STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **8000192**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/09/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMOND-HENRY DISTRICT HSP	**600 NORTH COLLEGE AVENUE , GENESEO, Illinois, 61254**

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S0000	Initial Comments Facility Reported Incident of 10/1/25/2633828	S0000		11/13/2025
S9999	Final Observations Statement of Licensure Violation 300.610a) 300.690b) 300.1210b) 300.3240a) 300.3240b) 300.3240c) 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. Section 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. Section 300.1210 General Requirements for Nursing and	S9999		11/13/2025

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

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S9999	Continued from page 1 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 300.3240 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) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act) c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative and to the Department. (Section 3-610(a) of the Act) Based on observation, record review, and interview the facility failed to protect a resident from abuse/mistreatment-specifically, V3/Certified Nursing Assistant-CNA was physically rough when providing incontinence for one resident (R1); failed to report an allegation of abuse to the abuse coordinator and the State Agency for 2 residents (R1 and R2) of three residents, reviewed for abuse, in a total sample of three residents. These failures resulted in V3/Certified Nursing Assistant-CNA continuing to be abusive to R1 which caused R1 to clench her teeth, grimace, moan, cry, cover her face, and take a defensive/protective posture. Findings include: The facility policy, entitled "LTC Abuse & Neglect Procedures", Last Periotic Review 5/3/2021, documents: a. All incidents and allegations will be reported immediately. d. The Nurse Manager will ensure that all	S9999		

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S9999	Continued from page 2 alleged violations involving abuse, are reported immediately, but not later than 2 hours after any allegation made if the events that cause the allegation involve abuse or cause serious bodily injury 24 hours if the allegations do not involve abuse or do not result in serious bodily injury, to administrator of the facility and to other officials (including to the State Survey Agency. “Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology”. R1’s Electronic Medical Record/EMR document: R1 is not cognitively intact and has a diagnosis of Alzheimer’s Disease, Osteoarthritis, Anxiety Disorder, Hypothyroidism, Hemorrhoids, Lyme’s Disease, Restlessness and Agitation, Hypertension, Hyperlipidemia, and Depression. R2's EMR documents R2 is cognitively intact with a Brief Interview for Mental Status as 14/15 and has a diagnosis to include: Polyneuropathy, Unspecified Dementia, Chronic Obstructive Pulmonary Disease, Urinary Tract Infection, Iron Deficient Anemia, Hypertension, Chronic Kidney Disease Stage 3, Hypercholesterolemia, Hypothyroidism, Generalized Osteoarthritis, Presence of Cardiac Pacemaker, and Weakness. Facility Document entitled “Corrective/Disciplinary Action”, dated 02/24/25, documents: It was previously verbally discussed with (V3) that a resident reported she was being rough during a transfer. Concerns were brought forth that she is being rough during rounds and changing. Facility Document entitled “Corrective/Disciplinary Action”, dated 07/23/25, document: It was reported to Manager on 7/24/2025 that a R2 stated that (V3) was rough during cares; (V3) was rough doing peri care. V3 has violated behavioral standards through these actions. 7/24/25 at 6:26 p.m.- (V8/Registered Nurse) notified (V2/Director of Nursing) that resident (R2) reported that (V3) was rough with her last night and hurt her; (V8) stated, "Resident said (V3) pulled her clothes off roughly. R2 said she told (V3) that she was slipping off the toilet and tried to grab the bar. (V3) told her she was fine and didn't need to hold the bar. (R2) said (V3) grabbed her roughly."; (R2) stated (V3) started to undress her and pulled the shirt and jacket off at the same time over the head instead of separately. Resident reported she thought it was going	S9999		

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S9999	Continued from page 3 to make a spot on her head bleed. Resident reported she was almost shaking. Resident said, "seems like she doesn't like me, I don't like her." Resident reports some nights she is nice. Some nights she is ferocious. Resident stated she didn't know if she could sleep that night but stated she did. Resident stated (V3) has a "horrible attitude" and "I don't know what her problem is. I don't know if it's just me." Resident reports one time she pushed her through the privacy curtain without opening it and the resident hit her on the door. Email communication sent from V4/CNA, witness to 7/24/25 incident, to V2: “(V3) and I went into (R1’s room) during first rounds to check and change the resident. I grabbed the blue cushion to use and (V3) asked why I was grabbing it to use. I said that we had to use it or at least attempt to use it. (V3) then said, "No we don't." and I just nicely mentioned that (R1’s daughter would like us to use it or attempt to. I mentioned that (R1’s daughter) can see if we are using it or attempting to use it through the camera. (V3) shook her head and said that the daughter was an idiot for coming into the facility with poison ivy on her arms and contaminating everybody, loudly. I said that I was going to stop talking because we were on camera. She said she didn't give a sh*t, I said "Well I do." After the conversation was over, she was also somewhat very rough with resident when it came time to do peri care on her.” On 10/1/25, at 12:30 a.m., a video recording (taken in R1’s room) shows during incontinence care: V6/CNA and V3 provided cares; V3 pressed and held R1’s hand down on R1’s chest; adjusted R1’s legs roughly; pressed R1’s hand into R1’s chest a second time-pushing down twice and R1 stated, “I didn’t do anything.”; V3 roughly adjusted R1’s legs again and R1 reached toward V3 and V3 pressed R1’s hand back to R1’s chest; V3 wiped R1’s perineal area forcefully causing R1 to grimace and moan to which V3 responded “Sorry, this is what your daughter wanted.”; V3 finished incontinence care and pulled on R1’s incontinence brief three times firmly enough that R1’s body jerked upwards in bed while R1 continued grimacing. On 10/1/25, at 2:13 a.m., video recording, taken in R1's room, shows: V3 and V6 providing cares; R1’s shirt was wet; V3 firmly/roughly pulls R1’s shirt off; R1 started crying while covering R1’s face with R1’s hand; V3 tied the gown and then without lifting R1’s head, pulled it over R1’s head which caused R1’s head to tilt upwards and R1 grimaced. On 10/3/25, V2 confirmed: the 7/24/25 abuse allegation	S9999		

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S9999	Continued from page 4 was not reported to the State Agency; the 10/1/25 video recording shows V3 was abusive to R1; V6 did not report V3 abuse of R1; and V3's employment was terminated. On 10/7/25, at 9:30 am, V6 stated, during R1's cares, on 10/1/25: (V3) was "Horribly rough and mean"; "overly aggressive, harsh, and unkind"; "way too hard"; "Resident (R1) was defensive and in protection mode."; "I tried to reassure (R1), but (R1) was stressed with (V3) and that is the reason (R1) was combative because of the harsh treatment. Before we (V3) and (V6) went into the room, (V3) told me to keep my mouth shut and follow her lead." When asked if she felt V3 was abusive, V6 replied, "Yes, (V3) was way out of line"; and "No, I did not report it because as agency, it was my word against hers (V3)." (B)	S9999		