

Illinois State Department of Health

|                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                         |                     |                                                                                                                          |  |                                                 |  |
|-------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|
| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>3000584</b> |                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                                                     |  | (X3) DATE SURVEY COMPLETED<br><b>03/03/2026</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><b>CASS COUNTY SENIOR LIVING &amp; REHABILITATION LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                         |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>530 EAST BEARDSTOWN STREET , VIRGINIA, Illinois, 62691</b>                   |  |                                                 |  |
| (X4) ID<br>PREFIX<br>TAG                                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                      |  |
| S0000                                                                                     | Initial Comments                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                         | S0000               |                                                                                                                          |  | 03/17/2026                                      |  |
|                                                                                           | Annual Health Survey                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                         |                     |                                                                                                                          |  |                                                 |  |
| S9999                                                                                     | Final Observations                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                         | S9999               |                                                                                                                          |  | 03/17/2026                                      |  |
|                                                                                           | Statement of Licensure Violations:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                         |                     |                                                                                                                          |  |                                                 |  |
|                                                                                           | ONE OF TWO:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                         |                     |                                                                                                                          |  |                                                 |  |
|                                                                                           | 300.610a)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                         |                     |                                                                                                                          |  |                                                 |  |
|                                                                                           | 300.1210a)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                         |                     |                                                                                                                          |  |                                                 |  |
|                                                                                           | 300.1210b)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                         |                     |                                                                                                                          |  |                                                 |  |
|                                                                                           | 300.1210c)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                         |                     |                                                                                                                          |  |                                                 |  |
|                                                                                           | 300.1210d)5)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                         |                     |                                                                                                                          |  |                                                 |  |
|                                                                                           | Section 300.610 Resident Care Policies                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                         |                     |                                                                                                                          |  |                                                 |  |
|                                                                                           | a) The facility shall have written policies and<br>procedures governing all services provided by the<br>facility. The written policies and procedures shall be<br>formulated by a Resident Care Policy Committee<br>consisting of at least the administrator, the advisory<br>physician or the medical advisory committee, and<br>representatives of nursing and other services in the<br>facility. The policies shall comply with the Act and<br>this Part. The written policies shall be followed in<br>operating the facility and shall be reviewed at least<br>annually by this committee, documented by written,<br>signed and dated minutes of the meeting |                                                                         |                     |                                                                                                                          |  |                                                 |  |
|                                                                                           | Section 300.1210 General Requirements for Nursing and<br>Personal Care                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                         |                     |                                                                                                                          |  |                                                 |  |
|                                                                                           | a) Comprehensive Resident Care Plan. A facility, with<br>the participation of the resident and the resident's<br>guardian or representative, as applicable, must develop<br>and implement a comprehensive care plan for each<br>resident that includes measurable objectives and<br>timetables to meet the resident's medical, nursing, and<br>mental and psychosocial needs that are identified in<br>the resident's comprehensive assessment, which allow                                                                                                                                                                                                      |                                                                         |                     |                                                                                                                          |  |                                                 |  |

Office of Primary Care and Health Systems Management

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

Illinois State Department of Health

|                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                         |                                                                                                                          |                                                                                                        |  |                                                 |  |
|-------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|
| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>3000584</b> |                                                                                                                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                                   |  | (X3) DATE SURVEY COMPLETED<br><b>03/03/2026</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><b>CASS COUNTY SENIOR LIVING &amp; REHABILITATION LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                         |                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>530 EAST BEARDSTOWN STREET , VIRGINIA, Illinois, 62691</b> |  |                                                 |  |
| (X4) ID<br>PREFIX<br>TAG                                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |                                                                                                        |  | (X5)<br>COMPLETION<br>DATE                      |  |
| S9999                                                                                     | <p>Continued from page 1</p> <p>the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)</p> <p>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.</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>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:</p> <p>5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.</p> <p>These requirements were not met as evidenced by:</p> <p>Based on observation, interview, and record review the facility failed to secure a treatment order promptly and delayed the implementation of new interventions once skin breakdown was discovered to prevent worsening of a pressure wound for one of two residents (R23) reviewed for pressure ulcers in the sample of 24. These failures resulted in R23's facility acquired pressure wound worsening to a stage three.</p> <p>Findings include:</p> <p>The Prevention of Pressure Ulcers/Injuries policy dated 07/2017 documents "The purpose of this procedure is to provide information regarding the identification of</p> | S9999                                                                   |                                                                                                                          |                                                                                                        |  |                                                 |  |

Illinois State Department of Health

|                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                         |                                                                                                                          |                                                                                                        |  |                                                 |  |
|-------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|
| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>3000584</b> |                                                                                                                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                                   |  | (X3) DATE SURVEY COMPLETED<br><b>03/03/2026</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><b>CASS COUNTY SENIOR LIVING &amp; REHABILITATION LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                         |                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>530 EAST BEARDSTOWN STREET , VIRGINIA, Illinois, 62691</b> |  |                                                 |  |
| (X4) ID<br>PREFIX<br>TAG                                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |                                                                                                        |  | (X5)<br>COMPLETION<br>DATE                      |  |
| S9999                                                                                     | <p>Continued from page 2<br/>pressure ulcer/injury risk factors and interventions for specific risk factors. Risk Assessment 4. Inspect the skin on a daily basis when performing or assisting with personal care or ADL's (Activities of Daily Living). a. Identify any signs of developing pressure injuries (i.e. (example), non-blanchable erythema). b. Inspect pressure points (sacrum, heels, buttocks, coccyx, elbows, ischium, trochanter, etc. (etcetera). Prevention Nutrition 1. Monitor the residents for weight loss and intake of food and fluids. 2. Include nutritional supplements in the resident's diet to increase calories and protein, as indicated in the care plan. Mobility/Repositioning 1. Choose a frequency for repositioning based on the resident's mobility, the support surface and use, skin condition and tolerance, and the resident's stated preferences. 3. At least every two hours or as tolerated reposition residents who are reclining and dependent on staff for repositioning. 4. Reposition more frequently as needed, based on the condition of the skin and the resident's comfort. Monitoring 1. Evaluate, report and document potential changes in skin. 2. Review the interventions and strategies for effectiveness on an ongoing basis.</p> <p>The Pressure Ulcer/Skin Breakdown – Clinical Protocol dated 04/2018 documents "Cause Identification 1. The physician will help identify factors contributing or predisposing residents to skin breakdown; for example, medical comorbidities such as diabetes or congestive heart failure, overall medical instability, cancer or sepsis causing a catabolic state, and macerated or friable skin. Treatment/Management 2. The physician will help identify medical interventions related to wound management; for example, treating a soft tissue infection surrounding an ulcer, removing necrotic tissue, addressing comorbid medical conditions, managing pain related to the wound or to wound treatments."</p> <p>R23's Face Sheet documents that R23 is a 96-year-old that admitted to the facility on 11/22/24 with diagnoses which included Mild Protein-Calorie Malnutrition, Peripheral Vascular Diseases, and Age-Related Osteoporosis. On 2/2/26 a diagnosis of Influenza A Virus with Respiratory Manifestations was added and on 2/11/26 a diagnosis of Pressure Ulcer of Right Buttock, Stage three was added.</p> <p>R23's Care Plan documents that R23 has potential impairment to her skin related to fragile skin. Date Initiated 12/2/24. R23 has an Activity of Daily Living self-care performance deficit related to weakness and limited Range of Motion of bilateral upper and lower extremities. Interventions – Bed Mobility R23 requires</p> | S9999                                                                   |                                                                                                                          |                                                                                                        |  |                                                 |  |

Illinois State Department of Health

|                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                         |  |                                                                                                        |                                                                                                                          |                                                 |                            |
|-------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|----------------------------|
| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>3000584</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                                   |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><b>03/03/2026</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><b>CASS COUNTY SENIOR LIVING &amp; REHABILITATION LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                         |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>530 EAST BEARDSTOWN STREET , VIRGINIA, Illinois, 62691</b> |                                                                                                                          |                                                 |                            |
| (X4) ID<br>PREFIX<br>TAG                                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                         |  | ID<br>PREFIX<br>TAG                                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |                                                 | (X5)<br>COMPLETION<br>DATE |
| S9999                                                                                     | <p>Continued from page 3</p> <p>total assistance by two staff to turn and reposition in bed. R23 is maximal/substantial assistance for one to two staff for transferring. Date Initiated 12/2/24. R23 has an actual alteration in skin integrity-new wound on coccyx. Interventions – See wound doctor weekly, alternating air loss mattress to bed, pressure reducing cushion in recliner, follow treatment orders, and apply barrier cream with incontinent care. Date Initiated 2/11/26. This same care plan does not document new interventions after R23's coccyx wound was identified on 2/6/26 until 2/11/26, five days later.</p> <p>R23's Braden Scale Pressure Risk Assessment dated 12/31/25 at 10:44 AM, documents that R23 scored a 13 indicating R23 was a moderate risk for development of pressure ulcers.</p> <p>The Weekly Skin Check dated 1/23/26 at 5:56 PM, documents no skin impairment.</p> <p>R23's Shower Sheet dated 2/6/26 at 2:30 PM, written by V18/Certified Nursing Assistant documents that R23 has an open wound on her right buttock. It was also noted on this shower sheet by V2/Registered Nurse/RN/Prior Director of Nursing/DON dated 2/7/26 that treatment was initiated and R23 would be seen by the Wound Doctor.</p> <p>R23's Skin Issue report written by V2/RN/Prior Director of Nursing dated 2/7/26 at 3:41 AM, documents a new issue – MASD on R23's buttock that was acquired in house. There was a presence of burning wound pain noted at dressing. The wound measured 4.83 cm (centimeters) by 7.65 cm. There was no dressing applied. This same skin assessment documents "Does this resident have one or more unhealed pressure ulcers injuries." Not assessed/no information was marked.</p> <p>A Fax sent to V11/R23's Primary Care Physician dated 2/7/26 documents that R23 was noted to have an area of MASD (Moisture Associated Skin Damage) across buttocks with superficial open areas. Barrier cream to area twice a day and put on the list for the wound doctor to see on Wednesday (2/11/26). V11 responded on 2/9/26 "Fine."</p> <p>R23's Nursing Note dated 2/9/26 at 1:28 PM, documents a new order for barrier cream to R23's buttock twice a day and R23 was put on the list to see the wound doctor on Wednesday (2/11/26).</p> <p>R23's Shower Sheet dated 2/9/26 at 2:30 PM, written by V18/Certified Nursing Assistant documents "Buttocks is red/yellow, gotten worse since Friday." On this same shower sheet was written "Tx (treatment) in place."</p> |                                                                         |  | S9999                                                                                                  |                                                                                                                          |                                                 |                            |

Illinois State Department of Health

|                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                         |                                                                                                                          |                                                                                                        |  |                                                 |  |
|-------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|
| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>3000584</b> |                                                                                                                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                                   |  | (X3) DATE SURVEY COMPLETED<br><b>03/03/2026</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><b>CASS COUNTY SENIOR LIVING &amp; REHABILITATION LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                         |                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>530 EAST BEARDSTOWN STREET , VIRGINIA, Illinois, 62691</b> |  |                                                 |  |
| (X4) ID<br>PREFIX<br>TAG                                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |                                                                                                        |  | (X5)<br>COMPLETION<br>DATE                      |  |
| S9999                                                                                     | <p>Continued from page 4<br/>This was not dated and was signed by V2/RN/Prior Director of Nursing.</p> <p>R23's Nursing Note dated 2/11/26 at 3:15 PM, documents that V10/Wound Doctor was at the facility to see R23 and new orders were received.</p> <p>R23's Initial Wound Clinic Evaluation and Management Summary dated 2/11/26 documents R23 has a stage three pressure wound that measured 2 cm by 2 cm by 0.2 cm with moderate Sero-sanguinous drainage. The wound is undergoing autolytic debridement. Dressing Treatment Plan – Alginate Calcium with silver and gauze dressing.</p> <p>R23's Physician Orders document Stage III (three) coccyx- apply calcium alginate with Ag (silver), cover with border gauze dressing, change daily and as needed for soiling and non-adherence. Dated 2/11/26.</p> <p>R23's Wound Clinic Evaluation and Management Summary dated 2/25/26 documents R23 has a stage three pressure wound that measured 1.5 cm by 1 cm by 0.2 cm with moderate Sero-sanguinous drainage. Surgical excisional debridement was done to remove necrotic tissue and establish the margins of viable tissue. Dressing Treatment Plan – Alginate Calcium with silver and gauze dressing.</p> <p>R23's Treatment Administration Record/TAR for February 2026 documents Barrier Cream every evening and night shift for MASD to buttock. Start Date 2/9/26 at 3:00 PM. Discontinued 2/11/26 at 1:12 PM. The same TAR documents Stage III (three) coccyx- apply calcium alginate with Ag (silver), cover with border gauze dressing, change daily and as needed for soiling and non-adherence. Start Date 2/11/26 at 10:00 PM. There is no documentation for treatment started from the date R23's wound was identified on 2/6/26 until 2/9/26, three days later.</p> <p>On 3/3/26 at 8:36 AM, V15/Licensed Practical Nurse went to R23's room to do R23's dressing change. R23 was dependent on V15 to turn and reposition R23 so V15 could do the dressing change. R23 was very thin, weak, and slightly confused. R23 stated she did not know she had a wound on her buttock. The wound was on R23's right buttock. The wound was a small open area. V15 applied the calcium alginate and covered it with a dressing.</p> <p>On 3/2/26 at 12:13 PM, V2/Registered Nurse/Prior Director of Nursing stated that she was working night shift and the morning of 2/7/26 V2 saw on R23 shower sheet that a wound was documented. V2 stated that when</p> | S9999                                                                   |                                                                                                                          |                                                                                                        |  |                                                 |  |

Illinois State Department of Health

|                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                         |  |                                                                                                        |                                                                                                                          |                                                 |                            |
|-------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|----------------------------|
| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>3000584</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                                   |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><b>03/03/2026</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><b>CASS COUNTY SENIOR LIVING &amp; REHABILITATION LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                         |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>530 EAST BEARDSTOWN STREET , VIRGINIA, Illinois, 62691</b> |                                                                                                                          |                                                 |                            |
| (X4) ID<br>PREFIX<br>TAG                                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                         |  | ID<br>PREFIX<br>TAG                                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |                                                 | (X5)<br>COMPLETION<br>DATE |
| S9999                                                                                     | <p>Continued from page 5</p> <p>she assessed R23's wound, V2 thought it was a moisture associated wound. Barrier cream was already being used on R23 when R23 was incontinent and V2 did not request a new treatment. There was no other treatment ordered until 2/11/26 when V10/Wound Doctor came to the facility and reclassified the wound as a stage three pressure ulcer. V2 also stated that prior to 2/6/26 R23 had been very sick with Influenza A and had not been getting out of bed.</p> <p>On 3/2/26 at 12:47 PM, V11/Primary Care Physician stated that R23's wound was caused by pressure.</p> <p>On 3/3/26 at 11:59 AM, V10/Wound Doctor stated that R23's wound was a stage three pressure ulcer.</p> <p>On 3/3/26 at 10:43 AM, V17/Current DON verified a wound was found on R23 during R23's shower on 2/6/26. There was not an order put in for any treatment until 2/9/26 when barrier cream was ordered. That order was discontinued on 2/11/26 when the order for calcium alginate was given by the wound doctor on 2/11/26. V17 also verified the Care Plan did not have any new interventions put in place when the wound was found on 2/6/26. There were no new interventions until the wound doctor classified the wound as a pressure ulcer.</p> <p>(B)</p> <p>TWO OF TWO:</p> <p>300.610a)</p> <p>300.1210a)</p> <p>300.1210b)</p> <p>300.1210c)</p> <p>300.1210d)6)</p> <p>Section 300.610 Resident Care Policies</p> <p>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</p> |                                                                         |  | S9999                                                                                                  |                                                                                                                          |                                                 |                            |

Illinois State Department of Health

|                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                         |                                                                                                                          |                                                                                                        |  |                                                 |  |
|-------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|
| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>3000584</b> |                                                                                                                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                                   |  | (X3) DATE SURVEY COMPLETED<br><b>03/03/2026</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><b>CASS COUNTY SENIOR LIVING &amp; REHABILITATION LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                         |                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>530 EAST BEARDSTOWN STREET , VIRGINIA, Illinois, 62691</b> |  |                                                 |  |
| (X4) ID<br>PREFIX<br>TAG                                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |                                                                                                        |  | (X5)<br>COMPLETION<br>DATE                      |  |
| S9999                                                                                     | <p>Continued from page 6<br/>annually by this committee, documented by written,<br/>signed and dated minutes of the meeting</p> <p>Section 300.1210 General Requirements for Nursing and<br/>Personal Care</p> <p>a) Comprehensive Resident Care Plan. A facility, with<br/>the participation of the resident and the resident's<br/>guardian or representative, as applicable, must develop<br/>and implement a comprehensive care plan for each<br/>resident that includes measurable objectives and<br/>timetables to meet the resident's medical, nursing, and<br/>mental and psychosocial needs that are identified in<br/>the resident's comprehensive assessment, which allow<br/>the resident to attain or maintain the highest<br/>practicable level of independent functioning, and<br/>provide for discharge planning to the least restrictive<br/>setting based on the resident's care needs. The<br/>assessment shall be developed with the active<br/>participation of the resident and the resident's<br/>guardian or representative, as applicable. (Section<br/>3-202.2a of the Act)</p> <p>b) The facility shall provide the necessary care and<br/>services to attain or maintain the highest practicable<br/>physical, mental, and psychological well-being of the<br/>resident, in accordance with each resident's<br/>comprehensive resident care plan. Adequate and properly<br/>supervised nursing care and personal care shall be<br/>provided to each resident to meet the total nursing and<br/>personal care needs of the resident.</p> <p>c) Each direct care-giving staff shall review and be<br/>knowledgeable about his or her residents' respective<br/>resident care plan.</p> <p>d) Pursuant to subsection (a), general nursing care<br/>shall include, at a minimum, the following and shall be<br/>practiced on a 24-hour, seven-day-a-week basis:</p> <p>6) All necessary precautions shall be taken to assure<br/>that the residents' environment remains as free of<br/>accident hazards as possible. All nursing personnel<br/>shall evaluate residents to see that each resident<br/>receives adequate supervision and assistance to prevent<br/>accidents.</p> <p>These requirements were not met as evidenced by:</p> <p>Based on observation, record review and interview, the<br/>facility failed to ensure residents were free from<br/>accident hazards and received adequate supervision and<br/>assistive devices to prevent accidents for one (R27) of</p> | S9999                                                                   |                                                                                                                          |                                                                                                        |  |                                                 |  |

Illinois State Department of Health

|                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                         |                     |                                                                                                                          |  |                                                 |  |
|-------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|
| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>3000584</b> |                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                                                     |  | (X3) DATE SURVEY COMPLETED<br><b>03/03/2026</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><b>CASS COUNTY SENIOR LIVING &amp; REHABILITATION LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                         |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>530 EAST BEARDSTOWN STREET , VIRGINIA, Illinois, 62691</b>                   |  |                                                 |  |
| (X4) ID<br>PREFIX<br>TAG                                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                      |  |
| S9999                                                                                     | <p>Continued from page 7</p> <p>one resident reviewed for accidents in the sample list of 24. This failure resulted in (R27), a resident prescribed a blood thinner (Eliquis), falling from a wheelchair and striking his head on the floor, sustaining a large, painful discolored area to the back of the head.</p> <p>Findings include:</p> <p>The facility's Change in a Residents' Condition or Status policy revised 5/2017 documents our facility shall promptly notify the resident, his or her attending Physician, and representative of changes in the resident's medical/mental condition and/or status (changes in level of care, resident rights, etcetera) The Nurse will notify the residents attending physician on call when there has been an accident or incident involving the resident. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.</p> <p>R27's Minimum Data Set Assessment (MDS) dated 2/11/26 documents R27 is severely cognitively impaired. This same MDS documents, R27, requires substantial/maximum assistance for transfers and is dependent on staff for dressing.</p> <p>R27's care plan documents R27 is at risk for falls due to his cognitive status and prior history of falls and is at risk for abnormal bleeding or hemorrhage related to the use of anticoagulant therapy related to personal history of pulmonary embolism.</p> <p>R27's Physician Orders revealed R27 was prescribed Eliquis Oral Tablet 5 milligrams (mg) twice daily, related to chronic embolism and thrombosis of unspecified deep veins of the left lower extremity, with a start date of 2/19/26.</p> <p>R27's Fall Risk Assessment dated 10/21/25 documents R27 is at risk for falls.</p> <p>R27's Risk Management Assessment documented R27 experienced a fall on 2/27/26 in his room while with Certified Nursing Assistants (CNAs). R27's Nurse Progress Note dated 2/27/26 at 7:33 AM documented that at approximately 6:00 AM a CNA notified the nurse that the resident had fallen. Upon entering the room, the nurse observed R27 lying on the floor but still in a seated position in his wheelchair, lying on his back with his head under a pillow. CNAs reported they were dressing the resident when he leaned back and the wheelchair tipped backward, causing him to fall onto</p> |                                                                         | S9999               |                                                                                                                          |  |                                                 |  |

Illinois State Department of Health

|                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                         |                     |                                                                                                                          |  |                                                 |  |
|-------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|
| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>3000584</b> |                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                                                     |  | (X3) DATE SURVEY COMPLETED<br><b>03/03/2026</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><b>CASS COUNTY SENIOR LIVING &amp; REHABILITATION LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                         |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>530 EAST BEARDSTOWN STREET , VIRGINIA, Illinois, 62691</b>                   |  |                                                 |  |
| (X4) ID<br>PREFIX<br>TAG                                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                      |  |
| S9999                                                                                     | <p>Continued from page 8</p> <p>the floor. A head-to-toe assessment identified an abraded area to the back of the resident's head, dark red in color and approximately the size of a quarter. Vital signs and neurological checks were within normal limits. R27 was assisted back to bed by three staff members, and anti-tippers were applied to the back of the wheelchair as an immediate intervention.</p> <p>R27's Electronic Medical record does not contain measurements for the abrasion on the back of R27's head.</p> <p>R27's Pain Comprehensive Assessment dated 2/27/26 documents "Resident is unable to describe pain just says, back of my head".</p> <p>R27's Nurse Progress Note dated 2/28/26 at 4:00 AM documented V11 (R27's Physician) was notified by fax and indicated to continue to monitor the resident following the fall and staff would continue to follow the plan of care.</p> <p>On 3/1/26 at 11:00 AM, R27 was sitting up in his wheelchair with a mechanical lift sling underneath him and a baseball sized discolored area on the back of R27's head.</p> <p>On 3/02/2026 at 12:09 PM, V13 (Certified Nursing Assistant/CNA) stated she was working day shift on 2/27/26 when R27 fell. V13 stated she was not in the room at the time of the fall, but V12 and V14 (CNAs) were in the room. V13 stated she was asked to assist with getting R27 off the floor. V13 further stated V12 reported that after placing the resident in the wheelchair she lifted R27's legs to look underneath him for a shirt, at which time the wheelchair tipped backward and the resident fell.</p> <p>On 3/02/2026 at 12:45 PM, V2 (Former Director of Nursing) stated she was currently typing V12 and V14's witness statements related to R27's 2/27/26 fall investigation. V2 stated she had been instructed by V1(Administrator) that she was not allowed to provide the original witness statements because they were considered part of the facility's Quality Assurance (QA) process. V2 stated she was instructed to retype V12 and V14's witness statements and provide the typed versions instead. V2 further stated the surveyor could attempt to contact V12 (CNA) directly but indicated V12 would likely not answer the phone.</p> <p>On 3/02/2026 at 12:55 PM, V12 (CNA) stated she and V14 (CNA) had transferred R27 to his wheelchair using a mechanical lift. V12 stated she could not locate R27's</p> |                                                                         | S9999               |                                                                                                                          |  |                                                 |  |

Illinois State Department of Health

|                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                         |  |                                                                                                        |                                                                                                                          |                                                 |                            |
|-------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|----------------------------|
| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>3000584</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                                   |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><b>03/03/2026</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><b>CASS COUNTY SENIOR LIVING &amp; REHABILITATION LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                         |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>530 EAST BEARDSTOWN STREET , VIRGINIA, Illinois, 62691</b> |                                                                                                                          |                                                 |                            |
| (X4) ID<br>PREFIX<br>TAG                                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                         |  | ID<br>PREFIX<br>TAG                                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |                                                 | (X5)<br>COMPLETION<br>DATE |
| S9999                                                                                     | <p>Continued from page 9</p> <p>shirt and believed it might be underneath him. V12 stated she lifted R27's legs up while he was seated in the wheelchair to check underneath him and the wheelchair tipped backward, causing R27 to fall backward and strike his head on the floor. V12 stated V14 went to notify the nurse.</p> <p>On 3/02/2026 at 1:15 PM, V1 (Administrator) stated the facility did not have to provide the witness statements from the 2/27/26 fall investigation because they were part of the facility's Risk Management Quality Assurance process.</p> <p>On 3/02/2026 at 1:45 PM, V11 (R27's Physician) V11 stated she would trust the nurse to call if there was a significant change and indicated that if a resident fell from a wheelchair and hit their head there would be impact and the physician should have been notified by phone rather than by fax since R27 was receiving a blood thinner and fell backwards from his wheelchair and hitting the back of his head.</p> <p>On 3/2/26 at 1:50 PM, V1 provided V12 and V14's original witness statements to incident on 2/27/26.</p> <p>R27's Fall Witness/Last Interaction statement dated 2/27/26 from V12 (CNA) at 6:00 AM, documents "V12 and V14 transferred R27 to his chair while getting R27 ready. We were unable to find his shirt and thought we may have sat him on it. V12 checked under R27's legs and the wheelchair fell back."</p> <p>R27's Fall Witness/Last Interaction statement dated 2/27/26 from V14 (CNA) documents "At about 6:05 AM we had just transferred R27 to his wheelchair and we could not find his shirt we had layed out for him. We thought it could possibly be underneath R27 in his wheelchair so V12 lifted R27's legs attempting to see if the shirt was underneath him when his wheelchair fell over backwards."</p> <p>On 3/03/2026 at 2:00 PM, V15 (Director of Nursing) stated the Medical Director should have been notified by phone regarding R27's accident on 2/27/26. V15 confirms she cannot find documentation that V11 was notified of R27's accident by phone. V15 further confirms R27's Fall investigation is not included in R27's Medical Record.</p> <p>(NO VIOLATION)</p> |                                                                         |  | S9999                                                                                                  |                                                                                                                          |                                                 |                            |