STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0056333	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVISTON COUNTRYSIDE MANOR	450 WEST 1ST STREET , AVISTON, Illinois, 62216

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S0000	Initial Comments Complaint Investigations: 25412743/2702105	S0000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.3210a)1) 300.3240a) 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 300.1210 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. Section 300.3210 General	S9999		

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

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S9999	Continued from page 1 a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by State or federal law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of the resident's status as a resident of a facility. 1) Residents shall have the right to be treated with courtesy and respect by employees or persons providing medical services or care and shall have their human and civil rights maintained in all aspects of medical care as defined in the State Operations Manual for Long-Term Care Facilities. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) Based on interview and record review the facility failed to ensure residents were free from verbal and mental abuse from staff for 3 of 5 residents (R2, R4, and R5) review for abuse and neglect in the sample of 10.This failure resulted in harm to R2 and R4 who were observed crying and emotionally distressed at the time of the said incidents, along with R5 who was scared, feeling of being unsecure and wanting to move. 1.R2's Admission Record documents an admission date of 11/23/24 and diagnoses including malignant neoplasm of overlapping sires of left female breast, cerebral infarction, depression, generalized anxiety, unspecified mood disorder, and mild cognitive impairment. R2's Minimum Data Set (MDS) dated 11/13/2025, documents under Section C a Brief Interview for Mental Status (BIMS) score of 5 which indicates severely cognitively impaired. Section B document's ability to hear as adequate. R2's Care Plan documents a focus area of R2 is at risk for abuse/neglect due to residing in a congregate facility with interventions to address all complaints/concerns promptly with grievance and procedures and report any suspected abuse/neglect to administrator immediately. On 01/15/26 at 9:34AM R2 stated that she doesn't remember if anyone has ever yelled at her or told her that her mother has passed. R2 said that if someone did tell her that her mother was dead that it would upset her very much.	S9999		

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S9999	Continued from page 2 On 01/15/26 at 10:42AM V7 (Physical Therapy Assistant) stated that she heard that V11 (Licensed Practical Nurse/LPN) was rude to the residents. V7 said that she knows that V15 (Director of Physical Therapy) was the one who has witnessed V11 (LPN) being rude to R2. On 01/15/26 at 12:19PM V15 (Director of Physical Therapy) stated that she witnessed V11 (LPN) being hateful to the residents. V15 said that one day R2 was asking for her mother recently she said that R2 kept asking for her mom and that V11 turned around to R2 and yelled “Dead, that is where your mom is at, she is dead”. V15 said that R2 got really upset and was crying after V11 said that. V15 said that V11 just isn’t nice to all the residents, she is just rude. V15 said that she did not report V11 stating that to R2. V15 said that she did have another time when V11 (LPN) was rude to another resident, and she did report that to V2 (Director of Nursing/DON). V15 said that only thing that happened to V11 when she reported it to V2 was that V2 talked to V11. V15 said that the way that V11 talked to R2 was verbally and mentally abusive. V15 said that when this happened it was on the weekend and there were no managers in the building at the time, so she didn’t report the incident to anyone. 2.R4’s Admission Record documents an admission date of 08/01/2021 and diagnoses Alzheimer’s disease, unspecified dementia, major depressive disorder, and insomnia. R4’s MDS dated 12/29/25, documents under Section C a BIMS score of 5 which indicates severely cognitively impaired. Section B documents ability to hear as adequate. R4’s Care Plan documents a focus area of R4 is at risk for abuse/neglect due to residing in a congregate facility with interventions of address all complaints/concerns promptly with grievances policy and procedure and report any suspected abuse/neglect to administrator immediately. On 01/15/26 at 12:05PM R4 stated that she doesn’t remember staff yelling at her, but she said that she forgets things often and she doesn’t know. R4 said that she just doesn’t have the best memory. R4 said that someone could have yelled at her and that she might have ignored it she really doesn’t remember she doesn’t really remember anyone yelling, but she isn’t saying that it didn’t happen. R4 said that she is just trying to stay out of trouble. R4 said that she does remember one time she wanted to call her son, and they wouldn’t	S9999		

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S9999	Continued from page 3 let her use the phone to call them. R4 said that it made her so upset and mad. On 01/15/26 at 9:53AM V3 (Registered Nurse/RN) stated that the facility has a newer nurse V11 (LPN) who is verbally mean to the residents. V3 stated that it is most of the residents that V11 talks mean to. V3 said that she has seen V11 be not so nice to R4. V3 said that V11 will yell at R4. V3 said that R4 likes to sleep in and V11 will yell at R4 from the hallway and tell her that she needs to get out of bed. V3 said that R4 will want to stay in bed longer and V11 will tell her that she is getting up. V3 said that she did not report V11 when she was yelling at R4 because it will put a target on your back. V3 said that way V11 was yelling at R4 she would consider it verbal and mental abuse. On 01/15/26 at 10:38AM V4 (Licensed Practical Nurse/LPN) stated that V11 is not very nice to the residents. V4 said that a couple of weekends ago R4 was crying and asking V11 to call her son. V4 said that V11 wouldn't call R4's son so she ended up calling R4's son for her and it helped calm R4 down. V4 said that V11 was sitting at the nurse's station one day and R4 was just sitting by the nurse's station and that V11 was yelling at R4. V4 said that she couldn't remember the content of the yelling, but it was very loud and rude. V4 said that it was upsetting R4. 3.R5's Admission Record documents an admission date of 04/03/25 with diagnoses of cerebral palsy, paraplegia, vascular dementia, bipolar disorder, major depressive disorder, anxiety disorder, and unspecified intellectual disabilities. R5's MDS dated 01/07/26 documents under Section C a BIMS score of 11 which indicates moderately impaired cognition. Section B documents ability to hear as adequate. R5's Care Plan does not document a focus area of abuse. On 01/15/25 at 1:57PM R5 stated that she did have a day when they got out of bed and made her take a shower. R5 said that V11 told her in a loud voice that she had to get up and take a shower. R5 said that she always takes a bed bath, and she didn't want to get up and take a shower. R5 said that V11 told her that she had to take a shower. R5 said that she has back and spine problems and that she doesn't get up and take showers only bed baths. R5 said that V11 made the staff get her up for the shower. R5 said that she is a mechanical lift, and she had an incident at another facility where she fell	S9999		

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S9999	Continued from page 4 out of the mechanical lift sling so now every time, she gets in the mechanical lift it scares her. R5 said that when V11 made her get up to take the shower that she was crying and so upset. R5 said that she is not happy at the facility. R5 said that she doesn't want to be at the facility anymore because they make her do things she doesn't want to do, and they raise their voices at her at times. On 01/15/26 at 10:38AM V4 (LPN) stated that she witnessed V11 (LPN) telling staff that they had to get R5 up out of bed and get her into the shower. V4 said that she couldn't remember the Certified Nurse Assistant that was working that day, but that R5 was saying that she didn't want to get a shower. V4 said that R5 is a mechanical lift and that she came from another facility and they dropped her out of the mechanical lift and now R5 is scared of the mechanical lift. V4 said that V11 was yelling at R5 that she was getting up and taking a real shower not a bed bath. V4 said that staff did get R5 up and she was crying and screaming she was so upset. V4 said that she never reported any of this to V1 (Administrator/ADM) or V2 (DON). On 01/15/26 at 10:50AM V9 (Certified Nurse Assistant/CNA) stated that she gave R5 a shower that usually she gets a bed bath, but V11 told her that R5 needed a shower. V9 said that R5 was refusing to get up out of bed to take a shower, but V11 said that I need to get R5 up and into the shower. V9 said that she doesn't remember if R5 was upset or not. On 01/15/26 at 1:58PM V21 (CNA) stated that on 01/06/26 she was working on her C hall and she could hear R5 yelling out and screaming from B hall. V21 said that was the first time she has ever seen R5 get up out of bed for a shower and V11 was the nurse who made her get up and take a shower. V21 said that R5 was so upset and just yelling out the whole time she was in the shower. On 01/15/26 this surveyor reported allegation of possible abuse to V1 (ADM) on R2, R4, and R5. On 01/15/26 at 2:57PM V2 (DON) stated that she just found out that V15 told V1 (Administrator/ADM) that V11 told R2 that her mom was dead. V2 stated that V15 didn't report anything to her about V11 yelling at R2 or about V11 saying to R2 that her mom was dead. V2 stated that V15 did report to her a while back that she overheard V11 telling another resident who was yelling out to quit yelling that no one needed to hear that. V2 said that she did talk to V11 about the incident, but she hasn't had any more reports about V11 being rude or	S9999		

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S9999	Continued from page 5 yelling at any other resident. V2 stated that it is hard to get R5 to take a shower she said that R5 was at another facility and was dropped out of the mechanical lift and that is how she is transported so she is scared to get up out of bed. V2 said that if R5 didn't want to get a shower, that V11 should not have made R5 get a shower. V2 said that no staff should yell at any resident. V2 said that no staff should yell at any resident for any reason. V2 said that if a resident such as R4 wanted to use the phone to call her son she should have been allowed to call her son. On 01/15/26 at 3:23PM V1 (ADM) stated that he is currently investigating the allegation of abuse and that he has suspended V11 at this time until the investigation is completed. On 01/16/26 at 9:41AM V11 (LPN) stated that there has been a misinterpretation with R2 that she was asking R2 how old she was and then how old R2's mother would be. V11 said that she never told R2 that her mother was dead. V11 said that she has raised her voice, because R2 is hard of hearing. V11 said that she did have R5 get up out of bed to take a shower, but she never refused. V11 said that R5 was doing her normal yelling when she was in the shower. V11 said that R5 does cry and yell with all care. V11 stated she had been at her medication cart when she told R5 that she needed to take a shower. V11 said that she assists R4 up every day and that she has not yelled at her. V11 said that she feels yelling is being misinterpreted because she is speaking louder for hard of hearing residents. V11 stated she would be across the room helping R4's roommate and she would tell her time to get up and get ready, but she is not yelling at her. V11 stated that she has never told R4 that she could not call her son, she did say that there are times during report that she has told R4 she would come find her to call her son once she had been done with report. V11 said that she has only raised her voice to resident that are hard of hearing not in a yelling or abusive way. V11 stated that yelling or screaming at a resident is considered abuse. The facility policy titled "Abuse Prevention Program Facility Procedures" (Undated) documents under Establishing a Resident Sensitive Environment: This facility desires to prevent abuse, neglect or misappropriation of property by establishing a resident sensitive and resident secure environment. (B)	S9999		