| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 14E701 | A. Building<br>B. Wing | 05/14/2026 |

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

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that food was served at palatable temperatures. This applied to residents reviewed for dining/palatable food which included R33, R37, R66 and the resident council in the sample of 31.The findings include:On 5/12/26 at 10:13 AM, R33 stated she eats in her room and in the dining room. R33 stated her food is served cold all the time.On 5/12/26 at 10:21 AM, R66 stated he eats in his room and his food that is supposed to be warm is cold by the time it gets to him. R66 stated the staff just drop his food tray off and leave. R66 stated he had told staff about and he was not aware he could have staff warm up his food.On 5/13/26 at 8:39 AM, R37 stated that sometimes her hot food is served cold. R37 stated yesterday when she received her lunch tray her ice cream was melted. R37 stated she doesn't know why that is and that she guesses it is just the way it is.On 5/13/26 at 10:34 AM, during the resident council meeting the residents stated that the hot food is served cold sometimes and they don't like it. They stated they were not crazy about the food to begin with and don't like the food to be served cold. They stated the food that is supposed to be warm is served cold in the dining room and for room trays.R33's Minimum Data Set (MDS) dated [DATE] showed no cognitive impairment. R66's MDS dated [DATE] showed no cognitive impairment. The MDS dated [DATE] for R37 showed no cognitive impairment.The February 23, 2026 Resident Council Meeting Notes showed room trays were getting cold food. Residents request the use of insulated covers and to stop using foil. Residents believe the microwave is broken as it does not properly heat food. Food in the dining room is cooling down too fast before being served.The March 16, 2026 Resident Council minutes showed residents stated the room trays were being delivered without the thermal food cover containers.The April 20, 2026 Resident Food Council Minutes showed there were issues with room tray delivery. Residents stated trays are being delivered without the thermal food cover containers. There are delays and other issues with food.On 5/13/26 at 1:41 PM, V1 (Administrator) stated she is currently over the dietary department. V1 stated they have been getting cold food complaints. V1 stated the room trays are all being plated up at the same time and then taken out to the halls, but they cool off because they sit on the rack waiting to be served. V1 stated the hot food should be served hot. The facility's Menu and Adequate Nutrition policy (2026) showed the facility will provide residents with nourishing, palatable and well balanced diets that meet his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident and establish menus based upon this guidance. |

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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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide shower assistance for a resident dependent upon staff for assistance. This applies to 1 of 3 residents (R25) reviewed for activities of daily living in the sample of 31. The findings include:R25's admission Record (Face Sheet) showed he was admitted to the facility on [DATE] with diagnoses to include but not limited to shortness of breath, depression, and arthritis. R25's 3/5/26 Quarterly Minimum Data Set (MDS) showed he was cognitively intact with a Brief Interview for Mental Status score of 13 out of 15. The MDS showed he required partial/moderate assistance for showering/bathing. On 5/12/2026 at 9:40 AM, R25 stated, .Last Friday (5/8/26) I didn't get a shower and it was about two weeks before I finally got one. Tuesday I get a shave and Friday I get a shower and a shave. It doesn't happen often, but it doesn't happen. They promised me twice on Friday, they promised me at 2:00 PM they would do it then they promised me again at 3:00 PM and I didn't get it. They didn't say anything why I didn't get my shower. They help me in the shower. I have to sit down and shower; I'm afraid I will fall. I like my shower, it makes me feel clean. I only get one or two a week so it's pretty important I get it. I don't have a shower in my room they have to take me to the shower room. I don't refuse my showers I really enjoy them. On 5/14/2026 at 9:22 AM, R25's shower sheets for the previous two months were requested from V2 (Director of Nursing.) On 5/14/2026 at 9:38 AM, V2 provided R25's shower sheets with the most recent being 4/24/26. On 5/14/2026 at 10:06 AM, V3 (Certified Nursing Assistant/CNA) stated the resident shower assignments are posted on the medication room door. V3 stated the shower sheets are placed by the nurses in the medication room. The posted scheduled showed R25's shower days were Tuesday and Friday. On 5/14/2026 at 10:13 AM, V2 stated she had collected all of the shower sheets and what was provided is all that was available. On 5/14/2026 at 11:02 AM, V2 (Director of Nursing) stated most residents are scheduled for two showers a week. V2 said, if a resident refuses a shower, it should be documented on the shower sheet. V2 said, Showers are important. It provides cleanliness, infection prevention, as well as mental and physical wellbeing. The facilities Resident Shower policy showed Residents will be provided showers as per request or as per facility schedule protocols and based upon resident safety. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>Based on observation, interview, and record review the facility failed to assess a resident experiencing a change in condition. This applies to 1 of 3 residents (R3) reviewed for changes in condition in the sample of 31. The findings include:R3's admission Record (Face Sheet) showed an admission date of 10/13/25 with diagnoses to include but not limited to heart failure, bipolar disorder, anxiety, and type 1 diabetes. R3's 3/17/26 Quarterly Minimum Data Assessment (MDS) showed she was not comatose, she could hear adequately, she could make herself understood, she could understand others, and she had adequate vision. R3's MDS showed she had moderate cognitive impairment with a Brief Interview for Mental Status score of 8 out of 15 (15 being a perfect score, cognitively intact). The BIMS showed she was able to repeat three words said to her, she correctly answered the month and the day of the week. On 5/12/2026 at 11:40 AM, R3 was in bed, on her back, and in hospital gown. R3 opened her eyes; however, she could not lock eyes and did not respond to any questions. On 5/12/2026 at 12:47 PM, R3 was in the same condition as previously described. R3's 5/12/26 Nurses' Note from 9:13 PM (Authored by V9 Registered Nurse), showed During routine rounds, noted resident to be difficult to arouse, lethargic, confused. She believes she is at her daughter's house. Overall presents with general weakness and fatigue, staying in bed all day, reduced appetite. Able to follow commands with several prompts/cues. Lungs clear throughout. [Vital signs taken] Call placed to POA (Power of Attorney) and he would like her sent to ER (Emergency Room) to be evaluated. [Local] Ambulance dispatched at 2053 (8:53 PM) for altered mental status, transported resident to [local area hospital]. R3's 5/13/26 Nurses note from 4:12 AM showed she returned to the facility at 3:48 AM after .She was given IVF and magnesium as her electrolytes were imbalanced. Res is a/o x 4 (alert and oriented times four; person, place, time, situation), states she feels better. VSS (vital signs stable). Multiple tests performed. No abnormalities found . On 5/13/26 at 1:27 PM, V6 (Registered Nurse) stated R3 took her morning medications on 5/12/26 and R3 was a .little sleepy. On 5/13/2026 at 1:35 PM, V3 (Certified Nursing Assistant/CNA) stated R3 is typically alert and she will answer questions. V3 said V8 (CNA) was R3's day shift CNA on 5/12/26. On 5/13/2026 at 2:02 PM, V8 (CNA) stated she is typically a memory care CNA; however, she does work skilled nursing, and she was familiar with R3 having worked with her a few times prior to 5/12/26. V8 said, .Prior to yesterday, she was a lot better, she had been getting up and going to meals stuff like that, talking, answer questions, and that was as recent as a couple of weeks ago. She goes to the dining room in her wheelchair. Yesterday, she was not responsive. She wouldn't talk much, she wouldn't eat, but I was able to get her to drink a little. How she was yesterday, that was a change in her condition. I did tell the nurse about it and I took her vitals. I told the day nurse a few times I didn't think she was right. I even told the next nurse because I just didn't feel like she was right. The day nurse was [V6 Registered Nurse/RN]. I told her (V6) a few times. She said she would go check on her and I did see her go in there. [V9] was the night nurse and I did tell her and she went down there right away. I told [V9], would you please go down and look at her she is really worrying me today. [R3] did not eat for me at all yesterday. I don't know if this is has ever happened to her before. V8 stated she requested V3 also look at R3 for her opinion and V3 agreed R3 was not at her baseline. On 5/13/2026 at 2:25 PM, V3 stated V8 did request she check on R3. V3 said, .Yesterday was so hectic, but I did go down there with [V8] and see her (R3) and I told [V8] to just keep telling the nurse that something is not right with her. I did agree with [V8] that something was not right. [R3] is normally not like that. How I saw her yesterday, that was a change in her condition. She normally eats without issue. Not eating breakfast, lunch, and dinner is not typical for her. She sometimes skips lunch but not all three meals. On 5/13/2026 at 2:50 PM, V6 stated, regarding 5/12/26, The CNA never told me anything about [R3]. She never asked me to go check on her. On 5/13/26 at 2:40 PM and 5/14/26 at 8:30 AM, V9 (RN) was called, and a message was left. On 5/14/26 at 8:33 AM, a request was made with V2 (Director of Nursing) for her to contact V9 and have V9 return the call for an interview; no return call was made<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | prior to exiting this survey. R3's vital signs showed V8 documented an oxygen saturation and temperature at 6:00 PM. No other vital signs were documented by the day shift on 5/12/26. R3's Progress notes show no documented entries or assessments by V8 or any nurse during the day shift on 5/12/26. R3's May 2026 meal intakes showed she refused all three meals on 5/12/26. The May intakes showed this was the only time this occurred and she only refused two other meals for the month. R3's Assessments heading in the electronic charting showed no documented change in condition or similar assessments for 5/12/26. R3's 2/25/26 Nurses note from 2:38 PM, showed CNA went in to perform AM cares and res (resident) sitting on edge of bed searching for dog. CNA reports res also attempted to push her out of the way with her elbow and then run her w/c (wheelchair) towards her as if to go through her. Res was assisted and brought to breakfast, where she continued to demand her dog and accuse staff of stealing it and hiding it from her. Phoned 911 to send res for eval for altered mental status and acute delusions.Res returned via our transportation at 1400 (2:00 PM). Hospital reports res has UTI (urinary tract infection) and magnesium was low again. R3's 1/17/26 Nurses' Note from 6:04 PM, showed 1545 (3:45 PM) CNA's got resident up for supper. Resident was leaning forward in the w/c, twitching. Resident unable to keep self-upright in w/c. Resident is A&O to self , Resident would answer a question but then fall back to sleep. Notified POA. He agreed to have resident evaluated at the hospital. R3's 1/17/26 Nurses' Note from 7:23 PM showed R3 had a Urinary Tract Infection and her magnesium level was low. The note showed she received intravenous magnesium and an antibiotic. On 5/14/2026 at 11:08 AM, V2 stated if a nurse is notified of a change in condition, they .should go down and do an assessment then notify the doctor, then notify the family. Assessment includes vital signs and a targeted assessment based on the symptoms. V2 said the assessment should be documented in the progress notes. V2 said the day nurse on 5/12/26 should have listened to the CNAs and assessed R3. V2 said the purpose of an assessment is to identify a change in condition as well as gather information to present to the provider so they can make appropriate decisions and determine if the resident requires emergency care. |

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| F 0687<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate foot care.<br><br>Based on observation, interview, and record review the facility failed to ensure footcare including monitoring and treatment was provided after a residents toe was cut during a podiatry visit for 1 of 3 residents (R37) reviewed for foot care in the sample of 31.The findings include:On 5/13/26 at 8:39 AM, R37 stated the doctor cut her toenail too short last time that she had her toenails trimmed. R37 stated there was bleeding to the big toe on the left foot after her toenails were cut. R37 stated she hasn't had her toenails cut since this happened.On 5/13/26 at 1:19 PM, V2 (Director of Nursing/DON) stated she was not aware of R37's toe being cut by the podiatrist and that it wasn't reported to her.On 5/14/26 at 8:30 AM, V2 (DON) stated she investigated R37 and the podiatrist cutting her toe. V2 stated she found a secure conversation written by the nurse to the resident's primary physician on 3/9/26 that showed R37 was seen by the podiatrist, her toenails were clipped, the left big toe was bleeding and wrapped by the podiatrist. The note stated the family wanted to use a Dremel or nail grinder for podiatry visits and asked if it was okay to use. The response from the doctor was to add her to his list. The doctor never said yes or no if it was okay to use the Dremel tool. V2 stated there weren't any treatment orders given for the cut on R37's toe. V2 stated the facility should have reviewed this closer. V2 stated they should have followed up on the secure conversation. V2 stated they should have followed up on what the doctor said and followed up on the visit with the doctor. V2 stated skin checks should have been done and a proper treatment put in place; R37 is diabetic. V2 stated they still don't have the podiatrist's notes from the visit. V2 stated an incident report should have been done after this; V2 stated she did one last night. A secure conversation note dated 3/9/26 for R37 showed she was seen by the podiatrist, her toenails were clipped, and the left toe was bleeding and wrapped by the podiatrist. The family was in to visit and wants to use a Dremel or nail grinder for all podiatry visits. The communication showed the nurse asked if this was okay and asked if the nurse practitioner could look at the resident's toe. The physician responded to add the resident to his list.R37's physician notes showed the doctor did not see her until 4/9/26. The physician's note showed he saw the resident that day for a routine nursing home visit. The note did not show anything regarding her toenails or the cut to her left big toe.The New Skin Alteration Incident that V2 filled out on 5/13/26 for R37 showed on 3/9/26 the podiatrist visited and performed toenail care to the left foot, nicked the resident's left foot and bleeding was noted. R37 witnessed the provider nicking her left great toe during the treatment.The Nurse's Note entered by V2 (DON) dated 5/14/26 for R37 showed her left great toe was assessed on 5/14/26 (two months after the incident) with no open areas noted around the toe. The toenail was noted with black and yellow discolorations under the nail bed of the left great toe. R37 denied pain to the area when it was palpated.The Face Sheet dated 5/14/26 for R37 showed diagnoses including type 2 diabetes mellitus, hypertension, gout, edema, muscle weakness, anemia, and obesity.The Care Plan for R37 dated 2/23/26 did not show any concerns related to foot/toenail care and her diabetes.The facility's Skin Integrity - Foot Care policy (2025) showed it is the policy of this facility to ensure residents receive proper treatment and care within professional standards of practice and state scope of practice, as applicable, to maintain mobility and good foot health. This policy pertains to maintaining the skin integrity of the foot. The facility will provide foot care and treatment in accordance with professional standards of practice including the prevention of complications from the resident's medical conditions. Medical conditions will be managed and interventions will be implemented in accordance with professional standards of practice to prevent complications of medical conditions. Registered nurses - RN and licensed practical nurses - LPN will participate in the management of medical conditions by following physician orders, assessment of residents, and reporting changes in condition to the resident's physicians. Interventions will be modified in a resident's plan of care as needed. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on observation, interview, and record review, the facility failed to ensure a gait belt was applied and used correctly during a transfer and failed to ensure a bed alarm was turned on for 2 of 2 residents (R37 & R4) reviewed for safety in the sample of 31.The findings include:1. On 5/12/26 at 12:56 PM, V11 (Certified Nursing Assistant/CNA) took a gait belt and put it loosely around R37's lower chest are slightly above her hanging breasts. V11 assisted R37 to transfer from the wheelchair to the toilet and the gait belt moved up under R37's arms. V11 stated that she tries to put the gait belt under R37's breast but sometimes places it on the resident's chest just under her armpits because it is more comfortable. V11 stated R37 transfers with supervision and did not need the gait belt. V11 stated a resident that is a one assist for transfers needs a gait belt.On 5/13/26 at 1:19 PM, V2 (Director of Nursing/DON) stated gait belts should be applied around a resident's waist. The gait belt should not be around the chest and under the residents' arms. That is not appropriate to be up there; the center of gravity would be off. V2 stated R37 was to have a gait belt for transfers for her safety.On 5/14/26 at 2:20 PM V4 (Licensed Practical Nurse/LPN) stated gait belts are applied around the resident at the waist to for support and resident safety.The Care Plan dated 3/6/26 for R37 showed she transfers with 1-2 staff into a wheelchair. R37 does not walk and chooses not to. R37 has a history of a left shoulder dislocation but does not wear a sling any longer.The facility's Use of Gait Belt policy (2025) showed it is the policy of the facility to use gait belts with residents that cannot independently ambulate or transfer for the purpose of safety. All employees will receive education on the proper use of gait belt during orientation and annually.2. On 5/13/26 at 9:25 AM, R4 was on his back in bed. R4 had a bed alarm on his bed that was not turned on. At 9:30 AM V7 (CNA) was called to the room and confirmed that the bed alarm was off and should be turned on. V7 turned the alarm on and stated that an agency nurse had this resident and was told that the alarm needed to be turned on. V7 stated R4's alarm needed to be on for his safety because he gets out of bed. V7 stated that is why the mattress is on the floor because he will fall to his knees.On 5/13/26 at 1:33 PM, V2 (DON) stated R4 should have the bed alarm on when he is in bed and that it is for fall prevention. V2 stated he has had that in place for a long time for his falls. The face Sheet dated 5/14/26 for R4 showed diagnoses including dementia, epilepsy, major depressive disorder, generalized anxiety disorder, hypertension, irritability and anger, history of falling, left artificial knee joint, tear of medial meniscus of right knee, right shoulder rotator cuff complete tear or rupture, osteoarthritis, and failure to thrive.The Care Plan dated 2/18/26 for R4 showed that R4 is at risk for falls related to a history of falls, diagnosis of seizures, and receives psychotropic medications to help manage moods. Sensor pad alarm in bed.The facility's Resident Alarms policy (2025) showed it is the policy of this facility to utilize resident alarms in limited circumstances, in accordance with the resident's needs, goals, and preferences, so the resident will be able to attain or maintain his or her highest practical level of physical, mental, and psychosocial well-being. The facility shall establish and utilize a systemic approach for safe and appropriate use of resident alarms.implement interventions to reduce risk; and monitor for effectiveness of the interventions and modifying interventions when necessary. When alarms are utilized, additional monitoring shall be provided, including but not limited to: verifying alarms are used in accordance with the resident's care plan. Verifying alarms are working properly. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure an indwelling urinary catheter was maintained in a manner to prevent cross contamination for 1 of 2 residents (R8) reviewed for catheters in the sample of 31. The findings include:R8's face sheet showed he was admitted to the facility 2/26/26 with diagnoses to include cerebral infarction due to embolism of bilateral anterior cerebral arteries dysphagia, hypertension, acute kidney failure with tubular necrosis, hypokalemia, retention of urine, and obstructive and reflux uropathy. R8's facility assessment dated [DATE] showed he has an indwelling urinary catheter. R8's Care Plan initiated 3/3/26 showed, [R8] has an indwelling foley catheter. Observe for any kinds in tubing, that it is flowing properly and positioned correctly at bedside, when up in chair, wheelchair, etc. R8's May 2026 Physician Order sheet showed, . Foley Catheter 16 FR with 30 cc [NAME] to closed drainage system. Diagnosis of Urinary Retention.On 5/12/2026 at 10:47 AM, R8 was sitting in his wheelchair in the activity area. R8's catheter drainage bag was touching the floor, and his tubing was on the floor. On 5/12/2026 at 11:33 AM, R8 was in the dining room sitting at his table. R8's catheter drainage bag was touching the floor, and the tubing was on the floor under his chair.On 5/14/2026 at 9:43 AM, R8 was independently propelling his wheelchair down the hallway near the nurse's station with his catheter bag and the tubing dragging on the floor.On 5/14/2026 at 11:23 AM, V10 (Infection Preventionist) said, The catheter bag should be in a privacy bag and attached to the wheelchair so it is up off the floor. It should not be dragging on the floor for infection control purposes, because residents are already prone to UTIs (urinary tract infections). It should be off the floor for cleanliness and hygiene purposes too. The facility's policy and procedure with revision date of 9/2014 showed, Urinary Catheter Care. Purpose: To provide standard of care for the care and maintenance of indwelling catheters. It is the policy of this facility that the catheter and perineal care will be provided in a manner that will promote and provide cleanliness, acceptable infection control. |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to administer insulin in accordance with manufacturer's instructions. This applies to 3 of 3 residents (R6, R38, and R43) reviewed for insulin in the sample of 31. The findings include:1. R6's admission Record (Face Sheet) showed he was admitted to the facility on [DATE] with diagnoses to include but not limited to diabetes type 2, dementia, and depression. R6's May 2026 Medication Administration Record (MAR) showed he received 12 units of long-acting insulin every 12 hours. On 5/13/2026 at 7:56 AM, V6 (Registered Nurse/RN) prepared R6's long-acting insulin multidose injection pen (commonly referred to as an insulin pen). V6 attached the needle to the pen; she did not wipe the rubber seal with alcohol. V6 then dialed the pen to 12 units of insulin. V6 did not prime the insulin pen. V6 then wiped R6's right lower abdomen with an alcohol wipe, held the pen to his skin, depressed the plunger, and held the plunger for less than two seconds. The manufacturer's instructions (revised 5/11/23) showed, .D. Wipe the rubber seal with a new alcohol pad. The instructions showed after the needle is attached, .Always prime a new pen needle before each injection. Turn the white dose knob to 2 dose units. You will hear a ?click' for each unit turned.with the pen upright, press the injection button in until it stops moving and the dose window shows ?0'. The instructions continue, Step 6. Inject your dose.press the purple injection button all the way in. The white dose knob will turn and you will hear ?clicks' as you press down. Hold the purple injection button down for 10 seconds after the dose window shows ?0'. The facility's Insulin Pen policy showed, .insulin pens will be prior to each use to avoid collection of air in the insulin reservoir. The policy showed, .Attach the pen needle.wipe the rubber seal with an alcohol pad. The policy continued, .Injecting the insulin:. Fully depress the plunger until the dosing numbers count back to zero. While still pressing the plunger, keep the needle in the skin for up to 6-10 seconds and then remove the needle from the skin. 2. R38's admission Record (Face Sheet) showed he was admitted to 1/14/25 with diagnoses to include diabetes type 2, stroke, and weakness. R38's May 2026 Medication Administration Record (MAR) showed a one-time order for 18 units of long-acting insulin to be given on 5/13/26. On 5/13/2026 at 9:33 AM, V4 (Licensed Practical Nurse/LPN) began preparing R38's long-acting insulin. V4 attached the needle to the pen; V4 did not wipe the rubber seal with an alcohol wipe. V4 then dialed the pen to 18 units; V4 did not prime the pen. V4 wiped R38's left-lower abdomen with an alcohol pad, inserted the needle into his skin, depressed the plunger, and injected the insulin. V4 held the plunger for less than 3 seconds. The manufacturer's instructions (dated 11/2022) showed, after a new needle is attached, . Prime your pen. Turn the dose selector to select 2 units. Press and hold the dose button. Make sure a drop appears.Give your injection. Insert the needle.press and hold the dose button. After the dose counter reaches 0, slowly count to 6. 3. R43's admission Record (Face Sheet) showed an original admission date of 5/19/22 with diagnoses to include but not limited to diabetes type 2, dementia, and depression. R43's May 2026 Medication Administration Record (MAR) showed she received 16 units of long-acting insulin daily. On 5/13/2026 at 7:29 AM, V5 (LPN, trainee), began preparing R43's long-acting insulin. V5 attached the needle and turned the dose selector to 16 units. V5 did not wipe the rubber seal or prime the pen. V5 and V4 (LPN) entered R43's room with her long-acting insulin pen. R43 refused insulin at this time. V5 placed R43's insulin pen back in it's pouch. On 5/13/2026 at 10:21 AM, V4 stated R43 had agreed to receive her insulin. V4 removed R43's insulin pen and attached a new needle to the pen. V4 did not wipe the rubber stopper with an alcohol pad. R43's pen was dialed to 16 units from the previous attempt. V4 wiped R43 left lower abdomen with an alcohol pad, inserted the needle into R43's skin, depressed the plunger, and held the plunger for less than 3 seconds before removing it from R43's skin. The manufacturer's instructions (revised 5/11/23) showed, .D. Wipe the rubber seal with a new alcohol pad. The instructions showed after the needle is attached, .Always prime a new pen needle before<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 14E701 | A. Building<br>B. Wing | 05/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Big Meadows | 1000 Longmoor<br>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.

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | each injection. Turn the white dose knob to 2 dose units. You will hear a ?click' for each unit turned.with the pen upright, press the injection button in until it stops moving and the dose window shows ?0'. The instructions continue, Step 6. Inject your dose.press the purple injection button all the way in. The white dose knob will turn and you will hear ?clicks' as you press down. Hold the purple injection button down for 10 seconds after the dose window shows ?0'. On 5/13/2026 at 3:03 PM, V2 (Director of Nursing) stated she expects staff to follow insulin pen manufacturer's instructions. V2 stated the purpose of priming the insulin pen and holding the plunger is to ensure the full dose of insulin is administered. The facility's Insulin Pen policy showed, .insulin pens will be prior to each use to avoid collection of air in the insulin reservoir. The policy showed, .Attach the pen needle.wipe the rubber seal with an alcohol pad. The policy continued, .Injecting the insulin:. Fully depress the plunger until the dosing numbers count back to zero. While still pressing the plunger, keep the needle in the skin for up to 6-10 seconds and then remove the needle from the skin. |