STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057364	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMBODEN CREEK SENIOR LIVING	180 WEST IMBODEN , DECATUR, Illinois, 62521

(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) COMPLETION DATE
S0000	Initial Comments Complaint Investigation 2565797/IL195327	S0000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.690 a) 300.1010 h) 300.1210 b) 300.1210 d)3) 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. 300.690. Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a	S9999		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. 300.1010. Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 300.1210. General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. These requirements are not met as evidenced by: Based on interview and record review, the facility failed to conduct a fall investigation, and failed to promptly notify a physician of a resident's change in	S9999		

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S9999	Continued from page 2 condition and significant decline in mobility, which resulted in prolonged discomfort/pain for one cognitively impaired resident (R1). More than twenty-four hours after the initial change of condition was noted, an x-ray was obtained and R1 was sent to the Emergency Room, admitted, and had surgical repair of a left intertrochanteric hip fracture. R1 is one of three residents reviewed for falls in the sample of four. Findings Include: R1's Medical Diagnosis List, dated June 2025, documents R1 is diagnosed with Falls, Muscle Weakness, Difficulty Walking, Cognitive Communication Deficit, and Anxiety. R1's Minimum Data Set (MDS), dated 6/20/25, documents upon admission R1 was severely cognitively impaired and had Hallucinations, Delusions, Wandered Daily, had no impairment to her lower extremities, used a walker, and required supervision or touching assistance from staff for transfers and toileting. Upon discharge, R1 required substantial/maximal assistance for transfers and toileting. R1's Physical Therapy Treatment Encounter Note, dated 6/18/25, documents V14, Physical Therapy Assistant (PTA), completed R1's therapy session. R1 reported a new onset pain in her left lower extremity with movement. On 7/3/25 at 10:45 AM, V14, PTA, stated V28, Physical Therapist, completed R1's initial therapy evaluation on 6/17/25. Baseline R1 was assessed to require supervision and touching assist/contact guard with gait belt for transfers. V14 stated she completed therapy with R1 on 6/18/25, and R1 reported new onset left lower extremity (LLE) pain when lifting her LLE off of the foot pedal, however, R1 could still stand and bear weight. V14, PTA, stated on 6/19/25, V15, PTA, asked her to assist with R1, and at that time, R1 could hardly bear any weight on her LLE. R1 had declined to a maximal two assist with two PTAs. R1 was still complaining of LLE pain with movement. V14 stated she told V15 R1 had a significant change from the day before, and she should let the nurse know to notify the doctor and get an x-ray to make sure nothing was broken.	S9999		

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S9999	Continued from page 3 R1's Physical Therapy Treatment Encounter Note, dated 6/19/25, documents V15, Physical Therapy Assistant, (PTA) completed R1's therapy session. R1 was noted to be voicing complaints of pain in her left lower extremity and hip area with movement and weight bearing. R1 kept stating she thinks her hip is broken. V15 notified R1's nurse (V22, Licensed Practical Nurse) and requested V22 follow up with a provider and get an x-ray of R1's left hip due to increased pain which was severely limiting R1's movement. At that point, R1 required maximal assistance of two therapist to transfer to the toilet. On 7/2/25 at 12:40 PM, V15, Physical Therapy Assistant (PTA), stated she completed R1's therapy on 6/19/25. R1 was having LLE pain with movement and weight bearing. R1 said she thought her hip is broken. V15 stated she notified V22, LPN, and requested she get an x-ray. R1 seemed to be in a lot of discomfort when V14 and V15 were toileting R1. V15 stated it was a significant change in condition from when she assisted with transferring R1 from her daughter's car to the wheelchair upon admission on 6/16/25, just three days prior. V15 stated she was concerned something was broken. R1's Physical Therapy Treatment Encounter Note, dated 6/20/25, documents V16, Physical Therapy Assistant, (PTA) completed R1's therapy session. R1 was noted to have left hip pain and could not bare weight. R1 did not use or move her left leg except to place it on the footrest for comfort. On 7/3/25 at 10:57 AM, V16, PTA, stated she worked with R1 for about a half hour on 6/20/25, and did not attempt to make R1 stand or transfer due to her left hip pain and subsequent inability to stand or bare weight. V16 PTA stated she was told an x-ray was just ordered for R1. The progress note, dated 6/20/25, documents V5, R1's Daughter, came up to the nurses' station very upset that something happened to R1's left hip and an x-ray had not been completed yet. A call was placed to V6, Medical Director, and a STAT x-ray was ordered to assess R1's left hip pain. R1's Radiology Patient Report, dated 6/20/25, documents R1 had a recent fall and new onset pain while weight	S9999		

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S9999	Continued from page 4 bearing in therapy. R1's report documents R1 sustained an acute left intertrochanteric hip fracture. On 7/1/25 at 1:15 PM, V5, R1's Daughter, stated R1 arrived at the facility on 6/16/25 by car and could transfer with one assist and a walker. R1 was admitted to the facility for rehab after sustaining a fall at her assisted living facility. R1 was confused and impulsive, and required constant monitoring for safety. Later, on 6/16/25, V5 was notified R1 had fallen at the facility and was sent to the emergency room for evaluation. R1 returned to the facility with no acute injuries noted. V5 stated she came to visit R1 on 6/17/25, and R1 was walking around the facility pushing her own wheelchair and wandering unsupervised. V5 stated R1 was not complaining of any pain at that time. On 6/18/25, V5 stated she did not visit R1. On 6/19/25 when V5 came to visit R1, V5 stated she saw R1 sitting in her wheelchair and she was not trying to get up or move like she normally did. V5 stated V15, PTA, told her R1 was unable to move her left leg in therapy and she was complaining of a lot of pain. V15 told V5 she had told the nursing staff and requested they get a x-ray. V5 stated on 6/20/25 when she came to visit R1, she was being transferred to the commode by two unknown staff members, and R1 was screaming out in pain. V5 stated she was furious that her mom (R1) was still in pain and no x-ray had been completed. V5 stated she confronted V2, Director of Nurses, at the nurses station, who stated she was not aware that R1 had left hip pain or a change of condition. V2 called V6, Medical Director, and got an order for a x-ray. V5 stated later that evening, she got a call from the facility that her mom R1 was being sent to the hospital for a left hip fracture. On 7/2/25 at 1:55 PM, V2, Director of Nurses, stated on 6/20/25, R1's daughter (V5) came up to the nurses' station and was upset that an x-ray of R1's left hip had not yet been completed. V2 stated she was not aware anything was wrong with R1's left hip. V22, Licensed Practical Nurse, was also at the nurses' station and told V2 the day prior (6/19/25), V15, PTA, told V22 that R1 was complaining of left hip pain and could not bare weight anymore. V15 requested V22 notify the doctor and ask for an x-ray of R1's left hip to check for injuries. V2 stated she asked V22 if she had spoken with R1's doctor, and she stated she had not. V2 confirmed V22 had not documented any assessment or change of condition in R1's medical record, and confirmed V22 did not notify R1's physician or obtain an order for an x-ray. V2 confirmed staff should be	S9999		

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S9999	Continued from page 5 documenting changes of condition, completing assessments, notifying physicians and families, and following up concerning the resident's change in condition in a timely manner. V2 confirmed V22, LPN, should have notified a provider on 6/19/25 when V15, PTA, informed her about her concerns with R1's change in physical condition/new onset - increased pain. On 7/3/25 at 2:15 PM, V9, Nurse Practitioner, stated the facility notified the provider group of R1's fall on 6/16/25 with no injuries, and asked to notify them if there were any changes in R1's condition. V9 denied the primary group was ever notified of R1's new onset left hip pain or decreased ability to bare weight. V9 confirmed the sooner they were notified, the sooner R1's hip fracture would have been identified, and the sooner she could have received treatment. On 7/3/25 at 1:40 PM, V24, Certified Nurse's Assistant (CNA), stated on 6/18/25, she took R1 back to her room and put her to bed. V24 stated she lowered the bed and gave R1 the call light. V24, CNA, stated she left the room for a few minutes, and she heard R1 scream out. As V24 went back into R1's room, she stated she observed R1 standing up by her bed and falling backwards. V24 stated she ran over and caught R1 under her arms and lowered her the rest of the way to the floor. On 7/3/25 at 2:00 PM, V1, Administrator, confirmed there was no fall investigation completed for R1's fall on 6/18/25. V1 stated she did not consider it a fall since R1 was lowered to the floor and did not hit the ground. V1 confirmed she was under the impression V24 had been transferring R1 when it happened, and was not aware R1 had gotten out of bed on her own and lost her balance. The facility's Change in a Resident's Condition or Status policy, dated 5/28/24, documents the facility shall promptly notify the resident, his or her attending physician, and representative of any changes in the resident's medical/mental condition and/or status. The nurse should notify the resident's physician or physician on call when there has been a significant change in the resident's physical/emotional/mental condition. The facility's Falls - Clinical Protocol policy revised on March 2018 documents the facility will evaluate, and	S9999		

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S9999	Continued from page 6 document falls that occur while the resident is in the facility. For example, details such as when and where they happen as well as any observations of the events will be recorded. A possible cause will be identified, and an appropriate intervention will be put into place and the care plan updated. The resident's response to new interventions will be monitored and documented. (B)	S9999		