STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006514	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEIGHBORS HEALTH CENTER	811 WEST 2ND BYRON, IL 61010

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation: 2514160/IL192107 2514159/IL192092 2514480/IL192699 2514251/IL192356	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.3210t) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006514	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEIGHBORS HEALTH CENTER	811 WEST 2ND BYRON, IL 61010

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 1	S9999		

failed to keep residents free from physical abuse. This applies to 4 of 6 residents (R1, R2, R3 & R4) reviewed for abuse in the sample of 41. This failure resulted in R1 being sent to the local hospital and diagnosed with a posterior head laceration and initial CTH with acute SDH (computed tomography with acute subdural hematoma) of the left frontal, parietal, and temporal lobes.

The findings include:

1. The facility's final report to the state surveying agency regional office dated December 20, 2023, shows, "It was immediately reported to Administrator (V1) that R1 sustained a fall with injury while in the memory care dining room. Staff reported that they heard a female resident say that a resident is moving the chair around and to leave it alone, when the one CNA (Certified Nursing Assistant) turned toward the resident she saw R1 and another male resident (R2) both had hold of the chair and due to the momentum of both residents tugging at the chair they both fell. R2 the other male resident landed on top of R1 which caused him to hit his head on the corner of the wall.... Conclusion: Based on a thorough investigation resident (R1) sustained a laceration to the back of his [head] requiring staples and had a small subarachnoid hematoma requiring no surgical interventions as a result of two dementia residents wanting to move the same chair around the table, they lost their balance and fell together...."

On May 14, 2025, at 1:58 PM, V11 (CNA) stated, she witnessed the incident between R1 and R2 on December 20, 2023. She was in the dining room helping another resident with her back turned towards R1 and R2. R1 was sitting at a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006514	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEIGHBORS HEALTH CENTER	811 WEST 2ND BYRON, IL 61010

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 2	S9999		

table in the dining room. R2 was up walking around. She heard R12 (another female resident) screaming, "They are going to fight. They are going to fight." so she turned around to see R1 and R2. R1 was trying to stand up from the table as R2 had a chair and was "shoving" the chair towards R1. She tried to grab the chair but was not able too. R2 "shoved the whole chair" into R1 hitting him and causing him to fall back and hit his head on the corner of the wall. R1 hit the wall so hard there was pieces of plaster/dry wall on the floor. He was also bleeding badly.

On May 15, 2025, at 8:03 AM, V3 (CNA) stated, R1 and R2 were fighting. R2 hit R1 and caused R1 to fall backward and hit his head hard on the wall. R2 was in an aggressive mood and wanted to still fight R1. R2 would get aggressive with staff but never the other residents. This was the first time he hit a resident that she knew of.

R1's local hospital paperwork dated December 31, 2023, shows, "History and Physical: ...R1 was admitted to local hospital on 12/20/2023 after a fall at his nursing home, he had an argument with another NH (nursing home) resident who pushed him backward against a wall and struck his head. He had a posterior head laceration and initial CTH with acute SDH (computed tomography with acute subdural hematoma) of the left frontal, parietal, and temporal lobes..."

R1's progress notes dated December 20, 2023, shows, "The resident fell in the common area during breakfast and hit the back of his head on the corner of the wall. Bleeding was noted...."

R2's progress notes dated December 20, 2023, shows, "Resident fell in the common area during breakfast as a result of pushing a chair. Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006514	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEIGHBORS HEALTH CENTER	811 WEST 2ND BYRON, IL 61010

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 3	S9999		

has no injury and was able to stand up by himself..."

2. R3's progress notes written by V9 (Licensed Practical Nurse/LPN) dated December 7, 2023, shows, "Resident had a disagreement with his roommate that had escalated between them. Decision was made to separate the roommates per both of their requests."

On May 15, 2025, at 8:33 AM, V9 (LPN) stated, the incident with R3 and R4 happened in the middle of her shift, December 2023. R3 and R4 got into a fight. R3 and R4 both got up and were arguing. R3 tried to walk over to R4 and fell. R4 started kicking him. She broke them apart and separated them. V8 (CNA) was there also. She moved R3 into another room and called V1 (Administrator). She stated, V1 (Administrator) told her how to document the incident.

On May 14, 2025, at 12:57 PM, V8 (CNA) stated, she heard commotion and went to R3 and R4's room. When she walked in R4 was kicking R3 "pretty badly." She yelled for V9 (LPN). V9 came down and together they got them separated.

R3's progress notes written by V1 (Administrator) dated December 8, 2023, shows, "Administrator followed up with resident regarding his disagreement with his roommate. Resident explained that they were having a disagreement about the television being loud and when this resident went to get up to try to turn his roommate's television down, he said, "my chair got away from me and I sat on the floor." He states that his roommate then laughed at him because he sat on the floor. Staff heard this resident asking for help and they assisted the resident back into his chair...."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006514	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEIGHBORS HEALTH CENTER	811 WEST 2ND BYRON, IL 61010

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 4	S9999		

R3's progress notes written by V7 (Nurse Practitioner/NP) dated December 12, 2023, shows, "CC (current concern): bruising, recent fall. HPI (history of presenting illness): Patient is reporting that on 12/7 he was pushing his wheelchair and it got away from him. He fell landing on his buttocks. He goes on to report that while he was on the floor, his roommate "kicked me." He points to bruises to his right upper arm and elbow and the top of his head. He previously has denied any physical contact was made.... ...Bruising noted to right hip and along right gluteal fold. Tenderness with palpation to right hip and low back. Right upper arm with resolving bruise and bruising noted at right elbow. Tender with palpation. Elbow with full ROM (range of motion). No BLE (bilateral lower extremity) edema. IMPRESSION/PLAN: 1. S/P Fall: x-ray right humerus, elbow, hip, pelvis, and lumbar/sacral spine. 2. Contusions: due to being on Brilinta and ASA increased bruising is expected and appears to be resolving. 3. Head contusion: denies LOC. No h/a. Resolving bruising."

On May 14, 2025, at 12:16 PM, V6 (LPN) stated, R3 and R4 never really got along. She wasn't the nurse when they got into "a fight in their room" however she was the nurse a few days later. It was reported to her that R3 had some bruises on him. She asked him what the bruises were from. R3 told her that he had a fall and when he was on the ground R4 was kicking him. She reported that information to V1 (Administrator) and V7 (NP). R3 was alert and oriented x3. V7 ordered x-rays and when the x-rays came back R3 had a fracture on his lower spine.

On May 14, 2025, at 12:28 PM, V7 (NP) stated,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006514	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEIGHBORS HEALTH CENTER	811 WEST 2ND BYRON, IL 61010

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 5	S9999		

these two guys (R3 & R4) were "rowdy" guys. She was asked to see R3 because he had some bruising, and no one knew where it was from. She assessed R3 and thought his bruises were of a defensive nature. He had bruising on the back of his arms and covering his head. R3 told her his wheelchair got away from him and he fell on the floor. He was on R4's side of the room and R4 started kicking him. His statement was supportive with the bruising she assessed. R3 was "not happy" she put her documentation in of what she saw on R3.

On May 19, 2025, at 12:01 PM, R4 stated, he remembered R3. R3 was threatening to "kick his a**." He told him, "No you won't." R3 came at him, and he knocked him down and started kicking him. "I warned him."

R4's electronic medical record does not show, any documented incidents with R3.

The facility's final report to the state surveying agency regional office dated August 19, 2024 shows, "Administrator received an anonymous call today reporting that some time back in December 2023 the two residents (R3 & R4) had a disagreement in their room and R4 made physical contact with R3. R3 no longer resides in the nursing home, he was discharged as of 6/6/2024. The caller refused to provide any additional information. Local police department was notified, and they provided a case number but because it was an anonymous call and no claim from the victim, they will not be investigating..."

R4's minimum data set dated October 2, 2023, shows, he is cognitively intact.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006514	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEIGHBORS HEALTH CENTER	811 WEST 2ND BYRON, IL 61010

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 6 The facility's abuse prevention guidance dated October 2022 shows, "Policy Statement: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this guidance is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents.... Definitions: The following definitions are based on federal and state laws, regulations and interpretive guidelines. Abuse: Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means (210 ILCS 45/1-103). Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident (42 CFR 483.5)...." "A"	S9999		