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	07/02/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from verbal abuse from facility staff members for one (R2) of five residents reviewed for abuse in the total sample list of six. This failure resulted in R2 being made to feel pressured, outnumbered, and extremely insignificant. Findings include:R2's Minimum Data Set (MDS), dated [DATE], documents R2 has diagnoses including Frontal Lobe and Executive Function Deficit Stroke, Atrial Fibrillation, Cerebrovascular accident (CVA), and Hemiparesis. R2's Electronic Medical Record (EMR) documents an admission date of 01/17/2025.R2's Minimum Date Set (MDS), dated [DATE], documents R2 is cognitively intact.R2's Progress Note written by V2, Director of Nursing, dated 6/18/2026, documents R2 was transferred to the Emergency Department for further evaluation and treatment related to possible infection. On 6/30/2026 at 10:30 AM, R2 stated R2 was sent to the hospital on 6/18/26 because R2 was not feeling well and the staff were informing R2 that R2 was not looking well. R2 stated R2 agreed to go to the hospital but not by ambulance. R2 stated R2 did not want to incur more charges with the ambulance company. R2 stated R2 was treated at the local hospital emergency department for low potassium and was to be returned to the facility. R2 stated R2 was told R2 would not be allowed back to the facility as there were no available beds. R2 stated V1, Administrator, and V2 came to the hospital on 6/25/26. R2 stated V15, Company Owner, and V17, Corporate Administrator, were on V1's phone on speaker. R2 stated V1 and V2 were verbally abusive. R2 stated V1 and V2 yelled at R2. R2 stated V1, V2, V15, and V17 stated R2 could not return to the facility. R2 stated V1 and V2 were rude. R2 stated V1, V2, V15, and V17 claimed R2 had behavioral issues, owed the facility a lot of money, and stated R2 was a bad person. R2 stated R2 felt pressured and outnumbered. R2 stated R2 felt terrible, awful, and two inches tall. R2 stated R2 never told the staff R2 did not want to come back until V1, V2, V15, and V17 told R2 they did not want R2 back. R2 had no difficulty hearing during this interview.On 6/30/2025 at 12:13 PM, V2 stated V2 sent R2 to the hospital on 6/18/26 because R2 had become weak, dizzy, and appeared pale.On 6/30/2026 at 10:40 AM, V8 (hospital Licensed Social Worker) stated R2 was transported to the hospital on 6/18/26 by private transportation. V8 stated R2 was initially evaluated for sepsis but was found to have a low potassium level. V8 stated the emergency department treated R2 and R2 was stable to return to the facility. V8 stated the facility refused to accept R2 back. V8 stated V2 came to the emergency room to have R2 sign a bed hold form. V8 stated V2 was rude, unpleasant, and harassed R2 in the waiting room of the emergency department. V8 stated the facility refused to take R2 back because R2 owed the facility a lot of money. V8 stated they informed the facility the hospital had no diagnosis to admit R2 to the hospital. V8 stated R2 stated R2 wanted to return to the facility until R2 was told R2 could not. V8 stated on 6/25/26, V1 and V2 came to the hospital to talk to R2. V8 stated they were told they were going to discuss R2's return to the facility. V8 stated V1 started telling R2 that R2 owes a lot of money to the facility and that is why R2 could not come back. V8 stated V1 asked if the conversation could be recorded and V8 stated no. V8 stated V1 put V15 and V17 on speaker phone. V8 stated V8 could not verify it was V15 and V17, but they identified themselves as V15 and V17. V8 stated V1 and (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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	V2 were aggressive and yelled at R2 about behaviors and were citing various incidences with R2. V8 stated they tried to redirect the conversation to a lower tone and back to the subject of R2 returning to the facility. V8 stated R2 stated feeling R2's rights were violated and R2 felt harassed. V8 stated V1 and V2 were harassing R2 and were trying to convince R2 not to want to come back. V8 stated the interaction was not therapeutic, V1 and V2 were listing off negative encounters with R2 and not discussing return to the facility. V8 stated the conversation was going nowhere so V8 terminated the visit and asked V1 and V2 to leave.On 6/30/2026 at 12:30 PM, V9 (hospital Licensed Social Worker) stated staff from the facility returned on 6/25/26 to deliver a letter to R2. V9 was on call on the night of 6/18/26 when R2 was brought to the emergency room for evaluation. V9 stated V2 was very rude and demanding to R2.On 6/30/2026 at 1:02 PM, V10 (hospital Case Manager) stated when R2 was ready to discharge and return to the facility, V2 stated the facility would not take back R2 and R2 knew why. V10 stated on 6/22/26, V1, V2, and V12, facility Social Services, came to the hospital to deliver a letter to R2 listing reasons why R2 cannot come back. V10 stated V1 and V2 returned to the hospital on 6/25/26 to discuss with R2 about R2's return to the facility. V10 stated V1 called V15 and V17. V10 stated V1 and V2 began to tell R2 all the problems R2 has caused for the facility. V10 stated R2 became very upset. V10 stated V1 and V2 stated R2 could return if R2 paid on R2's bill. V10 stated V1 and V2 were unpleasant to R2. V10 stated V8 asked them to leave.On 7/1/2026 at 12:35 PM, V1 stated V1 and V2 went to the hospital on 6/25/26 to talk to R2. V1 stated V15 and V17 were on the phone on speaker. V1 asked V8 if they could record the conversation and V8 stated it was against hospital policy. V1 stated V1 went through the letter that was written to R2. V1 stated V2 went through the bullet points of what got them to this point. V1 stated V1 asked R2 how R2 was going to change R2's behaviors. V1 stated they had to yell at R2 because R2 is heard of hearing. V1 stated V8 asked them to stop yelling and to calm down.R2's Progress Note, dated 6/18/2026 at 6:27 PM written by V2, documents V2 visited resident at a local hospital to provide the Bed Hold Policy and Bed Hold Notification form.R2's Progress Note, dated 6/22/2026 at 5:11 PM written by V1, documents V1 and V12 delivered a formal notification the facility will not accept R2 back to the facility.R2's Progress Noted, dated 6/25/2026 at 4:13 PM written by V1, documents V1 and V2 visited R2 at the hospital.The Facility's Abuse Prevention Policy and Procedure, dated 08/16/2025, documents, 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. This facility is committed to protecting our residents from abuse by anyone including, but no(t) limited to facility staff, other residents, consultants, volunteers, staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals. This facility will not knowingly employ individuals who have been convicted of abusing, neglecting, or mistreating individuals.

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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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a safe and planned discharge to an appropriate facility for one (R2) of three residents reviewed for inappropriate discharge in the sample list of six. Findings include:R2's Minimum Data Set (MDS), dated [DATE], documents R2 has diagnoses of Frontal Lobe and Executive Function Deficit Stroke, Atrial Fibrillation, Cerebrovascular accident (CVA), and Hemiparesis. R2's Electronic Medical Record (EMR) documents an admission date of 01/17/2025.R2's Minimum Date Set (MDS), dated [DATE], documents R2 is cognitively intact.R2's Progress Note written by V2, Director of Nursing, dated 6/18/2026, documents R2 was transferred to the Emergency Department for further evaluation and treatment related to possible infection. On 6/30/2026 at 10:30 AM, R2 stated R2 was sent to the hospital on 6/18/26 because R2 was not feeling well, and the staff told R2 that R2 did not look well. R2 stated R2 agreed to go to the hospital but not by ambulance. R2 stated R2 did not want to incur more charges. R2 stated R2 was treated at the local hospital emergency department for low potassium and was to be returned to the facility. R2 stated R2 was told R2 would not be allowed back to the facility as there were no available beds. R2 stated V1, Administrator, and V2, Director of Nursing, came to the hospital on 6/25/26. R2 stated V15, Facility Owner, and V17, Corporate Administrator, were on V1's phone on speaker. R2 stated V1 and V2 were verbally abusive. R2 stated V1 and V2 yelled at R2. R2 stated V1, V2, V15, and V17 stated R2 could not return to the facility. R2 stated V1 and V2 were rude, claimed R2 had behavioral issues, owed the facility a lot of money, and stated R2 was a bad person. R2 stated R2 felt coerced, pressured and outnumbered. R2 stated R2 felt terrible, awful, and two inches tall. R2 stated R2 never told the staff R2 did not want to come back until V1, V2, V15, and V17 told R2 they did not want R2 back. R2 stated R2 never notified the facility R2 was not planning to return.R2's facility bed was unoccupied on 6/30/26 and 7/1/26 and R2 had no issues with hearing during a telephone interview on 6/30/26.On 6/30/2026 at 1:43 PM, V1 (Administrator) confirmed all 95 beds in the facility are dually (Medicare/Medicaid) certified.On 6/30/2026 at 10:40 AM, V8 (hospital Licensed Social Worker) stated R2 was transported to the hospital on 6/18/26 by private transportation. V8 stated R2 was initially evaluated for sepsis but was found to have a low potassium level. V8 stated the emergency department treated R2 and was stable to return to the facility. V8 stated the facility refused to accept R2 back. V8 stated V2 came to the emergency room to have R2 sign a bed hold form. V8 stated V2 was rude and unpleasant and harassed R2 in the waiting room of the emergency department. V8 stated the facility refused to take R2 back because he owed a lot of money. V8 stated they informed the facility the hospital had no diagnosis to admit R2 to the hospital. V8 stated R2 stated R2 wanted to return to the facility until R2 was told R2 could not.On 7/1/2026 at 3:20 PM, V8 stated V15 had been on the phone with R2 on 6/25/25, and V15 sounded aggressive and was attacking R2 regarding R2's past behaviors. V8 stated the meeting was misrepresented; V8 was told this meeting was to discuss R2's return to the facility but instead it was more of a reprimand and the visit was terminated.V8 stated V1 and V2 came to the hospital to talk to R2 on 6/25/26. V8 stated they were told they were going to discuss R2's return to the facility. V8 stated V1 started telling R2 that R2 owes $123,000 to the facility and that is why R2 could not come back. V8 stated V1 asked if the conversation could be recorded and V8 stated no. V8 stated then V1 had V15 and V17 on speaker phone. V8 stated V8 could not verify that it was V15 and V17, but they identified themselves as V15 and V17. V8 stated V1 and V2 were harassing R2 and were trying to convince R2 to not want to come back. V8 stated the interaction was not therapeutic; V1 and V2 were listing off negative encounters with R2 and not discussing return to the facility. V8 stated the conversation was going nowhere so V8 terminated the visit and asked V1 and V2 to leave. V8 stated R2 was only admitted to the hospital because the facility refused to pick up or allow R2 back into the facility. On 6/30/2026 at 12:13 PM, (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V2 stated V2 sent R2 to the hospital because R2 had become weak, dizzy, and appeared pale. V2 stated R2 had an episode similar to this before and refused to be evaluated at the hospital, but on the 18th, R2 agreed to go because of a possible infection. V2 stated V2 went to the local hospital when R2 was in the emergency room to have R2 sign a bed hold agreement. V2 stated R2 refused to sign it. V2 stated when R2 refused to sign the form, V2 left. V2 stated V1 and V2 went to see R2 in the hospital on 6/25/26, V2's role was to have R2 sign the bed hold form. V2 stated R2 refused again. V2 stated the hospital called at 2:00 AM on 6/19/26 for R2 to return to the facility and V2 refused to let R2 return at that time.On 6/30/2026 at 12:30 PM, V9 (hospital Licensed Social Worker) stated V9 was on call on 6/18/26 when R2 was in the emergency room. V9 stated they were alerted to a situation when the emergency room nurse tried to return R2 to the facility around midnight. V9 stated R2 was brought to the emergency room for septic-like symptoms and was treated for low potassium. V9 stated R2 was treated and was stable to return to the facility. V9 stated when the emergency room called the facility, the hospital was told R2 was not welcomed back and R2 knew why. V9 stated V2 was rude. V9 stated V2 told V9 it was illegal to disclose why R2 could not come back and if the hospital sent R2 back to the facility, V2 will call the police. V9 stated R2 wanted to return to the facility. V9 stated staff from the facility returned on 6/25/26 to deliver a letter to R2. V9 stated the hospital made multiple calls to the facility and had a difficult time getting ahold of anyone.On 6/30/2026 at 1:02 PM, V10 (hospital Case Manager) stated when R2 was ready to discharge and return to the facility, V2 stated the facility would not take back R2 and R2 knew why. V10 stated V1, V2, and V12 came to the hospital on 6/22/26 to deliver a letter to R2 listing reasons why R2 could not go back. V10 stated V1 and V2 returned to the hospital on 6/25/26 to discuss with R2 about R2's return to the facility. V10 stated V1 and V2 began to tell R2 all the problems R2 has caused for the facility. V10 stated R2 became very upset. V10 stated V1 and V2 stated R2 could return if R2 paid on R2's bill. V10 stated V1 and V2 were unpleasant to R2. V10 stated V8 asked them to leave.On 7/1/2026 at 9:00 AM, V12, facility Social Services, stated V12 went to the hospital with V1 to deliver a letter and have the resident sign a bed hold form. V12 stated V12 did not fully understand what a bed hold form was. V12 was unable to explain what the bed hold policy was and what the form meant. V12 stated R2 refused to sign the form. V12 stated R2 had no difficulty hearing at normal volume. V12 stated R2 never stated R2 did not want to come back.On 7/1/2026 at 12:35 PM, V1 stated V1 and V2 went to the hospital on 6/25/26 to talk to the resident. V1 stated V15, facility owner, and V17, Corporate Administrator, were on the phone on speaker. V1 asked V8 if they could record the conversation and V8 stated it was against hospital policy. V1 stated V1 went through the letter that was written to R2. V1 stated V2 went through the bullet points of what got them to this point. V1 stated V1 asked R2 how R2 was going to change R2's behaviors. V1 stated they had to yell at R2 because R2 is heard of hearing. V1 stated V8 asked them to stop yelling and to calm down. V1 stated R2 was argumentative despite being offered financial assistance from V15. V1 stated V1 reiterated the bill that R2 has acquired during his stay at the facility. V1 stated V2 read the letter to the resident. V1 stated V1 told R2 that R2 had to make changes and pay towards the bill before R2 can return. V1 stated when residents leave the facility briefly for an outing, doctor's appointment, or a medical evaluation, a bed hold form is not typically necessary.On 7/2/2026 at 10:11 AM, V21, Corporate Nurse, stated R2 stated at the hospital R2 was not going to return to the facility. V21 stated based on R2's statement and request to not return, R2 was appropriately discharged from the facility. V21 stated a Quality Assurance and Performance Improvement was completed for R2's discharge. V21 stated when R2 decided not to return to the facility, V21 considered R2 self-discharged . V21 stated R2 was never offered to sign a Leave Against Medical Advice ([NAME]) form.R2's Progress Noted, dated 6/18/2026 at 3:48 PM written by V2, documents V1 and V12 met with R2 regarding concerns for possible infection. R2 was educated on the signs and symptoms of infection and the potential risks of untreated infection, including worsening illness and hospitalization. R2 was informed that nursing staff have a responsibility to advocate for R2's health and well-being and to recommend appropriate (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medical evaluation when clinically indicated. After discussion and education, R2 verbalized understanding of the risks associated with delaying treatment and agreed to be transferred to the Emergency Department for further evaluation and treatment.R2's Progress Note, dated 6/18/2026 at 3:57 PM written by V2, documents R2 was pale, had altered mental status, and was lethargic.R2's Progress Note, dated 6/18/2026 at 6:27 PM written by V2, documents V2 visited R2 at the hospital to provide the Bed Hold Policy and Bed Hold Notification form.R2's Progress Note, dated 6/22/2026 at 3:23 PM written by V12, documents a delivery of formal notification that R2 will not be accepted back to the facility.R2's Progress Note, dated 6/22/2026 at 5:11 PM written by V1, documents V1 and V12 delivered a formal notification that the facility will not accept R2 back to the facility upon discharge from the hospital.R2's Progress Note, dated 6/25/2026, documents R2 continued to refuse to sign a Bed Hold Agreement.R2's Care Plan, dated 2/4/2026, I (R2) wish to discharge to another facility or in the community at a future date of my (R2) choosing. This Care Plan documents an intervention of Referrals will be made to facilities of my (R2) choice. The facility will keep me (R2) updated with referral responses from facilities that I (R2) choose.R2's Progress Note, dated 6/30/2026 at 12:20 PM, documents R2's belongings were picked up by R2's pastor.The Facility Bed Hold Policy dated March 2017 documents Private Pay residents who decide not to sign the bed hold/ transfer letter, pay the bed hold per diem at 100% of the daily rate charge, or communicate to the facility they will not be returning to the facility will be discharged from the facility after being advised in writing of any action that must be taken to hold the bed while hospitalized or to seek a new episode stay.