STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146154	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Concordia Village Care Center	4101 West Iles Avenue Springfield, IL 62711

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 - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review, the facility failed to ensure residents were free from verbal abuse from staff for 1 of 3 residents (R31) reviewed for abuse in the sample of 34. Findings Include:R31's Face Sheet, print date of 1/5/26, documented R31 has diagnoses including Parkinson's disease, dementia, visual hallucinations, aphasia, and dysphagia.R31's MDS (Minimum Data Set) documented R31 is severely cognitively impaired and is dependent on staff for mobility. R31's care plan, print date of 1/5/26, documented R31 has a diagnosis of anxiety disorder with physical manifestations of hallucinations with interventions including touch hands/shoulder to show caring or provide comfort. Provide 1-1 interaction. The Facility's IDPH (Illinois Department of Public Health) Notification form, dated 11/21/25, documented date of alleged incident: 11/8/25 and 11/11/25, General Category: Resident verbal abuse, Name of Resident: (R31), Mental Status: Alert and oriented X1. It continues, during the process of investigation, medical record review and interview of witnesses, etc., the following conclusions have been determined about the alleged incident: Residents room has electronic monitoring in place with signage at the entrance of her room to indicate this. The residents spouse reviewed camera footage from 11/8/25 and 11/11/25 and showed this footage to the DON (Director of Nursing) on 11/17/25. In the video footage from 11/8/25, the staff member, (V18, CNA/ Certified Nurse Assistant) is getting the resident ready for a shower. The resident is naked, and the staff member (V18) is putting the (mechanical lift) sling underneath the resident. The resident has a urinary incontinent episode. The staff member (V18) responds to resident, Girl, of course you would pee right now. Right now, of all the times in the world! In the footage from 11/11/25, the staff member (V18) is providing care for the resident and is also on her personal cell phone using the speaker mode talking to someone. She uses explicit language during the call as the resident is present. The staff member (V18) states, 'It is so f*****g the bomb. Oh, my f*****g God. I'm trying to make all this shit make sense.' Immediately after viewing this video, administrator was notified, and the staff member was suspending pending investigation. Based on the regulation, this is verbal abuse. The staff member (V18) was suspending during the investigation. Residents and staff were interviewed with no further findings of abuse. The facility's Corrective Action form for employee V18, dated 11/20/25, documented V18 was terminated on 11/20/25 via phone with Administrator and DON present for verbal abuse. On 1/6/25 at 2:35 PM, V2, DON (Director of Nursing), stated she reviewed the video footage of the verbal abuse by a CNA to R31. V2 stated, It was definitely abuse; we immediately suspended the CNA and then terminated her.On 1/8/25 at 9:20 AM, V1, Administrator, stated her abuse investigation did substantiate verbal abuse occurred to R31 by V18, CNA. The facility's Abuse/Neglect Prevention and Response policy, revision date of 7/29/21, documented residents and clients of facility campuses and programs will live and be served in an environment that promotes dignity, respect and strives to be free from abuse, neglect, and exploitation. Allegation of potential or actual abuse, neglect or exploitation will be immediately reported to the appropriate leadership 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146154	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	government agency, the resident protected, and the allegation investigated. Definitions: Abuse the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish as well as the deprivation of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. It continues, verbal abuse is defined as any use of oral, written, or gestured language that includes disparaging and derogatory remarks to residents/clients or their families within their sign or hearing, regardless of the resident or client's ability to comprehend the language.

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NAME OF PROVIDER OR SUPPLIER Concordia Village Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4101 West Iles Avenue Springfield, IL 62711	

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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 interview, observation, and record review, the facility failed to implement fall interventions for 2 out of 6 residents (R4, R46) in a sample of 34 reviewed for Quality of Care. Findings include:1.R4's Facesheet documented she was admitted to the facility on [DATE] with diagnoses of dysphasia, drug induced Parkinsonism, and chronic obstructive pulmonary disease.R4's Minimum Data Set (MDS), dated [DATE], documented she was severely cognitively impaired and was dependent on staff to roll in bed and for chair/bed to chair transfers. The MDS also documented they could not complete transfers involving sit to lying, lying to sitting, sit to standing, toilet, or shower due to R4's current illness, exacerbation or injury.R4's Care Plan, dated 1/24/22, documented she is a risk for falls with interventions of: on 1/28/22 provide body pillow while in bed; on 10/19/23 fall mat in place next to bed; on 8/21/25 fall body pillow (already implemented on 1/28/22) to assist resident comfortably on her side to help with pressure reducing to coccyx/wound area; Fall 10/26/25 continue current interventions, ensure bear is in reach of resident while in bed; on 1/24/22 fall risk assessment to be completed on admission, quarterly, if significant changes, and with falls.The facility's Adverse Event Documentation, dated 8/21/25, documented R4 fell due to contributing factors of improper positioning in bed and R4 stated she was rolling over in bed. The document continued to report R4 was found next to her bed. The facility's Adverse Event Documentation, dated 10/26/25, documented, (R4) slid out of bed to the floor. Did not call for help prior to fall. Stated she did hit her head. No obvious injuries noted. No bumps, swelling, abrasions or bleeding noted on head or on any extremity. The document continued to report the contributing factors to R4's fall were form incontinence, disease process, and prior left sided cerebral vascular accident (CVA) routinely leaning to right and R4 stated she was attempting to grab her bear that had fallen off the bed. R4's Fall Risk Assessments, dated 6/5/25, 6/20/25, 8/13/25, 9/9/25 and 12/5/25, all documented R4 is a low fall risk and documented she has not had any falls. No Fall Risk Assessment was completed for R4's falls on 8/21/25 or 10/26/25. On 1/8/26 at 8:30 AM, V12 (Licensed Practical Nurse/LPN) was assisting with transferring R4 in from her bed to her wheelchair and stated she honestly does not know where her body pillow is right now or why it isn't in her room and nodded in agreement it should be. No body pillow was observed in R4's room, besides the one her roommate had in her bed, as she was lying in bed preparing to be transferred. 2.R46's Facesheet documented he was admitted to the facility on [DATE] with diagnoses of hemiplegia, heart failure, and muscle weakness.R46's MDS dated [DATE] documented he was severely cognitively impaired and required substantial/maximal assistance from staff to roll left and right in bed, and for all transfers. R46's Care Plan, dated 11/3/25, documented he is at risk for falls with interventions of, in part, on 11/3/25 side rail(s) as an enabler to assist with transfers and bed mobility- grab bars; remind and reinforce safety awareness, lock brakes on bed, chair, etc. before transferring; educate/remind Rich and/or family to request assistance for all ambulation and transfers; non-skid socks; appropriate footwear; fall risk assessment to be completed on admission, quarterly, and with significant changes. On 11/25/25 interventions of; in part, were to place R46 where visible to staff, encourage activity participation; on 1/1/26 to check on R46 beginning at 8:30a (AM) to see if he is ready to get out of bed; use of body pillow for positioning while in bed; continue will all current fall interventions, including ensuring call light is in reach, encourage activities, personal items are in reach and provide toileting assistance every 1-2 hours. The facility's Adverse Event Documentation, dated 11/23/25, documented R46 was sitting near the edge of his wheelchair and lowered down to the floor by staff but did not include an interview of what R46 was attempting to do. The (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	document continued to report the fall was due to contributing factors of confusion/memory deficit, change in mental status, and impaired communication. The facility's Adverse Event Documentation, dated 1/1/26, documented R46 fell and was found hanging out of bed with his knees on the floor mat but did not provide an interview of what the R46 was attempting to do. The documentation continued to report the contributing factors of the fall were due to confusion/memory deficit and alerted gait/balance/tripped. The facility's Adverse Event Documentation, dated 1/1/26, documented R46 fell and was found on the floor after hearing a loud noise. R46 had two skin tears found after the fall. The document continued to report R46's fall was due to contributing factors of (again) confusion/memory deficit and disease process improper/self-transfer. R46's Fall Risk Assessment, dated 11/18/25, documented he is a low fall risk with no new evaluation completed. On 1/6/26 at 1:30 PM, V16, Licensed Practical Nurse (LPN), took R46's socks (with no grips) off to show his foot wounds and reapplied them, put his blanket back over his feet and left him the same way he was found (wearing socks without grips and no body pillow in bed).On 1/6/26 at 1:30 PM, V16 (LPN) stated R46 has a skin tear on his left forearm from his last fall. V16 stated R46 doesn't always use his call light and will get up by himself. V16 stated R46 is very unsteady on his feet.On 1/8/26 at 9:08 AM, V22, Certified Nursing Assistant (CNA), stated fall prevention interventions include gait belts, proper footwear, proper use of walkers and looking at the resident's sheets for detailed interventions. V22 stated she is new and doesn't know a lot, but can ask co-workers for information on the residents. On 1/8/26 at 9:10 AM, V23 (CNA) stated, For (R46's) fall preventions, we have a body pillow for him in bed, frequent checks, and a fall mat. V23 stated she thinks his falls are due to them not being able to get to him in time; he gets up on his own sometimes. V23 stated R46 is always incontinent. V23 stated R4's fall interventions also include a body pillow and is not sure what else or why she has fallen in the past. V23 stated for all residents she likes to make sure the beds are low, and body pillows are in place. V23 (CNA) stated hand hygiene is done before and after glove use; before and after serving a resident food and before and after feeding a resident with gloves.On 1/8/26 at 9:12 AM, V24 (CNA) stated R46's fall preventions include a long pillow in bed, a fall mat, a call light in reach. V24 stated she wasn't sure why he has fallen in the past, but he is with it enough to answer simple questions such as what he was doing before the fall. V24 (CNA) stated hand hygiene is done before and after glove use; before and after serving a resident food and before and after feeding a resident with gloves.On 1/8/26 at 12:15 PM, V1 (Administrator) stated risk assessments are completed quarterly, and upon admission, also after each fall the nurse completes a mini root cause assessment to determine new interventions and after that a deeper investigation is done; care plans are updated with new interventions. V1 stated any resident that has fallen in the last 6 months would not be considered a low fall risk. V1 stated R4's body pillow intervention added 8/21/25 she considered to be new just utilizing the same tool in a different way. On 1/8/26 at 1:09 PM, V2, Director of Nursing (DON), stated she expects the staff to be following fall interventions. The facility's Management of Falls policy last revised 9/14/22, documented, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The policy continued to document staff will identify and implement relevant interventions to try to minimize serious consequences of falling.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to transcribe and follow the physician's orders for 1 of 5 (R1) reviewed for physician orders in the sample of 34. The findings include:R1's Facesheet, dated 1/6/26, documents R1 was admitted on [DATE] with diagnoses of Aortic Valve replacement, Pulmonary emboli and fibrosis, Atrial Fibrillation, Atherosclerotic heart disease, Diabetes Mellitus Type 2, Malignant neoplasm of bronchus or lung, Benign Prostatic Hyperplasia (BPH), Depression, and Chronic Obstructive Pulmonary Disease. R1's Care Plan, dated 12/24/25, documents R1 is on an anticoagulant and is at risk for bleeding. R1 is at risk for falls/injury as evidenced by history of falls, cognitive status/behavior, vision status, continence, mobility, balance. R1 has Activities of Daily Living (ADL) selfcare deficit related to decreased mobility and muscle weakness. R1's Minimum Data Set (MDS), dated [DATE], documents R1 is cognitively intact and requires partial/moderate assistance from staff for ADLs.R1's Physician Order (PO), dated 12/20/25, documents, Warfarin 10 MG (milligram) tablet 1 Time Daily for 1 Day. First scheduled time is 12/20/25 at 8:00 PM. There was no Warfarin order entered prior to this order.R1's Nursing Event Note, dated 12/20/25 at 8:50 PM, documents, Writer doing chart audit check and noticed that Coumadin was on all discharge instructions. Writer contacted supervisor and went over orders with her. LPN (Licensed Practical Nurse) called on call doctor to obtain new orders for INR of 1.1. Residents coumadin was found in medication room with multiple different doses. R1's Nursing Progress Note, dated 12/20/25 at 9:15 PM, documents, Call returned from Dr. Following new orders received. Coumadin 10 MG now. Coumadin 5 MG 10/21/25 and repeat INR (International Normalized Ratio) 12/22/25.V1, Administrator's, Investigation for R1's Medication Event, dated 12/21/25, documents, Resident admitted to the facility on [DATE]. On 12/20/25 a chart audit was performed and was found that resident had orders for Warfarin (Coumadin) upon admission that were not entered. Resident went 5 days without receiving Warfarin. INR obtained and was 1.1. Physician advised and new Warfarin orders and INR orders obtained. Resident and family aware. During risk analysis, it was determined that resident's medication list was faxed over prior to admission on 12/15. This list was used to create resident's medication list. Resident arrived at the facility on 12/15 with an updated set of orders in hand. The two list were not reconciled. The facility has taken the following actions based on the facts and conclusions of the investigation: admission audits will be completed within 24 hours of admission to include a reconciliation of medications, review of MARs (Medication Administration Records) from discharging facility.R1's Nursing Note, dated 12/23/25 at 3:40 PM, documents, Resident INR 2.2 left message with (V28, Physician) Nurse (V30, Certified Medical Assistant). (V30) called back and (V28) wants to stay with 5 MG of Warfarin and recheck INR in 1 week.R1's INR (International Normalized Ratio) results, dated 12/20/25 as 1.1, on 12/22/25 as 1.7, on 12/23/25 as 2.2, on 12/30/25 as 4.0, and on 1/2/26 as 1.9. According to the Cleveland Clinic website (https;//my.clevelandclinic.org/health/diagnostics/prothrombin-time-test), the normal ranges for INR results are 0.8 to 1.1 and an INR of 2.0 to 3.0 if you're taking Warfarin.R1's Medication Administration Record (MAR), dated December 2025, documents Warfarin was entered on 12/20/25. On 1/8/26 at 11:15 AM, V2, Director of Nursing (DON), stated, When a resident is admitted , we do an admission Audit within 24 hours of the resident's arrival. This audit looks to see if all physician orders and resident assessments have been completed. When (R1) was admitted , apparently the audit was not done for 5 days after his arrival. I think if it was originally done, they were looking at the faxed orders instead of the orders that came with him. I would expect the 24-hour admission Audit to be completed within the first 24 hours after admission. On 1/8/26 at 11:20 AM, V20, Registered Nurse (RN), stated, When a resident is admitted , the nurse should (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fax all physician orders to the pharmacy, who will then enter each medication into the EMR (electronic medical record). We then will do a double check by acknowledging each med in the system to get them going. The nurse will then complete all resident assessments. Us nurses (sic) don't do the 24-hour audit; that is done by a supervisor.On 1/8/26 at 9:55 AM, attempted to contact V28, Medical Director, regarding R1's Coumadin Medication Event. V30, V28's Certified Medical Assistant (CMA), stated V28 is out of the country and will not be back until 1/21/26. V30 stated V29, Nurse Practitioner (NP), is covering for V28. V30 stated her notes show R1 was put back on Coumadin 5 MG daily on 12/22/25 and she is unable to tell surveyor anything further.On 1/8/26 at 12:55 PM, V29, NP, stated, It is not ideal for anyone on Warfarin to not get their Warfarin. There is no way to know the risk of not taking the Warfarin for 5 days. I don't believe (R1) had any harm from missing his Warfarin. I would expect any nurse to follow the physician orders.The facility's Reconciliation of Medication Policy, dated 2/19/25, documents, The purpose of this procedure is to ensure medication safety by accurately accounting for the resident's medication, route, and dosage upon admission or readmission to the community and transfers between levels of care. Preparation: 1. Gather the information needed to reconcile the medication list: a. Discharge summary from referring hospital, MAR from other transferring facility. b. admission order sheet. c. All prescription and supplement information obtained from the resident/family during the medication history. d. Most recent medication administration record (MAR) if there is a readmission. Steps in the Procedure: 1. Obtain a medication history from the resident and/or representative. 2. The information from the medication history should include a. Prescription medications, including those taken only as needed; b. Non-prescription/over the counter medications, including those taken only as needed, c. Herbal or dietary supplements, including vitamins and minerals; d. Patches, eye drops, creams, inhalers, shots, sample medication; e. Dosage, route, frequency and last dose taken for all items; and f. Reason(s) for taking each medication/supplement. 3. Review the list carefully to determine if there are discrepancies/conflicts. 4. If there is a discrepancy or conflict in medication, dosage, route or frequency, contact the physician within 24 hours and document. 5. When a resident is transferred to another facility, or within the organization, send the reconciled medication list to the receiving physician.The facility's admission Assessment and Follow Up: Role of the Nurse Policy, dated 2/19/25, documents, The purpose of this procedure is to gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission for the purposes of managing the resident, initiating the care plan or Individualized Service Plan (AL/ALMC), and completing required assessments. Steps in the Procedure: 5. Reconcile the list of medications from the medication history, admitting orders, the previous MAR (if available), and the discharge summary from the previous institution, according to established procedures. 6. Contact the physician and review the findings of the initial assessment and any other pertinent information and either obtain admission orders or reconcile orders that arrive with the resident that are based on these findings.