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	06/10/2026

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement their abuse policy related to misappropriation of funds for one (R2) of six residents reviewed for abuse in a sample of 23 residents.Findings include:The facility's policy, Abuse Prevention and Policy, dated 8/16/2026, documented, This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion. This facility therefore prohibits mistreatment, neglect or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect or abuse of our residents.R2's Minimum Data Set, dated [DATE], documents R2's cognition is intact.On 6/8/2026 at 10:30 AM, R2 stated R2 had kept R2's debit card in R2's drawer and no one had access to it. R2 stated R2 cancelled the card on 5/21 or 5/22/26. R2 said R2 gave R2's debit card to a V3, CNA (Certified Nurse Assistant), who works at the facility to buy R2 some orange slices at a local store. V3, CNA, got the candy for R2 around the beginning of May, and V3 brought the card back with the receipt. But there has been over $10,000 taken out of R2's account prior to V3 going to the store for R2. R2 stated R2 noticed on 5/22/2026 the money was missing when R2 called and ordered pizza from a local pizza restaurant and R2's card was declined. R2 called the bank and got R2's debit card shut off. R2 stated R2 does not do online shopping but will call for food to be delivered. R2 stated R2 would give his friend (V9) his debit card and V9 knows the pin but V9 is the only one who has R2's pin number. R2 stated V9 brought R2 in a new phone and V9 has R2's new debit card and pin number. R2 stated R2 had never given out R2's pin number to the staff and that the friend was the only one who had it. R2 stated when R2 had V3 go to a local store for R2, that was the only time R2 gave R2's card to a staff member.On 6/8/2026 at11:15 AM, V1, Chief Operations Officer, stated V1 has started the investigation into R2's allegation today (6/8/2026) and stated the current interim Administrator was made aware of it last Monday (6/1/26), but thought it was related to R2's billing, but R2 didn't pay anything, and no investigation was started.On 6/8/2026 at 11:40 AM, V3, Certified Nursing Assistant (CNA, stated V3 has been employed by the facility for three years. V3 stated V3 knew R2 from a different facility. V3 stated R2 asked V3 when V3 was going on break and asked if V3 wanted pizza because R2 was buying pizza for the staff that day. V3 stated V3 was going to go to a local restaurant to get V3's meal and R2 asked V3 if a local store was down the road and if V3 would pick R2 up some orange slices (candy). V3 stated V3 got R2 three bags of orange slices and then wrapped R2's receipt around R2's debit card and gave it back to R2. V3 stated V3 was not sure of the facility policy as to if they were allowed to go to a store if a resident asked and give them their debit card to get them something. V3 stated this was the only time V3 did this for R2 and all V3 did was run to the store and back.On 6/9/2026 at 10:40 AM, V8, Licensed Practical Nurse (LPN), stated R2 was upset and R2 told V8 that someone in the facility had been stealing money from R2's account. V8 stated V8 reported it to V10, Interim Administrator, and to V2, Director of Nurses. V8 also stated R2 has not asked V8 to get R2 anything from the store or give V8 R2's debit card.On 6/9/2026 at 11:20 AM, V2, Director of Nurses, stated V2 was made aware of R2 having money missing out of R2's account along (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with V10, Interim Administrator, last Monday (6/1/2026) when the nurses did morning rounds with them that day. V2 stated V2 assumed V10 started an investigation.On 6/9/2026 at12:22 PM, V10, Interim Administrator, via phone call, stated R2 told V10 the owner of the company stole R2's money out of R2's bank account, but V10 did not start an investigation because V10 wasn't aware of the money missing out of R2's bank account.R2's Progress note, dated 6/1/2026, documented R2 has been angry with staff all shift making accusation that R2 believed the facility stole money from R2's account. Management has already been notified of the behavior and the threats of calling state if R2's money hasn't been returned. No further complaints from the resident at this time was documented.R2's Local Police report, dated 6/8/2026, documented it was reported to them by V1, Chief Operations Officer, on 6/8/2026. There was no further documentation regarding statements by R2 or V3, CNA.R2's bank statement, dated 1/2026, 2/2026, 3/2026, 4/2026 and 5/2026, documented there were multiple online purchases, local restaurant purchases, and local grocery store purchases, totaling approximately $19,650. It also documented a purchase to a local store around 5/8/2026 totaling $15.05 for the candy R2 had V3, CNA, purchased for R2. There was no investigation documentation presented to the State Agency by the facility during this investigation.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to investigate misappropriation of property for one (R2) of six residents reviewed for abuse, in a sample of 23 residents.Findings include:On 6/8/2026 at 11:15 AM, V1, Chief Operations Officer, statedV1 has started the investigation into R2's allegation today (6/8/2026) and stated the current interim Administrator was made aware of the missing money last Monday (6/1/26) but thought it was related to R2's billing, but R2 didn't pay anything, and no investigation was started.On 6/8/2026 at 11:40 AM, V3, Certified Nursing Assistant/CNA stated V3 has been employed by the facility for three years. V3 stated V3 knew R2 from a different facility. V3 stated R2 asked V3 when V3 was going on break and R2 asked if V3 wanted pizza because R2 was buying pizza for the staff that day. V3 stated V3 was going to go to a local restaurant to get V3's meal and R2 asked V3 if a local store was down the road and if V3 would pick him up some orange slices (candy). V3 stated V3 got him three bags of orange slices and then wrapped R2's receipt around R2's debit card and gave it back to R2. V3 stated V3 was not sure of the facility policy as to if they were allowed to go to a store if a resident asks and give them their debit card to get them something. V3 stated this was the only time V3 did this for R2 and all V3 did was run to the store and back.On 6/9/2026 at 10:40 AM, V8, Licensed Practical Nurse (LPN), stated R2 was upset and R2 told V8 that someone at the facility had been stealing money from R2's account. V8 stated V8 reported it to V10, Interim Administrator, and to V2, Director of Nurses. V8 also stated R2 has not asked V8 to get R2 anything from the store or give V8 R2's debit card.On 6/9/2026 at 11:20 AM, V2, Director of Nurses, stated V2 was made aware of R2 having money missing out of R2's account along with V10, Interim Administrator, last Monday (6/1/2026) when the nurses did morning rounds with them that day. V2 stated that V2 assumed V10 started an investigation.On 6/9/2026 at 12:22 PM, V10, Interim Administrator, via a phone call, stated R2 told V10 that the owner of the company stole R2's money out of R2's bank account, but V10 did not start an investigation because V10 wasn't aware of the money missing out of R2's bank account.R2's Progress note, dated 6/1/2026, documented R2 has been angry with staff all shift making an accusation that R2 believed the facility stole money from R2's account. Management has already been notified of the behavior and the threats of calling state if R2's money hasn't been returned. No further complaints from the resident at this time.R2's Local Police report, dated 6/8/2026, documented it was reported to them by V1, Chief Operations Officer on 6/8/2026. There was no further documentation regarding statements by R2 or V3, CNA.R3's bank statements dated 1/2026, 2/2026, 3/2026, 4/2026 and 5/2026, documented there were multiple online purchases, local restaurant purchases and local grocery store purchases, totaling approximately $19,650. It also documented a purchase to a local store around 5/8/2026 with a total of $15.05 for the candy R2 had V3, CNA, purchase for R2. There was no investigation documentation presented to the State Agency by the facility during this investigation.The facility's policy, Abuse Prevention and Policy, dated 8/16/2026, documented, VI. Internal Investigation of Abuse, Neglect or Misappropriation Allegations and Response 1. All incidents will be documented, whether or not abuse occurred, was alleged or suspected. 2. Any incident or allegation involving abuse, neglect or misappropriation will result in an abuse investigation. 3. Following the Resident Protection Abuse Investigation Procedures. The appointed investigator will follow the Resident Protection Abuse Investigation Procedures, attached to this policy. The Procedures contain specific investigation paths depending on the nature of the allegation, and procedures for investigation, interview parameters, and reporting requirements.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to update the care plan with targeted interventions for one (R8) of three reviewed for care plan interventions following a fall on a sample list of 23 residents.Findings Include: R8's Electronic Health Record (EHR) documented R8 was admitted to the facility on [DATE] and continues to reside at the facility. According to the R8's EHR, R8 has several diagnoses including Chronic Systolic (Congestive) Heart Failure, Essential (Primary) Hypertension, Atherosclerotic Heart Disease of Native Coronary Artery Without Angina Pectoris, Emphysema, Protein-Calorie Malnutrition, and Unilateral Primary Osteoarthritis, Right Hip, and repeated falls.On 6/9/2026 at 10:34AM, V8, Licensed Practical Nurse (LPN), stated the note V8 authored on 6/6/26 at 2:07PM was due to a conversation with R8's Power of Attorney (POA). V8 stated R8 sustained a fall on 6/1/26 or 6/2/26 at an unknown time as V8, LPN, was not at work but had read the Risk management in the medical record.On 6/9/2026 at 11:45AM, V11 (R8's) family member stated R8 fell on or about 6/2/26 and family has not seen any new fall interventions put in place for R8.On 6/9/2026 at 12:05PM, V2, Director of Nursing (DON), confirmed there is a fall investigation for 6/2/26 for R8. V2 confirmed the care plan did not contain any updates or targeted interventions following the documented fall of 6/2/26.R8's Care Plan, with an initiation date of 5/29/26, documented R8 is a fall risk. Interventions were put into place dated 6/1/26. The same document did not contain any other targeted interventions following the fall dated 6/2/26.Falls and Fall Risk, Managing policy, dated March 2018, documents under the resident centered approaches, Section 5, documents if falling occurs despite initial interventions, staff will implement additional or different interventions will be implemented.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 safely transfer and supervise three (R8, R19, R22) of four residents reviewed for accidents in a sample of 23 residents. Findings include: 1.R8's Electronic Health Record (EHR) documents R8 was admitted to the facility on [DATE] and continues to reside at the facility. According to R8's EHR, R8 has several diagnoses including Heart Failure, Heart Disease, Emphysema, Osteoarthritis, Hypertension, and Repeated Falls. R8's Care Plan, dated 5/29/26, documented R8 is a fall risk. R8's Minimum data Set (MDS), dated [DATE], documents R8 is not cognitively intact. On 6/9/2026 at 1:25PM, V15 and V11, R8's family members, stated R8 had to use the bedside commode. V18, Certified Nursing Assistant (CNA), and V16, Certified Nursing Assistant, came into the room to assist R8. V18 lifted R8 by R8's under arm only, and V16 lifted R8 under R8's arm while holding the gait belt. V18 and V16 transferred R8 from R8's recliner onto the bedside commode. V16 and V18 then exited the room, leaving R8 unattended. R8 made multiple attempts to stand unassisted. On 6/9/2026 at 1:28PM, V6, Licensed Practical Nurse (LPN), alerted V18, CNA, and V16, CNA, that R8 needed assistance. V18 and V16 entered R8's room. V18 then wiped R8 from front to back with a peri wipe and pulled up R8's incontinence brief, which had yellow stains in it, and pulled up R8's pants. V18 and V16 both lifted R8 under R8's arms with only V16 using the gait belt and placed R8 back into R8's recliner. On 6/9/2026 at 1:40PM, V6, LPN, stated, I would not expect (R8) to be left alone on the bedside commode the way (R8) is now. 2. On 6/9/2026 at 1:55 PM, V18, CNA, was preparing to lay R19 in bed from R19's bedside recliner. R19 was sitting on a full mechanical lift sling and leaning to the right. There was not a chair alarm present underneath the resident. V18 hooked up the full mechanical lift to the lift sling. V12, Activity Assistant, was present in the room and stated that V12 was there to assist V18. V18, CNA, operated the full mechanical lift but V12 did not support R19's body nor did V18. V12 stood off to the side of the room, by the bathroom door, during the full mechanical lift transfer. While R19 was being transferred by the full mechanical lift, the sling was swaying side to side, until R19 was lowered to the bed. R19's Minimum Data Set (MDS), dated [DATE], documented R19's cognition was not intact. It continues to document R19 required partial to moderate assistance from staff to transfer to and from a bed to a chair (or wheelchair). R19's Care Plan, dated 6/18/2025, documented, Observe for incontinent episodes and provide care. It also documented, Bed and Chair alarm for resident to alert staff of movement in room. It did not document an intervention for a full mechanical lift to be used. 3. On 6/10/2026 at 10:15 AM, V20, CNA, placed a gait belt on R22 who was sitting on the side of (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R22's bed. R22 was being transferred from R22's bed to the shower chair. V20 performed standby assistance, not touching or assisting R22 while R22 stood up from R22's bed. R22 was very shaky and moving very slowly. V20, CNA, stated R22 could actually transfer self with no assistance but R22 stated that R22 would not transfer by self without V20 or another CNA, to assist R22. R22's MDS, dated [DATE], documented R22's cognition was intact and that R22 required partial to maximal assistance to transfer to and from a bed to a chair (or wheelchair). R22's Care plan, dated 2/1/2026, documented, Staff to utilize the (partial full mechanical lift) machine for all transfers. On 6/10/2026 at 10:00 AM, V20, CNA, stated a gait belt should be used to transfer residents, and a full mechanical lift should be used with two CNAs with one CNA driving the lift and the other holding on to the resident in the sling. V20 also stated V20 was not aware that R22 needed a partial full mechanical lift when transferred. On 6/10/2026 at 11:25 AM, V23, CNA, stated there must be two staff members when using a full mechanical lift. One CNA working the controls on the lift and the other holding on to the resident in the sling. On 6/10/2026 at 11:40 AM, V22, CNA, stated that when using a full mechanical lift or a partial full mechanical lift, there must be two staff members when using it. One CNA is working the controls on the lift and the other holding on to the resident in the sling. On 6/10/2026 at 11:40 AM, V1, Chief Operations Officer, also stated two staff members are used when a full mechanical lift or a partial full mechanical lift is used. The facility's policy, Safe Lifting and Movement of Residents, dated 7/2017, documented, 1. Resident safety, dignity, comfort and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents. 2. Manual lifting of residents shall be eliminated when feasible. 3. Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan. Such assessment shall include Resident's preferences for assistance; Resident's mobility (degree of dependency); Resident's size; Weight-bearing ability; Cognitive status; Whether the resident is usually cooperative with staff; and the resident's goals for rehabilitation, including restoring or maintaining functional abilities. 4. Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices. 5. Mechanical lifting devices shall be used for heavy lifting, including lifting and moving residents when necessary.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to perform incontinence care in a manner to prevent infection and potential skin irritation for three (R8, R19, R23) of three residents reviewed for incontinence care in a sample of 23 residents. Findings include: 1. On 6/9/26 at 1:25 PM, V18, Certified Nurse Aide (CNA), and V16, CNA, provided incontinence care to R8. V18 and V16 began the care by pulling down R8's urine saturated incontinence brief and pants. V18 then wiped R8's perineal area once with an incontinence wipe. V18 did not wipe in between R8's labia folds or clean R8's thighs. After they were finished providing the incontinence care to R8, they pulled up R8's urine saturated incontinence brief and then pulled up R8's pants. V18 and V16 then placed R8 back into R8's recliner. On 6/10/2026 at 2:00 PM, V18, Certified Nursing Assistant (CNA), stated the whole peri-area should be cleansed when doing incontinence care. 2. On 6/9/2026 at 1:55 PM, V18, CNA, removed R19's soiled adult incontinent brief. R19 was lying on R19's back. V18 CNA cleansed the front groin, inner thighs, penis and scrotum appropriately using moistened care wipes. V18 then turned R19 on to R19's right side and cleansed R19's rectal area and left buttock. V18 then applied a clean adult incontinent brief and rolled R19 onto R19's back and covered R19 up. V18 did not cleanse R19's right hip, thigh or buttock. R19's MDS, dated [DATE], documented R19's cognition was not intact. It also documented R19 was always incontinent of urine and feces. It also documented diagnoses of Spinal Stenosis and Dementia with Agitation. R19's Care plan, dated 6/18/2025, documented, Observe for incontinent episodes and provide care. 3. On 6/10/2026 at 11:36 AM, V22, CNA, removed R23's urine soiled adult incontinence brief. V22 then used a moistened care wipe and cleaned front to back, the center of R23's labia, once, without cleansing R23's bilateral groins or thighs. R23's MDS, dated [DATE], documented R23's cognition was intact. It also documented R23 was always incontinent of urine and feces. It also documented diagnoses of Parkinson's Disease and Dementia. R23's Care plan, dated 7/23/2024, documented, TOILET USE: The resident requires assistance adjust clothing, cleaning self, transfer onto toilet, transfer off toilet to use toilet. On 6/10/2026 at 11:25 AM, V23, CNA, stated when doing incontinence care, all areas are cleansed including the groin and inner thighs. On 6/10/2026 at 11:40 AM, V22, CNA, stated all areas are cleansed when performing incontinence care. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy, Perineal Care, undated, documented, The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition. It continued, For a female resident: a. Wet washcloth and apply soap or skin cleansing agent. B. Wash perineal area, wiping from front to back. (1) Separate labia and wash area downward from front to back. (Note: If the resident has an indwelling catheter, gently wash the juncture of the tubing from the urethra down the catheter about three inches. Gently rinse and dry the area.) (2) Continue to wash the perineum moving from inside outward to the thighs, Rinse perineum thoroughly in same direction, using fresh water and a clean washcloth. (3) If the resident has an indwelling catheter, hold the tubing to one side and support the tubing against the leg to avoid traction or unnecessary movement of the catheter. (4) Gently dry perineum. It continues, m. Wash and rinse the rectal area thoroughly, including the area under the scrotum, the anus, and the buttocks. n. Dry area thoroughly.