STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E701	A. Building B. Wing	12/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Meadows	1000 Longmoor Savanna, IL 61074

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a resident was treated with respect and dignity and not subjected to verbal abuse from a facility employee for 1 of 3 residents (R3) reviewed for Resident Rights and abuse in the sample of 3.The findings include:R3's admission record shows she was admitted to the facility on [DATE]. The quarterly resident assessment and care screening of 11/24/25 documents R3 to have moderate cognitive impairment. The same document shows she is dependent on staff for activities of daily living and for mobility.On 12/6/25 at 1:30 PM, R3 said the incident happened a while ago, and does not recall the exact words, but remembers the girls were nasty towards her while providing care. R3 said the way they spoke to her was disrespectful. She recalled the staff saying, 'Well, if you weren't so old,' just nasty things. I told her to knock it off and she did not listen, and said, 'I don't know why they send you (old) people here.' The facility's investigation showed a statement written by V11 (Certified Nursing Assistant/CNA) on 11/7/25 documented R3 put her call light on around 10:30 PM on 11/7/25 and stated she was not doing well. R3 asked her if the shift had changed and was told the second shift had left the building. V11 documented R3 said the two aides (V4 CNA and V5 CNA) who had been in her room had hurt her. V11 immediately informed the nurse. V11 documented when she received report from V4 (CNA), V4 told her she had said something to R3 along the line of R3 belonging on the (dementia) unit if she keeps digging herself out, and R3 had replied fine then take me there and V4 told R3 Let's go. The investigation showed V4 and V5 denied the events took place. The facility's post-incident follow-up documents that V4 made the comment to V11 she had told R3 she belongs on the (dementia) unit if she keeps digging herself out.The facilities final report states Investigation into verbal abuse is substantiated.On 12/6/25 at 1:30 PM, V1 (Administrator) said on 11/7/25, V4 and V5 were both working the evening shift, and V11 came in at 10 PM to work the night shift. She said R3 reported her concerns to V11 and that V12 (Registered Nurse) also spoke with R3 regarding the issue. V1 said the incident was called to her and an investigation was initiated.Phones calls on 12/6/25 to V11, V4, V5, and V12 were not answered nor returned prior to exit.The facilities Abuse Program Policy states the definition of verbal abuse is defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents, or their families, or withing their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include but are not limited to; threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again.

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