| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146106 | A. Building<br>B. Wing | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Scott County Nursing Center | Rural Route 2<br>Winchester, IL 62694 |

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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect the resident's right to be free from verbal abuse by another resident for 1 of 2 residents (R41) reviewed for abuse in the sample of 24. This failure resulted in R41 feeling scared and threatened.Findings Include:On 4/22/26 at 9:20 AM, R41 stated she was in the dining room talking with some of the other ladies, when R22 propelled himself in his wheelchair over to her and ran into her with his foot pedals, backed up, and did it two more times. R41 stated R22 then said to her get out, she wasn't needed, and he was going to go out and get a corn stalk out of the field and wrap it around her neck. R41 stated she was scared, felt threated, and reported it to the nurse and V1 (Administrator). R41 stated she was so scared that she had the nurse watch her to make sure she made it to her room and R22 wasn't following her. R41 stated she had one other incident with R22, she was in the dining room, moving chairs over to a table for her and some other residents to play dominos, when R22 wheeled over to her and told her to get out of there, she wasn't wanted there. R41 stated she didn't say anything back to R22 and tries to avoid him. R41 stated she understands R22 had a stroke and has dementia, which has caused him to be like that, but he still scares her. R41 stated they moved R22 and to another hall, so she isn't near him.R41's Face Sheet, undated, documents R14 has a primary diagnosis of Disorders of the Muscle.R41's MDS (Minimum Data Set), dated 2/2/26, documents R41 has a BIMS (Brief Interview of Mental Status) score of 14, indicating R41 is cognitively intact.On 4/22/26 at 10:45 AM, R22 denied any concerns with abuse or any past conflicts with other residents.R22's Face Sheet, undated, documents R22 has a primary diagnosis of TIA (Trans ischemic Attack).R22's MDS, dated [DATE], documents R22 has a BIMS score of 13, indicating R22 is cognitively intact.R22's Care Plan, dated 1/23/25, documents resident recently had a verbal altercation with another resident. This resident has requested to be moved away from other resident at mealtimes where altercation took place. Staff is to monitor and makes sure this resident and the other resident are not in contact at any time. Resident continues to have behaviors of yelling and stating false accusations towards staff. He also becomes verbally aggressive with staff during care with his wife.The Facility Abuse Investigations Final Report, dated 7/7/25, documents on 7/7/25 at 4:30 PM, there was an allegation of a resident-to-resident altercation involving R22 and R41. R41 came to administrator to report that she thinks R22 has went nuts. R41 stated R22's eyes were bulging out of his head like an alien. R41 thinks R22 made a threat at her, but she cannot remember exactly what R22 said. R41 stated she thinks it was something about wrapping corn around her neck but is unsure. R41 stated she was not even talking to R22 when he stated this statement to her. R41 immediately left the area of R22. Staff were not present during this time and did not hear any threats being made. R41 stated she is going to stay away from R22 from now on. Administrator spoke with R22 and he stated there was a fight because he feels R44 is being rude to his wife. R22 denied threatening R41. R22 doesn't sound upset about the incident and stated he is going to stay away from R41. The Facility Abuse Investigation Final Report, dated 9/28/25, documents on 9/25/25 at 1:30 PM, there was an alleged resident to resident altercation involving R41 and R22. Administrator followed up on the incident. Administrator spoke to staff member that was<br>(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 |
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| Scott County Nursing Center | Rural Route 2<br>Winchester, IL 62694 |

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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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | present and states R22 raised his voice at R41 and stated, get your a** out of here, you cannot play this game. R41 did not reply but immediately left the area. Staff member confirmed that residents did not physically touch each other and the incident was quickly over. Administrator spoke with R41 who says R22 is not like he was when she worked with him, he is very different. Residents do know each other from outside this setting. R22 does not want R41 to play dominos as she has mentioned in front of several residents before that the game is dumb. Administrator explained everyone is allowed to play the games here if they wish. Administrator encouraged to start two games at separate tables so everyone can play. No further incidents occurred. On 4/22/26 at 11:05 AM, V1 (Administrator) stated when the incident on 7/7/25 occurred, the staff immediately separated the residents and discussed the incident with both residents. V1 stated they reviewed and updated their care plans to keep away from each other. R22 claimed he did not threaten R41. When the incident on 9/25/25 occurred, R41 was going to play dominos with other residents and R22 told R41 to get out of there, she couldn't play. V1 stated at that time the residents would play dominos at one big table together and after that, they divided it into 2 separate games and different tables with staff present. V1 stated there haven't been any further incidents since then. On 4/23/26 at 10:23 AM, V13 (Medical Director) stated he is not aware of any current or past behaviors with R22 or R41 and he would expect the facility to follow their Abuse Policy. The Abuse Prevention Program Policy, with a revision date of 1/26/24, documents this facility advocates for the prevention of, reporting of, and immediate investigation of allegations of resident abuse, neglect, mistreatment, and misappropriation of resident funds or property. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 146106 | A. Building<br>B. Wing | 04/23/2026 |

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| Scott County Nursing Center | Rural Route 2<br>Winchester, IL 62694 |

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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 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to follow physician's orders for weight loss supplements to prevent weight loss for 1 (R5) of 2 residents reviewed for weight loss in the sample of 24. This failure resulted in R5 losing 12 pounds which is 10.34% of weight in less than 30 days.Findings include:R5's Undated Face Sheet documents she was initially admitted to the facility on [DATE]. R5's admission Minimum Data Set (MDS) dated [DATE] documents R5 is severely cognitively impaired. Independent with eating. Height 63 inches and 113 pounds. No or unknown weight loss of 5% or more in the last month or 10% or more in the last 6 months.R5's Care Plan dated 12/1/2025 documents resident has a regular diet with thin liquids, (supplemental ice cream) BID (twice a day.)R5's Registered Dietitian Note, dated 11/19/2025 documents, resident recently admitted r/t (related to) L (left) Femur Fx (fracture.) Hx (history) of UTI (urinary tract infection) and weakness. Regular diet remains adequate for nutrition needs, weight at 113# (pounds), w/n IBW (ideal body weight) Range. Alert and independent at meals. (Supplemental ice cream) started 2x/day for weight support, continue to monitor, Refer PRN (when needed.) Est (estimated) Needs: 1275 cal (calories)/day, 52 g (grams) Pro (protein)/day and 1500 ml (milters)/day not documented what this is related to. R5's Physician's Order Sheet (POS) dated 11/16/2025 documents (supplemental ice cream) BID (twice a day.)R5's Medical Record (electronic and paper chart) dated 11/2025, 12/2025 and 1/2026 no documentation R5 received (supplemental ice cream) BID per physician's orders. R5's Electronic Medical Record, dated 1/5/2026 R5's weight was documented 116.0 pounds and on 1/30/2026 R5's weight was documented 104.0 pounds. R5 lost 12 pounds in less than 30 days, which is 10.34% weight loss. On 4/21/2026 at 12:15 PM R5 was sitting up in wheelchair in dining room. R5 ate 75% of meal including Swedish potatoes with noodles. No (supplemental ice cream) was on her lunch tray.On 4/22/2026 at 9:22 AM V7 (Licensed Practical Nurse/LPN) stated she doesn't administer (supplemental ice cream) to residents because that is a frozen health supplement similar to ice cream that is served to the residents during meal, and the kitchen staff administer them to the residents. V7 stated she doesn't document R5 ate the (supplemental ice cream) because it is administered by kitchen staff and she doesn't know if the resident ate it and she doesn't administer it. On 4/22/2026 at 11:00 AM V5 (Dietary Supervisor) went to the shed and looked in the freezer and stated they do not have any (supplemental ice cream), and they only have one resident that takes it which is (R5) and she will order some today and give R5 extra protein until the (supplemental ice cream) is ordered. V5 stated she wasn't aware the facility didn't have (supplemental ice cream) in stock and didn't know how long it has been since (R5) received a (supplemental ice cream). V5 stated she didn't report to any staff that the facility doesn't have any (supplemental ice cream), and she didn't notify the registered dietician either. On 4/22/2026 at 12:15 PM V11(Registered Dietitian/RD) stated she expects the facility to follow facility policy on implementing RD recommendations and stated she expects her recommendations to be implemented within a week after she documents the recommendations. V11 stated she expects the facility to document health supplements including (supplemental ice cream) to for weight support to be documented as administered and to be available for the resident at the facility as ordered. If any of the health supplements she ordered weren't available, she expects the facility to call and let her know so she can order a different health supplement, so the resident doesn't experience avoidable weight loss. V11 stated she wasn't aware the facility didn't have (supplemental ice cream) available at the facility. On 4/22/2026 at 12:30 PM V1 (Administrator) stated she expects the facility to follow all physician's orders including health supplements to prevent weight loss. V1 stated kitchen staff put (supplemental ice cream) on resident's meal trays because it is meant to be served cold and nurses do not have a way to serve cold items. V1 stated kitchen staff document the (supplemental ice cream) was served. V1 was not aware that the facility didn't have any (supplemental ice cream) in stock and stated they should have<br>(continued on next page) |

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| | 146106 | A. Building<br>B. Wing | 04/23/2026 |

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| Scott County Nursing Center | Rural Route 2<br>Winchester, IL 62694 |

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|---|---|
| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | them if it's a physician's order. On 4/22/2026 at 2:04 PM V1 stated the kitchen staff are not documenting the (supplemental ice cream) are being administered and no one to her knowledge notified the RD that the facility didn't have any (supplemental ice cream). V1 stated she wasn't aware the kitchen staff weren't documenting they were administering the (supplemental ice cream) or if the resident was eating the (supplemental ice cream). V1 stated if the resident is prescribed a (supplemental ice cream) for weight loss and doesn't receive it or doesn't eat it then that intervention isn't working and she expects the dietary staff to notify her or the Director of Nurses (DON) so they can notify the RD, so the resident doesn't experience weight loss. V1 stated she couldn't find any invoices that (supplemental ice cream) were ordered and/or delivered to the facility. The Facility's Nutritional Replacement Policy, dated 1/19/2012, documents all residents exhibiting weight loss or weigh below their ideal body weight average consecutively (with consideration to their weight history) may be place upon a program of Nutritional Replacement and administered as physician orders. Purpose: to prevent weight loss which is frequently observed in elderly residents. Special instructions: The Nutritional Replacements will be given as per physician's orders. A consulting dietician will be in the facility on a monthly basis. As per the dietician's recommendations, nutritional replacements may be recommended to be altered per the resident's physician. The dietary service will provide these replacements. |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their abuse policy by not reporting an allegation of abuse and for not preventing abuse for 2 of 2 residents (R22, R41) reviewed for abuse in the sample of 24.Findings Include:On 4/22/26 at 9:20 AM, R41 stated there was an incident that happened last year with R22. R41 stated she was in the dining room talking with some of the other ladies, when R22 propelled himself in his wheelchair over to her and ran into her with his foot pedals, backed up, and did it two more times. R41 stated R22 then said to her get out, she wasn't needed, and he was going to go out and get a corn stalk out of the field and wrap it around her neck. R41 stated she was scared, felt threatened, and reported it to the nurse and V1 (Administrator). R41 stated she was so scared that she had the nurse watch her to make sure she made it to her room and R22 wasn't following her. R41 stated she had one other incident with R22, she was in the dining room, moving chairs over to a table for her and some other residents to play dominos, when R22 wheeled over to her and told her to get out of there, she wasn't wanted there. R41 stated she didn't say anything back to R22 and tries to avoid him. R41 stated she understands R41 had a stroke and has dementia, which has caused him to be like that, but he still scares her. R41 stated they moved R22 to another hall, so she isn't near him.R41's Face Sheet, undated, documents R14 has a primary diagnosis of Disorders of the Muscle.R41's MDS (Minimum Data Set), dated 2/2/26, documents R41 has a BIMS (Brief Interview of Mental Status) score of 14, indicating R41 is cognitively intact.R41's Progress Note, dated 7/04/25 at 8:48 PM, documents the following: Reported to this nurse from another resident (R41) that during supper time, R41 told R22 that he does not know how to be a husband and doesn't do anything right. R41 reported to other nurse, R22 told her to shut up with big mean eyes. Did not give a reasoning as to why he had told her to shut up.R22's Face Sheet, undated, documents R22 has a primary diagnosis of TIA (Trans ischemic Attack).R22's MDS, dated [DATE], documents R22 has a BIMS score of 13, indicating R22 is cognitively intact.R22's Care Plan, dated 1/23/25, documents resident recently had a verbal altercation with another resident. This resident has requested to be moved away from other resident at mealtimes where altercation took place. Staff is to monitor and makes sure this resident and the other resident are not in contact at any time. Resident continues to have behaviors of yelling and stating false accusations towards staff. He also becomes verbally aggressive with staff during care with his wife.R22's Progress Note, dated 7/04/25 at 8:45 PM, documents the following: Resident summoned writer to room and stated that he needs to talk to me. R22 stated that during supper time, another resident (R41), told him that he does not know how to be a husband and does nothing right. Res informed me that he did yell at her and told her Shut up! You know everybody's' business and if you don't know it you, are trying to find out! Resident is requesting for him and his wife to sit together away from R41 during mealtimes.The Facility Abuse Investigations Final Report, dated 7/7/25, documents on 7/7/25 at 4:30 PM, there was an allegation of a resident-to-resident altercation involving R22 and R41. R41 came to administrator to report that she thinks R22 has went nuts. R41 stated R22's eyes were bulging out of his head like an alien. R41 thinks R22 made a threat at her, but she cannot remember exactly what R22 said. R41 stated she thinks it was something about wrapping corn around her neck but is unsure. R41 stated she was not even talking to R22 when he stated this statement to her. R41 immediately left the area of R22. Staff were not present during this time and did not hear any threats being made. R41 stated she is going to stay away from R22 from now on. Administrator spoke with R22 and he stated there was a fight because he feels R41 is being rude to his wife. R22 denied threatening R41. R22 doesn't sound upset about the incident and stated he is going to stay away from R41. The Facility Abuse Investigation Final Report, dated 9/28/25, documents on 9/25/25 at 1:30 PM, there was an alleged resident to resident altercation involving R41 and R22. Administrator followed up on the incident. Administrator spoke to staff member that was present and states R22 raised his voice at R41 and stated, get your a** out of here, you cannot play<br>(continued on next page) |

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| | 146106 | A. Building<br>B. Wing | 04/23/2026 |

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|---|---|
| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | this game. R41 did not reply but immediately left the area. Staff member confirmed that residents did not physically touch each other and the incident was quickly over. Administrator spoke with R41 who says R22 is not like he was when she worked with him, he is very different. Residents do know each other from outside this setting. R22 does not want R41 to play dominos as she has mentioned in front of several residents before that the game is dumb. Administrator explained everyone is allowed to play the games here if they wish. Administrator encouraged to start two games at separate tables so everyone can play. No further incidents occurred. On 4/22/26 at 11:05 AM, V1 (Administrator) stated when the incident on 7/7/25 occurred, the staff immediately separated the residents and discussed the incident with both residents. V1 stated they reviewed and updated their care plans to keep away from each other. R22 claimed he did not threaten R41. When the incident on 9/25/25 occurred, R22 and R41 were going to play dominos with other residents and R22 told R41 to get out of there, she couldn't play. V1 stated at that time the residents would play dominos at one big table together and after that, they divided it into 2 separate games and different tables with staff present. V1 stated there haven't been any further incidents since then. On 4/22/26 at 2:30PM, V1 (Administrator) stated she does not have an allegation of abuse for 7/4/25, only the one for 7/7/25. V1 stated she would expect the staff to follow their abuse policy.The Abuse Prevention Program Policy, with a revision date of 1/26/24, documents this facility advocates for the prevention of, reporting of, and immediate investigation of allegations of resident abuse, neglect, mistreatment, and misappropriation of resident funds or property. |

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|---|---|
| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an allegation of a verbal resident to resident altercation in 2 of 2 residents (R22, R41) reviewed for reporting of alleged abuse violations in the sample of 24.Findings Include:R41's Face Sheet, undated, documents R14 has a primary diagnosis of Disorders of the Muscle.R41's MDS (Minimum Data Set), dated 2/2/26, documents R41 has a BIMS (Brief Interview of Mental Status) score of 14, indicating R41 is cognitively intact.R41's Progress Note, dated 7/04/25 at 8:48 PM, documents the following: Reported to this nurse from another resident (R41) that during supper time, R41 told R22 that he does not know how to be a husband and doesn't do anything right. R41 reported to other nurse, R22 told her to shut up with big mean eyes. Did not give a reasoning as to why he had told her to shut up.R22's Face Sheet, undated, documents R22 has a primary diagnosis of TIA (Trans ischemic Attack).R22's MDS, dated [DATE], documents R22 has a BIMS score of 13, indicating R22 is cognitively intact.R22's Progress Note, dated 7/04/25 at 8:45 PM, documents the following: Resident summoned writer to room and stated that he needs to talk to me. R22 stated that during supper time, another resident (R41), told him that he does not know how to be a husband and does nothing right. Res informed me that he did yell at her and told her Shut up! You know everybody's' business and if you don't know it you, are trying to find out! Resident is requesting for him and his wife to sit together away from R41 during mealtimes.There was not a Facility Abuse Investigation for the alleged verbal resident to resident altercation on 7/4/25.On 4/22/26 at 2:30PM, V1 (Administrator) stated she does not have an allegation of abuse for 7/4/25, only the one for 7/7/25.The Abuse Prevention Program Policy, with a revision date of 1/26/24, documents this facility advocates for the prevention of, reporting of, and immediate investigation of allegations of resident abuse, neglect, mistreatment, and misappropriation of resident funds or property. |