 10/24/25 at 3:30 PM, fall interventions continue to not be in place. On 10/28/25, throughout the morning, R4 remained lying in bed, no bed pillow was present at R4's side while in bed, no bed alarm was present, no overlay bolster to the mattress was present, and the call light was on the floor to the left side of the bed, with R4 facing the right side of the bed. On 10/28/25 at 11:50 AM, R4 was in bed with only one body pillow present on R4's right side, the call light cannot be located, and no bed alarm was present. V2 DON was present in the room during this observation and stated one body pillow is present, the call light cannot be located, and no bed alarm is present on R4's bed. 4. R5's MDS, dated [DATE], documents R5 is not cognitively intact. R5's Fall Risk Evaluation, dated 10/2/25, documents R5 is a fall risk. R5's medical record documents R2 has fallen on 7/1/25 and 10/14/25. R5's Care Plan, dated 10/14/25, documents a fall mat to be at the right side of the bed and to have the call light within reach. On 10/24/25 at 2:48 PM, a fall mat was not present at the side of the bed in R5's room and the call light was on the floor on the left side of the bed and not in reach. R5 stated R5 does not know where the call light is located. (continued on next page)

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	11/06/2025

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.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Falls and Fall Risk, Managing policy, dated March 2018, documents based on evaluations and current data, staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. This policy also documents the staff with the Interdisciplinary Team will implement a resident-centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk for falls or with a history of falls.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain accessible and complete medical records for five residents (R2, R4, R5, R7, R8) of five residents reviewed for medical records in the sample list of eleven. Findings include: 1. On [DATE] at 11:35 AM, 11:37 AM, and 11:40 AM, V15, Certified Nursing Assistant (CNA), V16 and V17, Licensed Practical Nurses (LPN), respectively were unable to verify which fall prevention interventions for R2, R4, and R5 had been implemented or completed because the fall interventions were not readily accessible in the resident's medical record. The facility's Electronic Medical Record system lacked a centralized location for staff to view or check off completed fall interventions which compromised staff's ability to deliver consistent care and monitor resident safety effectively. 2. The facility binder titled 'Face Sheet/Code Status' that resides in the front office for emergency use does not document advanced directives for R2, R7, and R8. R2's undated Face Sheet documents R2 admitted to the facility on [DATE]. R2's undated Face Sheet, Physician Order Sheet (POS), and Care Plan do not include R2's Advanced Directive. R2's Electronic Medical Record (EMR) does not include a Physician Order for Life Sustaining Treatment (POLST). R7's undated Face Sheet documents R7 admitted to the facility on [DATE]. R7's undated Face Sheet, POS and Care Plan do not include R7's Advanced Directive. R7's EMR does not include an easily accessible completed POLST form. R8's undated Face Sheet documents R8 admitted to the facility on [DATE]. R8's undated Face Sheet, POS and Care Plan do not include R8's Advanced Directive. R8's EMR does not include an easily accessible completed POLST form. On [DATE] at 3:30 PM, V13, Licensed Practical Nurse (LPN), stated R2's code status is not easily identifiable on R2's EMR. V13, LPN, stated a resident's code status should be on the Electronic Medical Record (EMR) Face Sheet. V13, LPN, stated if the EMR is down, then there is a binder in the office that should identify what the resident's code status is. V13, LPN, stated the binder should always be kept up to date or a resident may not be provided the lifesaving treatment of their choice. On [DATE] at 3:40 PM, V4, Licensed Practical Nurse (LPN), stated she could not find R8's code status in R8's EMR. V4, LPN, stated if R8 were to code, V4, LPN, would not know what R8's choices were in case of emergency. V4, LPN, stated V4 was not aware there is a binder and would not know where to look for it. (continued on next page)

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	145945	A. Building B. Wing	11/06/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 4:00 PM, V1, Administrator, stated if a resident 'codes' the staff are to initiate Cardiopulmonary Resuscitation (CPR) immediately and determine a resident's code status by the Electronic Medical Record (EMR). V1 stated if the power is out or if there is some reason the resident's EMR is not accessible, the Face Sheet binder located in the front office will identify what the code status is of every resident. V1, Administrator, stated she was able to find a POLST form for R2, R7, and R8 in the admission records uploaded into the miscellaneous section of each resident's EMR. V1, Administrator, stated R2, R7 and R8's POLST's were included in their perspective charts but were not at all easy to find. That is a problem. V1, Administrator, stated the Face Sheet binder is not up to date. V1, Administrator, stated the facility will update the Face Sheet binder as soon as possible. V1, Administrator, stated there is not a specific policy for this problem, but the facility is expected to maintain complete medical records, including Advanced Directives for all residents. V1, Administrator, stated the staff should have access to pertinent medical records to provide all necessary cares for all residents. V1 stated there is no policy for medical records being easily accessible for staff but that is the expectation. V1 Stated the facility keeps a Face Sheet binder that had not been up to date and that could cause a delay in emergency care for any resident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on observation, interview, and record review, the facility failed to employ an Infection Preventionist who remains onsite. This failure has the potential to affect all 70 residents residing in the facility. Findings include:The facility daily midnight roster, dated 8/24/25, documents 70 residents reside in the facility. The Facility Assessment, reviewed July 10, 2025, documents a member of the team of nursing directors is designated as the certified Infection Preventionist. Utilizing information exchange in daily report, referral reports, physician orders, pharmacy reports (antibiotic report) and quality measures, nursing directors are able to analyze data and know real time diagnosis and treatment to manage an effective infection control program. The facility is unable to provide an Infection Preventionist certificate for any employee working onsite. During standard survey observations on 10/24/25, 10/28/25-10/31/25, 11/4-11/6/25 there was not an Infection Preventionist in the facility. On 10/31/25 at 2:45 PM, V1, Administrator, stated the facility does not have an Infection Preventionist. V1, Administrator, stated corporate does have an Infection Preventionist, but that person is ‘never in the building.' V1, Administrator, stated she is aware the facility should have an Infection Preventionist and is working towards hiring one.