STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000418	A. BUILDING: _____ B. WING _____	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APOSTOLIC CHRISTIAN TIMBER RIDGE	2125 VETERANS ROAD MORTON, IL 61550

(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
Z 000	COMMENTS Annual Licensure Survey: 350.1010, 350.1060g), 350.1430a)1), 350.3240a)	Z 000		
Z9999	FINDINGS Statement of Licensure Violations 1 of 3 350.1010 Section 350.1010 Service Programs The facility shall provide, either directly or through arrangements with an outside resource, as needed by the individual resident, all resident living services, training and guidance necessary in the activities of daily living and in the development of self-help skills for maximum independence. These requirements were not met as evidenced by: Based on record review and interview, the facility failed to ensure outside services provided supervision for one of three individuals in the sample of three (R1) when an individual from another facility placed hands around R1's neck. Findings include: The 12/19/24 Individual Service Plan (ISP) identifies R1 as an individual who functions within the Severe Range for Individuals with Intellectual Disabilities. R1's ISP also documents R1 needs 24-hour supervision. Facility Resident Incident Report-Final dated 7/22/25 documents, one staff was taking an	Z9999		

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individual to the bus loading area and another staff was in another area changing an individual. Leaving no staff in R1's room. When one of the staff members came back in the room, Z5 (individual from another facility) was sitting on the couch next to (R1). Z5's hands were around R1's throat, shaking R1.

On 8/27/25 at 10:15 am, Z6 (Day Training Direct Support Person/DSP) stated on 7/22/25, the other DSP was outside the room and Z6 was taking an individual to the bathroom. R1 was on the couch and Z5 was sitting next to R1. When Z6 came back, Z5's hands were around R1's neck and shaking R1. Z6 also stated there should always be a staff member in the room to provide supervision and Z6 shouldn't have gone in the bathroom.

On 8/27/25 at 10:43 am, Z7 (Day Training Qualified Intellectual Disabilities Professional/QIDP) stated what was told to Z7 was on 7/22/25 Z6 was in the changing room and when Z6 came out, Z5 had his hands around R1's neck. Z7 also stated there is usually two staff in the room and another staff member should have been in the room while Z6 went into the changing room.

On 8/28/25 at 1:25 pm, E14 (QIDP) stated at day training, there should always be a staff member in R1's room to provide supervision.

(B)

Statement of Violations 2 of 3

350.1060g)
350.3240a)

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Z9999	Continued From page 2 g) Appropriate training and habilitation programs shall be provided residents with hearing, vision, perceptual, or motor impairments, in cooperation with appropriate staff. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. Section 350.1060 Training and Habilitation Services. These requirements were not met as evidenced by: Based on observation, record review, and interview, the facility failed to appropriately implement an individual's transfer as documented in the Individual Service Plan (ISP) and the facility neglected to ensure facility protocol was followed during a mechanical lift transfer resulting in a surgical repair, impacting one of four individuals in the sample of seven (R4). This has the potential to impact three inside the sample (R2, R5, R7) and 29 outside the sample (R8-R36). Findings include: The 4/17/25 Individual Service Plan (ISP) identifies R4 as an individual who functions within the Moderate Range for individuals with Intellectual Disabilities with diagnosis including spastic hemiplegic cerebral palsy. R4's ISP also documents R4 is non-ambulatory and is to be transferred by a mechanical lift/ceiling lift transfer. R4's spasticity interferes with ADL's (Activities of Daily Living) and ability to ambulate. R4 can answer yes/no questions.	Z9999		

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Facility Roster, undated, identifies R2, R5, R7-R36 reside in the facility.

On 8/21/25 at 10:23 am, E15 (Licensed Practical Nurse/LPN) stated R4 can appropriately answer yes/no questions.
Facility Roster, undated, identifies R2, R5, R7-R36 reside in the facility.
Resident Transfer Protocol printed 8/6/25 documents R4 as a mechanical lift/ceiling lift transfer.

On 8/28/25 at 2:23 pm, E19 (Occupational Therapy Assistant/OTA) stated she helps train staff on transfers and a mechanical lift transfer is to have two staff present throughout the whole transfer.

R4's Nurses Note dated 8/14/25 includes, "1215 (12:15 pm) An aide came to the desk and asked me to come to (R4's) room, because when they were transferring (R4) from (R4's) bed to the bathroom, so (R4) could have a bowel movement, via ceiling mechanical lift, (R4) started bleeding significantly from (R4's) rectum. When this nurse sent into the room there were multiple large to extra large drops of blood all over the floor, and the pad under (R4) was soaked with blood."

Facility Investigation Summary and Findings dated 8/18/25 includes, "On 8/14/25, (E8/Direct Support Person/DSP) was providing care to (R4), (R4) communicated that she (R4) needed to have a BM (bowel movement) very badly. (E8) got (R4) to her (R4) room using (R4's) wheelchair. (E8) then put the mechanical lift sling behind and under (R4) in preparation for a transfer of (R4) to the toilet seat. At some point (it's not clear exactly when), (E8) removed (R4's) pants and

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adult brief. (E8) states that (R4) began to slide down in (R4's) chair and that (E8) stepped a short distance away to poke (E8's) head out of (R4's) room door and ask for help. (E8) saw (E16/DSP) walking by and asked for help. (E16) entered the room. Both (E8) and (E16) stated that (R4's) positioning in the chair at this point was slid far down and to the right. Both (E8 and E16) stated that (R4) gets frantic when (R4) has to use the bathroom badly and (E8) stated that (R4) tends to bounce up and down. (E16) stated that when (E16) entered the room the mechanical lift sling was attached to the lift and the lift was raised slightly. (E16) stated that it she believes (E8) lifted the sling slightly in an attempt to cradle (R4) to prevent (R4) from falling out of the chair completely. (E8) confirmed that she raised it slightly for that purpose. (E8) admits that (R4) was unblocked (unbuckled) at that time and remained unbuckled as she (E8) stepped away to ask for help. As (E16) and (E8) began to raise the sling they noticed the entire chair was being lifted. (E16) stated that (E16) noticed the sling was caught on a foot rest (footrest) and (E16) stated they needed to lower the chair to correct the issue. Once the issue was corrected they (E8 and E16) were able to re-lift (R4) and while (R4) was being transferred they noticed BM and blood leaking down to the floor (and puddles of both on the floor). After inspecting the wheelchair there appears to be dried fecal matter on the wheelchair's right foot pedal break. The foot pedal break is located immediately off of the right and left ends of the chair edge. Logical Conclusions based on facts: (R4's) bleeding was the result of a rectal tear that occurred when the right foot break (brake) pedal of (R4's) wheelchair penetrated (R4's) rectum during a transfer using incorrect procedure. (E8) should have buckled (R4) in her chair before stepping away to find

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help. (E8) should not have raised the hoyer lift at all prior to having a 2nd person on site to assist."

On 8/21/25 at 8:07 am, R4's wheelchair was inside an exam room at the facility. Infront of the wheelchair seat were two silver bars angled up and toward the back of the wheelchair, one on each side of the wheelchair seat edge. Both bars are approximately three inches in length with a rounded top. There appears to be brown substance on the angled right bar and right front of the wheelchair pad.

On 8/21/25 at 8:58 am, E8 and E18 (Chief People Officer) entered the exam room. R4's wheelchair had a mannequin sitting in the chair. E8 was asked to demonstrate R4's transfer on 8/14/25. E8 placed the sling behind the mannequin. Tilted the wheelchair back and placed the sling underneath bilateral legs and up between the legs. E8 then crossed the leg straps and tilted the wheelchair back to a sitting position. E8 stated the bedroom door was to R4's back. R4 slid to the edge of the wheelchair, so E8 went to ask for help. E8 then slid the mannequin bottom toward the front of the wheelchair seat with the mannequin's legs to the front left and the bottom to the front right near the silver bar.

On 8/19/25 at 2:46 pm, E8 stated on 8/14/25, R4 is to be transferred by a mechanical lift. For a mechanical lift transfer, it requires two staff members. R4 had to go to the bathroom and was anxious. E8 unbuckled R4's seatbelt. R4 slid down in the wheelchair. The sling got tangled around the foot pedal. E8 walked to the bedroom door to get help. E8 stated she (E8) should have buckled R4's seatbelt when she walked away from the wheelchair. R4's rectum was bleeding.

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On 8/21/25 at 8:58 am, E8 stated on 8/14/25, R4 kept lifting so R4's adult brief slid below R4's buttock. When E8 went to get help, R4's seatbelt was unbuckled and the hoyer lift was elevated to cradle R4 so R4 wouldn't slide anymore.
On 8/21/25 at 12:52 pm, R4 stated yes when asked if the wheelchair caused the cut to R4's buttock.

On 8/21/25 at 10:23 am, E15 stated on 8/14/25 approximately 12:45 pm, E16 came and got me per E17's (Registered Nurse/RN) request. E15 went in R4's bedroom. R4's electric wheelchair was at the foot of R4's bed. Adult brief was at the foot of the wheelchair. Four to five good size piles of liquid BM with good amount of bright red fresh blood leading from the wheelchair to the bed. R4 was in bed and on R4's back. E17 was trying to see where the blood was coming from. We (E15 and E17) rolled R4 over on R4's left side and it looked like external hemorrhoid. E15 told E17 with the amount of blood, R4 needs sent out.

On 8/28/25 at 3:21 pm, E20 (Residential Service Director/Qualified Intellectual Disabilities Professional) stated R4 is a mechanical lift transfer only and a mechanical lift transfer should always have two staff.

R4's Emergency Department (ED) Hospital Admission Face sheet dated 8/14/25 includes, "Reason for Visit: rectal bleeding, laceration of buttock, and anal sphincter tear."

R4's Hospital OP (Operative) Note dated 8/14/25 includes, "Pre-operative Diagnosis: Perianal Trauma. Procedure: The wound was explored noting 4 cm external laceration on the left anterior lateral aspect involving the external sphincter

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complex. Necrotic tissue was sharply dissected and removed. An internal exam was performed noting extension of laceration into the rectal mucosa by approximately 1 cm. The laceration extended down to the superficial musculature fascia but did not appear to involve the muscle."

Facility Range of Motion, Repositioning, and Transfers Training, undated documents a mechanical lift lift transfer, "Must have two staff." Facility Client Rights Policy, undated includes, "Neglect: An employee's, agency's, or facility's failure to provide adequate medical care, personal care or maintenance, and causes an individual pain, injury or emotional distress, resulting in an individual's maladaptive behavior or the deterioration of physical or mental condition, or puts an individual's health or safety at risk of possible injury, harm or death. Rights: 18. No client is abused or neglected."

(A)

Statement of Licensure Violations 3 of 3

350.1430a)1)

Section 350.1430 Administration of Medication

a) 1) Medications shall be administered as soon as possible after doses are prepared at the facility and shall be administered by the same person who prepared the doses for administration, except under single unit dose packaged distribution systems.

These requirements were not met as evidenced by:

Based on observation, record review, and

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interview, nursing services failed to ensure administered medications immediately after they were prepared, impacting three individuals outside the sample (R19, R23, R35).

Findings include:

Facility Roster, undated, identifies R19, R23, and R35 reside in the facility.

The Physician's Order Sheet (POS) dated 8/21/25 document R19's 6:00 am medications include: baclofen 20 mg (milligrams), calcium D 250/125, esomeprazole 40 mg mix with 15 ml (milliliter) of water, gas relief drop 20/0.3 ml take 0.9 ml, glycopyrrolate 1mg, high potency tab mv/fa (multivitamin with folic acid) one tablet, polyethylene glycol powder 3350 mix 17 gm (grams) in 8 oz (ounces) of water, tizanidine 2 mg, vitamin D3 25 mcg (micrograms), vitamin C 1000 mg, zafirlukast 20 mg, and Zinc Sulfate 220 mg.

R23's POS dated 8/21/25 documents cephalexin 250 mg is to be given at 7:30 am.

R35's POS dated 8/21/25 documents the following 6:00 am medications: clonazepam 1 mg, epidiolex solution 100 mg/ml (must be left in original package) take 1.3 ml, famotidine 20 mg, Fosfomycin powder 3 gm weekly, lactulose 10 gm/15 ml take 15 ml, lamotrigine 175 mg, omeprazole 40 mg, risperidone 0.25 mg, simethicone drops take 0.6 ml, and tizanidine 8 mg.

On 8/21/25 at 6:10 am, three trays were sitting on top of the counter in the medication room. One tray had two medication cups of orange liquid and two cups of crushed powder. The second tray

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Z9999	Continued From page 9 had a cup with crushed powder, a medication cup with orange liquid, and a packet of esomeprazole. The third tray had a cup of crushed powder with liquid on top and a small cup of clear liquid. On 8/21/25 at 6:12 am, E15 (Licensed Practical Nurse/LPN) identified the first tray as R35's, the second tray as R19's, and the third tray as E23's. E15 also stated that E15 pre-popped the medications. On 8/21/25 at 6:42 am, E15 stated medications aren't allowed to be pre-popped. On 8/27/25 at 3:09 pm, E3 (Director of Nursing/DON) stated nurses are not allowed to pre-pop medications and it's not best practice. (C)	Z9999		