

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3001096		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/12/2026	
NAME OF PROVIDER OR SUPPLIER Fondulac Rehabilitation and Health Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 901 ILLINI DRIVE , EAST PEORIA, Illinois, 61611			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S0000	Initial Comments		S0000				
	First Probationary Licensure Survey						
S9999	Final Observations		S9999				
	Statement of Licensure Violations 1 of 13:						
	300.615b)						
	300.615c)						
	300.615g)						
	300.615j)						
	Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information						
	b) All persons seeking admission to a nursing facility must be screened to determine the need for nursing facility services prior to being admitted, regardless of income, assets, or funding source. (Section 2-201.5(a) of the Act) A screening assessment is not required provided one of the conditions in Section 140.642(c) of the rules of the Department of Healthcare and Family Services titled Medical Payment (89 Ill. Adm. Code 140.642(c)) is met.						
	c) Any person who seeks to become eligible for medical assistance from the Medical Assistance program under the Illinois Public Aid Code to pay for long-term care services while residing in a facility shall be screened in accordance with 89 Ill. Adm. Code 140.642(b)(4). (Section 2-201.5(a) of the Act)						
	g) If the results of the background check are inconclusive, the facility shall initiate a fingerprint-based check, unless the fingerprint check is waived by the Director of Public Health based on verification by the facility that the resident is completely immobile or that the resident meets other criteria related to the resident's health or lack of potential risk, such as the existence of a severe, debilitating physical, medical, or mental condition that nullifies any potential risk presented by the resident. (Section 2-201.5(b) of the Act) The facility shall arrange for a fingerprint-based background						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 check or request a waiver from the Department within 5 days after receiving inconclusive results of a name-based background check. The fingerprint-based background check shall be conducted within 25 days after receiving the inconclusive results of the name-based check. j) The facility shall be responsible for taking all steps necessary to ensure the safety of residents while the results of a name-based background check or a fingerprint-based background check are pending; while the results of a request for waiver of a fingerprint-based check are pending; and/or while the Identified Offender Report and Recommendation is pending. This requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure two of five residents (R5, R8) were screened prior to admission, initiated a fingerprint background and failed to implement interventions to ensure the safety of other residents in a sample of 22. This failure has the potential to affect all 77 residents in the facility. Findings include: The Identified Offender Policy dated 6/22, documents the facility as part of the admission screening process: Complete a mandatory criminal background information and authorization for criminal background check form. Initiate within 24 hours of a resident's admission, a request for a Uniform Criminal Information Act name-based criminal history record from the Illinois State Police using the Criminal History Information Response Process (CHIRP) for all persons 18 or older seeking admission to the facility.... R5 was admitted to the facility on 3/5/26. R5's CHIRP dated 3/6/26 documents "In Progress-HELD". R8 was admitted on 3/3/26. R8's CHIRP dated 3/4/26 documents "In Progress-HELD". On 3/12/26, V1 (Administrator) stated R5 and R8's "hit" status was undetermined at this time and no interventions were implemented to protect other residents until the CHIRP information was recoverable. (C)			S9999			

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S9999	Continued from page 2 Statement of Licensure Violations 2 of 13: 300.620b) Section 300.620 Admission, Retention and Discharge Policies b) An individual who needs services that are not readily available in a particular facility, or through arrangement with a qualified outside resource, shall not be admitted to or kept in that facility. The Department defines a "qualified outside source" as one recognized as meeting professional standards for services provided. This requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure a resident received a Physical/Occupation Therapy consult/evaluation and/or treatment services required upon admission for one of three residents (R5) who were new admissions, in a sample of 22. Findings include: The Facility-Wide Self-Assessment dated 1/1/26 documents services provided by the Facility include Physical and Occupational Therapy and a Restorative Nursing Program. The Admission Policy dated 12/24, documents to admit residents who can be cared for adequately by the facility. Prior to or at the time of admission, the resident's Attending Physician must provide the facility with information needed for the immediate care of the resident. R5 was admitted to the facility on 3/5/26 with diagnoses of Hemiplegia and Hemiparesis following a Cerebral Infarct affecting the left non-dominant side. R5's current care plan documents R5 wishes to return home but unsure of length of stay and the goal is for R5 to be discharged safely, back to the community when feasible. R5's Progress Notes dated 3/5/26 documents R5 is alert and oriented to person, place and time, able to make wants and needs known to staff. R5's Social Services History and Comprehensive Assessment dated 3/10/26 documents "Resident's stated goals for this admission to get strength back".	S9999					

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S9999	Continued from page 3 R5's record does not include Physician Orders to admit R5 to the facility, a Physical and/or Occupational Therapy Evaluation/Consult order, orders nor care plan interventions for restorative care nor has the Physician conducted an assessment as of 3/12/26, 7 days post admission. The Hospital's referral information documents R5 was admitted to the hospital on 2/28/26 through 3/5/26 for new onset of left leg paralysis and diagnosis of Cerebral Vascular Accident. The Hospital's referral information includes the Physical Therapy Initial Evaluation/Re-evaluation dated 3/2/26 and the Occupational Therapy Initial Evaluation/Re-evaluation dated 3/4/26 which documents R5 would benefit from Physical and Occupational Therapy after discharge from acute care to address longer term therapy needs, in order to safely return to highest functional level. The Discharge Summary also includes the statement that Physical and Occupational Therapy would benefit R5 post hospitalization. On 3/10/26 at 10:35 AM, R5 stated "They brought me here for rehab (rehabilitation) because I can't move my left leg. When they (facility) came to the hospital, they told me they had a great therapy program, but I haven't had any therapy. I wouldn't have come here if I wasn't going to get therapy." On 3/11/26 at 11:00 AM, "I talked with that lady up front (V11, Business Office Manager, R5 described V11's hair color, length, approximate height, where her office was located and then by name) and she told me therapy wasn't covered by my insurance, but the CNA's (Certified Nurse Aides) would walk be and do exercises with me. Nope. That hasn't happened." On 3/11/26 at 11:08 AM, V18 (Director of Rehabilitation) stated therapy services does not have or received a referral or order for a Physical or Occupation Therapy Evaluation for R5. V18 stated therapy services are dependent on insurance approval, although there is charity assistance for those in need. The therapy department just needs a referral from the physician, and an evaluation is usually done the same day or following day. Therapy services applies for the charity assistance for the residents in need. On 3/11/26 at 12:10 PM, V11 (Business Office Manager) stated R5 does not have a therapy payer source and the facility was "looking into charity aide. We just have to notify therapy, and they can evaluate (R5)." When asked about her discussion			S9999			

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S9999	Continued from page 4 with R5 and CNAs are to provide restorative cares, V11 stated "I didn't know anything about it (therapy referral) until now. I have never talked to him (R5). They (therapy services) just haven't gotten to it (therapy evaluation) yet." When asked why R5's Medicare Eligibility form for services dated 3/1/26 – 3/31/26 included Skilled Nursing Services, Physical Therapy and Occupational Therapy, V11 stated the therapy approved was for outpatient therapy only, although that was not indicated on the form. It was unable to be determined if V11 was "looking into charity aide", if she was going to notify therapy of the need for R5 to have an evaluation and need for charity assistance, if she was aware of the need for therapy services or how R5 was going to receive care based on the hospitals referral and residents goals without insurance coverage. On 3/12/26 at 2:30 PM, V1 (Administrator) stated R5 should have been referred for a therapy evaluation and therapy would get charity aide set up. V11 stated the facility does have a restorative program and staff should be working with R5 on strengthening and mobility with or without therapy services. V1 agreed the facility is responsible to ensure the residents admission needs and goals are able to be met prior to admission. (B) Statement of Licensure Violations 3 of 13: 300.670a) 300.670c) 300.670d) Section 300.670 Disaster Preparedness a. For the purpose of this Section only, "disaster" means an occurrence, as a result of a natural force or mechanical failure such as water, wind or fire, or a lack of essential resources such as electrical power, that poses a threat to the safety and welfare of residents, personnel, and others present in the facility. c. Disaster drills for other than fire shall be held twice annually for each shift of facility personnel. d. Fire drills shall include simulation of the evacuation of residents to safe areas during at least one drill each year on each shift. These requirements were not met as evidenced by:			S9999			

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S9999	Continued from page 5 Based on interview and record review, the facility failed to perform disaster drills twice annually for each shift and failed to have a simulated evacuation fire drill on each shift. These failures have the potential to affect all 77 residents who reside in the facility. Findings include: Facility "Emergency Management Plan," dated September 2017, documents "The Emergency Preparedness Program/EPP was developed to comply with all applicable state emergency preparedness requirements. The facility will conduct annual testing of the EPP and document all drills. Facility Room Roster, dated 3/10/26, documents 77 residents in the facility. Fire drill logs were reviewed from 1/15/25 through 2/23/26 and there was one simulated tabletop evacuation provided for a blizzard (disaster) dated 6/16/25. No simulated evacuation fire drills for each shift were conducted. No Disaster drills were performed twice annually for each shift. No disaster drills to review other than the one dated 6/16/25 for a blizzard, and one tornado drill dated 3/25/25 at 2:30PM. On 3/12/26 at 10:20AM, V7 Maintenance stated he was responsible for conducting the fire and disaster drills for staff. V7 verified no disaster drills were conducted by him (been in the position for three to four months), or documentation that disaster drills other than what was provided was able to be found. V7 verified no evacuation fire drills were conducted by him, or documentation that an evacuation fire drill for each shift was able to be found. (C) Statement of Licensure Violations 4 of 13: 300.696b) SECTION 300.696 INFECTION PREVENTION AND CONTROL b) Written policies and procedures for surveillance, investigation, prevention, and control of infectious agents and healthcare-associated infections in the facility shall be established and followed, including for the appropriate use of personal protective equipment as provided in the Centers for Disease			S9999			

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S9999	Continued from page 6 Control and Prevention's Guideline for Isolation Precautions, Hospital Respiratory Protection Program Toolkit, and the Occupational Safety and Health Administration's Respiratory Protection Guidance. The policies and procedures must be consistent with and include the requirements of the Control of Communicable Diseases Code, and the Control of Sexually Transmissible Infections Code. This requirement is not met as evidenced by: Based on interview, observation and record review, the facility failed to ensure staff maintained a sanitary environment and prevented cross contamination for three residents (R8, R7, R22) observed during wound care, in a sample of 22. Findings include: The Infection Prevention and Control Manual General Policies, no date, documents cleaning and disinfection of equipment are done to decrease the risk transmission of infectious organisms and maintain a clean and sanitary environment. The Spaulding Classification of devices, processes and germicidal products documents glucometers and podiatry equipment require a high level of disinfection with a disinfectant labeled to inactivate HIV, TB, HBV and HCV or Household bleach 1:10. Tabletops and equipment require low-level disinfection with a disinfectant without a label for TB, ethyl or isopropyl alcohol 70-90% or household bleach 1:500. On 3/10/26 at 11:26 AM, V12 (Licensed Practical Nurse/LPN) was observed to don non-sterile gloves, use a blood glucose meter to sample R8's blood, remove the gloves and discard in the trash, place the blood glucose meter in her pocket without sanitizing the meter or conducting hand hygiene. V12 walked out of R8's room and removed the blood glucose meter from her pocket and placed it back into the medication storage cart without sanitizing the meter. On 3/10/26 at 11:32 AM, V12 drew up R8's insulin into a syringe at the medication storage cart in the hallway, walked down the hallway into R8's room with the syringe and needle not capped, administered the insulin, exited the room, walk down the hall with the syringe and needle not capped and disposed of the syringe and needle in the needle box on the medication cart. On 3/11/26 at 10:20 AM, V3 (Assisting Director of Nursing) and V5 (Wound Nurse) conducted wound care on R7. V5 removed a pair of scissors from the treatment cart, cut off R7's soiled wound dressing,			S9999			

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S9999	Continued from page 7 laid the scissors on the bed sheets (no barrier), then discarded the dressing and placed the scissors back on top of the wound cart. V5 removed a bottle of Iodoform packing strips ½ inch by five yards labeled "Single use only. Do not reuse" which was not sealed or labeled with a resident's name, pulled out packing strip and cut it with the contaminated scissors, pushed the packing back into the bottle and placed the bottle into a drawer of the treatment cart. V7 removed a used roll of tape and black marker from the treatment cart, tore a piece of tape off, documented date and initialed the tape and placed on R7's dressing. Post dressing change, V5 removed trash from top of the treatment cart, placed the used roll of tape and black marker back into a drawer of the treatment cart with other multiple rolls of used tape, placed the lid back on top of the wound solution bottle and wound antiseptic wash bottle (both used for R7's dressing change) and left them on top of the treatment cart without removing gloves used during the dressing change. V3 and V5 exited R7's room and went into R14's room with the treatment cart and supplies without disinfecting the treatment cart's surface or supplies on top of the cart. Once in R14's room, V7 cleansed the contaminated scissors with antiseptic wound wash which did not meet the labeling requirements for disinfection of equipment in a healthcare setting. V7 removed the same bottle of Iodoform ½ inch by 5 yards labeled "Single use only. Do not reuse" bottle used for R7's wound care, cut the packing strip, returned the lid and placed it in a drawer in the treatment cart. The tape and black marker were removed, documented on and placed on R14's dressing, then replaced into the treatment cart's drawer. Post dressing change, V3 and V5 exited R14's room and went into another resident's room to conduct wound care with the treatment cart without disinfecting the treatment cart's surface or supplies left on top of the cart. On 3/12/26 at 2:30 PM, V1 (Administrator) stated the treatment cart should have been disinfected prior to entering another resident's room, contaminated equipment should be disinfected with approved disinfectants, single resident use items should not be used for multiple residents, gloves should be removed and hand hygiene conducted when moving from a dirty to clean area. (B) Statement of Licensure Violations 5 of 13: 300.1060A)			S9999			

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S9999	Continued from page 8 300.1060b) 300.1060c) 300.1060d) 300.1060f) 300.1060g) Section 300.1060 Vaccinations A. A facility shall annually administer or arrange for administration of a vaccination against influenza to each resident, in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention that are most recent to the time of vaccination, unless the vaccination is medically contraindicated or the resident has refused the vaccine. Influenza vaccinations for all residents age 65 and over shall be completed by November 30 of each year or as soon as practicable if vaccine supplies are not available before November 1. Residents admitted after November 30, during the flu season, and until February 1 shall, as medically appropriate, receive an influenza vaccination prior to or upon admission or as soon as practicable if vaccine supplies are not available at the time of the admission, unless the vaccine is medically contraindicated or the resident has refused the vaccine. b. A facility shall document in the resident's medical record that an annual vaccination against influenza was administered, arranged, refused or medically contraindicated. c. A facility shall administer or arrange for administration of a pneumococcal vaccination to each resident in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, who has not received this immunization prior to or upon admission to the facility unless the resident refuses the offer for vaccination or the vaccination is medically contraindicated. d. A facility shall document in each resident's medical record that a vaccination against pneumococcal pneumonia was offered and administered, refused, or medically contraindicated. f. A facility shall document in the resident's medical record that he or she was verbally screened for risk	S9999					

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S9999	Continued from page 9 factors associated with hepatitis B, hepatitis C, and HIV, and whether or not the resident was immunized against hepatitis B. g. All persons determined to be susceptible to the hepatitis B virus shall be offered immunization within 10 days after admission to any nursing facility. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to offer, administer, or arrange for vaccination for an annual influenza vaccine for four (R3, R5, R6, and R7) of five residents, and pneumococcal vaccine for two (R5 and R6) of five residents. Failed to document in each resident's medical record whether the influenza vaccine for one (R5) of five residents, and pneumococcal vaccines for two (R5 and R6) of five residents were offered, arranged, administered, refused, or medically contraindicated. Failed to document whether the resident was immunized against hepatitis B for four (R4, R5, R6, and R7) of five residents reviewed for immunizations. Failed to document in each resident's medical record they were screened for risk factors of hepatitis B, C, and HIV for five (R3, R4, R5, R6, and R7) of five residents reviewed for immunizations in a sample of 22. These failures have the potential to affect all 77 residents who reside in the facility. Findings include: Facility "Influenza Vaccine Program, dated 9/2022, documents "It is the policy of this facility that all residents will be offered immunization against influenza. Facility "Hepatitis B Vaccination Laws for Long-Term Care Facility," undated, documents "Illinois law states that all persons determined to be susceptible to the Hepatitis B virus shall be offered the immunization with 10 days of admission to any nursing facility. The facility shall document in the resident's medical record whether or not the resident was immunized against Hepatitis B." Facility Room Roster, dated 3/10/26, documents 77 resident's resident in the facility. R3's medical record documents an influenza vaccine was refused on 4/17/24; and no further documentation for the annual vaccination being offered, refused, administered, medically contraindicated, or arranged was found in R3's medical record.			S9999			

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S9999	Continued from page 10 R5's medical record has no documentation on a influenza vaccine; and no further documentation for the annual vaccination being offered, refused, administered, medically contraindicated, or arranged was found in R5's medical record. R6's medical record documents a influenza vaccine was administered on 11/01/2021; and no further documentation for the annual vaccination being offered, refused, administered, medically contraindicated, or arranged was found in R6's medical record. R7's medical record documents a influenza vaccine was administered on 9/11/2018; and no further documentation for the annual vaccination being offered, refused, administered, medically contraindicated, or arranged was found in R7's medical record. R5 and R6's medical records have no documentation on a pneumonia vaccine; and no further documentation for the vaccinations being offered, refused, administered, medically contraindicated, or arranged was found in R5 and R6's medical records. R4, R5, R6, and R7's medical records have no documentation on their Hepatitis B series vaccinations; and no further documentation for the vaccinations being offered, refused, administered, medically contraindicated, or arranged was found in R4, R5, R6, and R7's medical records. R3, R4, R5, R6, and R7's medical records have no documentation they were screened for risk factors of hepatitis B, C, and HIV. On 3/11/26 at 2:25pm, V2 DON/Director of Nursing RN/Registered Nurse stated they do not screen residents for Hepatis B, C, or HIV and did not know they were supposed screen or document this. V2 stated all immunizations for Influenza and Pneumonia vaccines are in the resident records, and they offer the influenza vaccine annually and pneumonia vaccine if they haven't had. (B) Statement of Licensure Violations 6 of 13: 300.700a) 300.700b)2)3) Section 300.700 Testing for Legionella Bacteria			S9999			

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S9999	Continued from page 11 a. A facility shall develop a policy for testing its water supply for Legionella bacteria. The policy shall include the frequency with which testing is conducted. The policy and the results of any tests and corrective actions taken shall be made available to the Department upon request. b. The policy shall be based on the ASHRAE Guideline "Managing the Risk of Legionellosis Associated with Building Water Systems" and the Centers for Disease Control and Prevention's "Toolkit for Controlling Legionella in Common Sources of Exposure". The policy shall include, at a minimum: 2. A water management program that identifies specific testing protocols and acceptable ranges for control measures; and 3. A system to document the results of testing and corrective actions taken. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to include in their policy the frequency for testing, testing protocols, acceptable ranges, and a system to document the testing and corrective actions for Legionella; and failed to have any baseline testing performed to establish for their ranges or testing frequency. These failures have the potential to affect all 77 residents who reside in the facility. Findings include: CDC- https://www.cdc.gov/control-legionella/media/pdfs/Control-Toolkit-All-Modules.pdf-February 17, 2026, Toolkit for Controlling Legionella in Common Sources of Exposure (Legionella Control Toolkit), documents the following: "People at increased risk for Legionnaires' disease: Includes people 50 years or older, current or former smokers, people with a chronic lung disease (like emphysema), people with weak immune systems or who take drugs that weaken the immune system, people with cancer, and people with underlying illnesses such as diabetes, kidney failure, or liver failure. Routine Legionella testing: Testing for Legionella to establish a baseline measurement for performance indicators or for validating a water management program or corrective action. Validation: Activities to confirm the water management program is working as intended and is effective for Legionella control.			S9999			

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S9999	Continued from page 12 Routine Testing for Legionella Purpose Use this document to help analyze hazards and establish Legionella control measures and complement existing resources for testing, sampling, and water management programs (WMPs). Elements of a healthcare water management program includes control measures, their locations and how to monitor them, and interventions when control limits are not met. It also ensures the program is running as designed and is effective, and includes documentation and communication on all activities." Facility Room Roster, dated 3/10/26, documents 77 resident's resident in the facility. Facility "Water Management Program Reduce Legionella Growth/Spread," undated, has no documentation for the frequency of testing, testing protocols, acceptable ranges, and a system to document the testing and corrective actions for Legionella. The facility was unable to provide any baseline testing of their water, any water sample analysis from the health department/town on their water. On 3/11/26 at 8:45AM, V1 Administrator stated they do not do testing of their water for legionella and have no tests from the town on water testing because he is not required to do testing. V1 was unable to answer how they would know if the facility had Legionella in their water, and what the facility water quality baseline range is. On 3/12/26 at 10:45AM, V7 Maintenance stated he does no testing for Legionella, and has no reports from the health or water department on testing their water. (C) Statement of Licensure Violations 7 of 13: 300.1210b)3) 300.1210d)1)2)6) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care			S9999			

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S9999	Continued from page 13 shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 3) All nursing personnel shall assist and encourage residents so that a resident who is incontinent of bowel and/or bladder receives the appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. All nursing personnel shall assist residents so that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary. 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. This requirement is not met as evidenced by: Based on interview, observation and record review, the facility failed to ensure appropriate infection control and enhanced barrier precautions were taken while performing urinary catheter care for one (R1) of three residents reviewed for Incontinence Care/Indwelling Catheter Care; and failed to ensure cares are provided as ordered (R7) of three residents reviewed for physician's orders. Failed to ensure residents and staff abide by the Facilities Smoking Protocol to prevent accidents and ensure residents safety for one (R8) of two residents who smoked in a sample of 22. Findings include: The Physician's Orders policy, revised 4/21, documents all medications, including non-legend medications shall be given only upon the written order of the physician. All such orders shall have			S9999			

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S9999	Continued from page 14 the handwritten or electronic signature of the physician. The Smoking Policy Acknowledgement, no date, documents "This facility has an outlined procedure ensuring the safety and well-being of all residents related to smoking. Residents are required to turn in all smoking materials to the designated departments (lights, matches pipes, cigarettes, e-cigs, tobacco, etc.)" Designated smoking times 9:00 AM-9:30 AM, 11:0 AM-11:30 AM, 1:00 PM-1:30 PM, 3:00 PM-3:30 PM and 7:00 PM-7:30 PM. The Registered Nurse and Licensed Vocation/Practical Nurse Job Descriptions, not dated, documents responsibilities include the ability to administer medications and treatments timely and according to facility policy; Demonstrates ability to carry out physician orders; Collaborate with other departments to provide timely effective care consistent with individual's needs, choices and preferences; Ensures the physician orders are followed as prescribed; Orders and reports diagnostic tests timely; Ensures the progress notes are reflective of the care plan and that the approaches on the care plan are being followed. Facility Infection Prevention and Control Manual-Enhanced Barrier Precautions policy, undated, documents Enhanced Barrier Precautions are recommended for residents with an indwelling medical device such as urinary catheters and gown, and gloves should be worn when performing "high contact resident care activities." The Enhanced Barrier Precautions Policy documents examples of high contact activities as "bathing/showering, providing hygiene, and caring for or using an indwelling medical device" Facility Urinary Catheter Care policy, undated, documents its purpose is to prevent catheter-associated urinary tract infections. The Urinary Catheter Care Policy documents personal protective equipment such as gowns and gloves should be worn and documents the catheter tubing and drainage bag should be kept off the floor. 1.On 3/10/2026 at 1:15 pm, R1 was observed in a wheelchair in the hallway with a urinary collection bag hanging under the seat of the wheelchair with the bottom of the bag touching the ground. On 3/10/2026 at 1:20 PM, V13 (Licensed Practical Nurse), stated the urinary collection bag should not			S9999			

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S9999	Continued from page 15 touch the floor or hang from under the wheelchair. On 3/11/2026 at 9:40 AM, V16 Certified Nursing Assistant/CNA performed hand hygiene, put on clean gloves and performed R1's daily catheter care. V16 did not have a gown available to wear in the room, and did not wear a gown while performing catheter care. At that same time, R1's bed was in its lowest position and R1's urinary collection bag hung from the bed frame with the bottom of the bag touching the floor. 2. R7 was admitted on 3/4/25 with diagnoses of Chronic Obstructive Pulmonary Disease, Spastic Quadriplegic Cerebral Palsy, Type 2 Diabetes Mellitus, Venous Insufficiency and Cellulitis. On 3/6/26, the physician ordered a wound culture to be done on the wound bed of the great and second toe of the left foot. R7's record did include documentation a wound culture was completed as of 3/11/26. On 3/11/26 at 2:30 PM, V2 (Director of Nursing) stated R7 has not had her left foot culture as ordered on 3/6/26. V2 stated the facility has been out of culture swabs for "a while" because the facility's swabs were expired. V2 stated "The contracted laboratory was supposed to bring some (culture swabs) but they still have not brought them. I will call and ask them when they are bringing them." V2 agreed the physician had not been notified the culture had not been done as ordered. 3. R8 was admitted on 3/3/26 with diagnoses of Cerebral Vascular Accident, Hypertension, Type 2 Diabetes Mellitus, Asthma and Respiratory Failure. R8's Minimum Data Set (MDS) dated 3/9/26 documents in section C had a Brief Interview for Mental Status of 14, cognitively intact. R8's Smoking Assessment dated 3/3/26 documents R8 is at low risk. R8's current care plan documents R8 is a smoker, and smoking materials are kept secure by staff. Smoking per facility protocol. R8 is supervised while smoking. On 3/10/26 at 11:12 AM, V12 stated R8 goes out to smoke whenever he wants to, and he kept his own smoking materials on his person. On 3/10/26 at 11:17 AM, R8's bedside table was			S9999			

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S9999	Continued from page 16 observed to have a package of cigarettes with cigarettes and a lighter inside the box. On 3/11/26 at 11:16 AM, R8 was observed to wheel himself from the smoking area to his room with a package of cigarettes in his lap. On 3/11/26 at 11:16 AM, R8 stated he goes out to the smoking area any time he wants to go out. R8 had the code to open the door to the smoking area and stated he had his own lighter. On 3/12/26 at 2:00 PM, V1 (Administrator) agreed R8 should not have the door code to the smoking area, a lighter or cigarettes in his possession. (B) Statement of Licensure Findings 8 of 13: 300.16302) Section 300.1630 Administration of Medication 2. Each dose administered shall be properly recorded in the clinical record by the person who administered the dose. These requirements were not met as evidenced by: Based on interview, observation, and record review, the facility failed to ensure medications were administered as ordered and in a timely manner for one (R8) of nine residents observed during medication administration, and failed to ensure medications were properly recorded by the person who administered the medications for one (R2) of 18 residents reviewed for medications in a sample of 22 Findings Include: Facility "Medication Administration Times" policy, undated, documents "medications scheduled to be administered at 8:00 AM may be given between 7:00 AM and 9:00 AM; and 12:00 PM may be given between 11:00 AM and 1:00 PM." Facility "Administration of Medications" policy, revised 4/21, documents "immediately after a drug is ingested, it should be recorded on the Medication Administration Record/MAR. If a physician's order cannot be followed, the physician shall be notified and noted in the progress notes in the resident's record. The facility shall check the Physician's Order Sheet and MAR against the current Physician's Orders, to assure proper administration		S9999				

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S9999	Continued from page 17 to each resident." Facility staffing schedule for March 10, 2026, documents V13 Licensed Practical Nurse/LPN as the nurse assigned to R2's hallway from 6:00 AM-2:00 PM. Facility staffing schedule for March 10, 2026, documents V14 Registered Nurse/RN as the nurse assigned to R2's hallway from 2:00 PM to 10:00 PM. 1.R2's MAR/Medication Administration Record, dated 3/10/2026 at 2:33 pm, documents 8:00 AM medications were not signed off as given. R2's Health Status Note, dated 3/10/2026 at 8:04 AM, documents "Resident experienced a witnessed two-minute seizure. New order for labs in AM to check Keppra and Lamotrigine levels and referral to neurology. (V3) Assistant Director of Nursing/ADON present during seizure." On 3/10/2026 at 1:30 PM, R2 was alert and oriented and stated, "I did not receive my seizure medication this morning and I had a seizure." On 3/10/2026 at 3:00 PM, V14 RN, logged on to R2's MAR and noticed all the 8:00 AM medications were highlighted red in the electronic health record with no nurse initials next to each medication. At that same time, V14 stated she recently arrived for second shift taking over for V13 Licensed Practical Nurse/LPN; and she was aware R2 had a seizure this morning. R2's MAR, dated 3/11/2026 at 9:10AM, documents 3/10/2026 at 8:00 AM medications as given and signed off with the initials of V14 Registered Nurse/RN, however, V14 had previously confirmed she was not working at 8:00 AM on 3/10/2026, and did not give R2 medications at 8:00 AM on 3/10/2026. On 3/11/2026 at 2:40 pm, V14 RN states she informed V2 Director of Nursing/DON about R2's 3/10/2026 8:00 AM meds were not documented in the MAR. When asked why the MAR currently documents the 3/10/2026 8:00 AM medications as given by V14, she stated she did not update the MAR and assumes V2 DON investigated and updated the MAR. On 3/11/2026 at 2:50 pm, V2 DON, stated that 3/10/2026 8:00 AM morning medications were given to R2 by V13 LPN/Licensed Practical Nurse but were	S9999					

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S9999	Continued from page 18 not documented. V2 DON stated "Maybe V14 RN/Registered Nurse updated the MAR to clear the red color from the screen showing meds were missed. V2 DON stated "documenting on the computer is new and staff are adjusting" because they have been using paper to document up until recently. V2 DON stated she was not sure what the proper procedure would be when documenting missed medications on the new computer. 2. R8 was admitted on 3/3/26 with diagnoses of Cerebral Infarct, Chronic Respiratory Failure with Hypoxia, Type 2 Diabetes Mellitus without complications, Chronic Obstructive Pulmonary Disease and Hypertension. R8's Brief Interview for Mental Status (BIMS) dated 3/3/26 documents R8 is cognitively intact. R8's Physician's Orders documents to administer Gabapentin 400 mg (milligrams) two capsules three times a day (8:00 AM, 12:00 PM and 4:00 PM) on 3/3/26; Losartan 50 mg one time daily in AM for Hypertension (8:00 AM) on 3/4/26; Humalog 100 units/ml (milliliters) administer 50 units subcutaneous twice daily (8:00 AM and 4:00 PM) on 3/5/26; and to apply Lidocaine External Cream 4% topically to low back each morning (8:00 AM) on 3/4/26; Diclofenac Sodium External Gel 1% apply to affected area (8:00 AM, 12:00 PM, 4:00 PM and 8:00 PM) on 3/3/26. On 3/10/26 at 11:17 AM, V12 (Licensed Practical Nurse/LPN) administered R8's 8:00 AM scheduled medications at 11:17 AM, greater than 2 hours after the scheduled administration time. R8's Medication Administration Record dated March 2026 was reviewed on 3/10/26 at 11:55 AM, documents Lidocaine External Cream 4% apply topically to lower back each morning was applied at 8:00 AM. The Lidocaine Cream was not observed to be applied during the 8:00 AM (11:17 AM) med pass; Losartan 50 mg was administered at 8:00 AM. The Losartan was not observed to be administered during the 8:00 AM (11:17 AM) med pass; Gabapentin 400 mg two capsules were administered at 8:00 AM (11:17 AM) and 12:00 PM. Gabapentin 2 capsules were observed to be administered; Humalog 100 units/ml solution 50 units were to be injected/administered at 8:00 AM. The Humalog 50 units were not observed to be administered at 8:00 AM med pass; Humalog100 units/ml after meals, post blood sugar level and per sliding scale 6 units were administered at 8:00 AM.			S9999			

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S9999	Continued from page 19 R8's MAR documents medications were not administered on 3/9/26 for the 8:00 AM and 12:00 PM medication pass. R8's Progress Notes do not indicate R8 was out of the facility on 3/9/26 for 8:00 AM and 12:00 PM medication passes. On 3/10/26 at 11:12 AM, V12 stated "I don't work this hall often enough to know the med passes (medication administration) and you (staff) can never find him (R8). He goes out to smoke whenever he wants. That's why I'm late giving him his medications." V12 agreed none of the 8:00 AM medications had been administered prior to 11:17 AM. (B) Statement of Licensure Findings 9 of 13: 300.1640a) 300.1640f) 300.1640g) 300.1640h) Section 300.1640 Labeling and Storage of Medications a) All medications for all residents shall be properly labeled and stored at, or near, the nurses' station, in a locked cabinet, a locked medication room, or one or more locked mobile medication carts of satisfactory design for such storage. (See subsections (f) and (g) of this Section.) f) The label of each individual multi-dose medication container filled by a pharmacist shall clearly indicate the resident's full name; licensed prescriber's name; prescription number, name, strength and quantity of drug; date this container was last filled; the initials of the pharmacist filling the prescription; the name and address of the pharmacy; and any necessary special instructions. If the individual multi-dose medication container is dispensed by a licensed prescriber from his or her own supply, the label shall clearly indicate all of the preceding information and the source of supply; it shall exclude identification of the pharmacy, pharmacist and prescription number. g) Each single unit or unit dose package shall bear the proprietary or nonproprietary name of the drug,	S9999					

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S9999	Continued from page 20 strength of dose and total contents delivered, lot or control number, and expiration date, if applicable. The names of the resident and the licensed prescriber do not have to be on the label of the package, but they must be identified with the package in such a manner as to assure that the drug is administered to the right resident. Appropriate accessory and cautionary statements and any necessary special instruction shall be included, as applicable. Hardware for storing and delivering the medications shall be labeled with the identity of the dispensing pharmacy. The pharmacist shall provide written verification of the date the medications were dispensed and the initials (or unique identifier) of the pharmacist who reviewed and verified the medications. The pharmacist need not store such verification at the facility but shall readily make it available to the Department upon request. The lot or control number need not appear on unit dose packages if the dispensing pharmacy has a system for identifying those doses recalled by the manufacturer/distributor or if the dispensing pharmacy will recall and destroy all dispensed doses of a recalled medication, irrespective of a manufacturer's/distributor's specifically recalled lot. h) Medication in containers having soiled, damaged, incomplete, illegible, or makeshift labels shall be returned to the issuing pharmacist, pharmacy, or dispensing licensed prescriber for relabeling or disposal. Medications whose directions for use have changed since the medication was originally dispensed and labeled may be retained for use at the facility, in accordance with the licensed prescriber's current medication order. Medications in containers having no labels shall be destroyed in accordance with federal and State laws. This requirement is not met as evidenced by: Based on interview, observation and record review, the facility failed to ensure medications were stored per manufacturers guidelines. This failure has the potential to affect five residents in the A-hall (R9, R10, R11, R12, and R13) and nine residents in the B-hall (R7, R8, R14, R15, R16, R17, R18, R19, and R20) who receive insulin, in a sample of 22. Findings include: The Storage and Return of Drugs policy dated 4/21, documents resident's medications shall be properly stored in a locked cabinet. Multi-dose vials and pens shall be stored and dated per the manufacturer's guidance.			S9999			

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S9999	Continued from page 21 The Manufacturers Guidelines for Insulin Pens documents to discard the pen 28 days after opening and do not share the pen with others (single patient use only). On 3/10/26 at 1:25 AM, the B-hall medication cart contained one 10 ml multidose vial of Humalog 100 units/ml insulin, one Basaglar Kwik Pen (Insulin)100 units/ml and one Lantus Solo Star injection (Insulin) pen100 units/ml were not labeled with a residents name or an open date or expiration date; and one Insulin Aspart flex pen read for single patient use only had an unreadable resident name and no open/expiration date. On 3/10/26 at 1:25 AM, V12 (Licensed Practical Nurse) stated Insulin pens should only be used for one resident and all opened multiuse vials and Insulin pens should have a resident's name label and an open date written on it. On 3/12/26 at 11:10 AM, the A-hall medication cart contained two Basaglar Kwik Pens (Insulin) with no open date written on them. On 3/12/16 at 11:10 AM, V17 (Registered Nurse) agreed the A-hall medication storage cart's two insulin pens did not have an open date written on it and should have. (C) Statement of Licensure Findings 10 of 13: 300.1820c)3) Section 300.1820 Content of Medical Records c) In addition to the information that is specified above, each resident's medical record shall contain the following: 3) Nurse's notes that describe the nursing care provided, observations and assessment of symptoms, reactions to treatments and medications, progression toward or regression from each resident's established goals, and changes in the resident's physical or emotional condition. This requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure resident cares and treatments were documented as indicated for three of seven residents (R6, R7, R8) reviewed for documentation, in		S9999				

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3001096		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/12/2026	
NAME OF PROVIDER OR SUPPLIER Fondulac Rehabilitation and Health Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 901 ILLINI DRIVE , EAST PEORIA, Illinois, 61611			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S9999	Continued from page 22 a sample of 22. Findings include: The Registered Nurse and Licensed Vocation/Practical Nurse Job Descriptions, not dated, documents responsibilities include the ability to administer medications and treatments timely and according to facility policy; Demonstrates ability to carry out physician orders; Collaborate with other departments to provide timely effective care consistent with individual's needs, choices and preferences; Ensures the physician orders are followed as prescribed; Effectively carry out medication management to ensure adequate supplies and that medications are handled in accordance with policy; Charts progress notes in an informative, factual manner that reflect the care administered as well as the resident's response to care; Orders and reports diagnostic tests timely; Accurately completes and is familiar with forms used throughout the resident's chart; Ensures the progress notes are reflective of the care plan and that the approaches on the care plan are being followed. 1. R6's Medication Administration Record dated 3/1/26 through 3/11/26 lacks documentation 8:00 AM and 12:00 PM medications were administered or that pain was monitored on 3/9/26. R6's Progress Notes do not indicate R6 was unavailable, refused or any other circumstances which prevented administration. 2. R7's Treatment Administration Record dated 3/1/26 through 3/11/26, lacks documentation multiple treatments such as skin barrier creams, positioning, wound cleansing and tubigrip application and removal were conducted as ordered. The Medication Administration Record dated 3/1/26 through 3/11/26 lacks documentation medications were administered, blood sugars were conducted and pain was monitored as ordered. R7's Progress Notes do not indicate R7 was unavailable, refused or any other circumstances which prevented administration. 3. R8's Medication Administration Record dated 3/1/26 through 3/11/26 lacks documentation medications and blood sugars were monitored on 3/9/26. R8's Progress Notes do not indicate R8 was unavailable, refused or any other circumstances		S9999				

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S9999	Continued from page 23 which prevented administration. On 3/11/26 at 3:00 AM, V2 (Director of Nursing) agreed the records lacked documentation that cares were provided, medication administered and pain was assessed and the Progress Notes do not indicate the residents were unavailable, refused or any other circumstance which prevented the administration. (B) Statement of Licensure Findings 11 of 13: 300.2100 Section 300.2100 Food Handling Sanitation Every facility shall comply with the Department's rules entitled "Food Code." These requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to have a delivery date, use-by date, or expiration date for multiple frozen and dry stored foods. This has the potential to affect all 77 residents in the facility. Findings include: Facility Food Storage (Dry, Refrigerated, and Frozen) policy, undated, documents all food items will be labeled. The label must include the name of the food and the date by which it should be sold, consumed, or discarded. Facility Dietary Manager job description, undated, documents the Dietary Manager is responsible for directing the ordering, delivery, storage, labeling, and appropriate utilization of food supplies. Facility Room Roster, dated 3/10/26, documents 77 resident's resident in the facility. On 3/10/2026 at 10:25 AM (during a tour with V6 Dietary Manager), multiple frozen and dry storage foods were observed without delivery dates, use-by dates, or expiration dates. The foods observed include the following: 24 boxes of individually wrapped oatmeal pies; Vanilla pudding and pie filling; multiple bags of frozen green beans, zucchini, peas, lima beans, broccoli, and California blend; 38 loaves of bread; 17 bags of hotdog buns; 9 bags of hamburger buns; 3 cake mixes; 19 chocolate syrup bottles; 10 fruit punch drink mixes;	S9999					

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S9999	Continued from page 24 6 frozen pie shells; and 5 bags of frozen bread sticks. At that same time, V6 (Dietary Manager) stated there should be labels with delivery dates, use-by dates, or expiration dates on all these products. (C) Statement of Licensure Findings 12 of 13: 300.2210b)6)7) Section 300.2210 Maintenance b. Each facility shall: 6. Maintain the grounds and other buildings on the grounds in a safe, sanitary and presentable condition. 7. Maintain the grounds free from refuse, litter, insect and rodent breeding areas. These requirements were not met as evidenced by: Based on observation and interview, the facility failed to keep grounds free from refuse and keep refuse receptacles covered with lids to deter insect and rodent breeding. This has the potential to affect all 77 residents in the facility. Findings include: Facility "Residents Rights for People in Long term care facilities" booklet, revised 6/2008, documents "You have the right to safety and good care. Your facility must be clean." Facility Room Roster, dated 3/10/26, documents 77 resident's resident in the facility. On 3/10/2026 at 11:45am (during a tour with V6 Dietary Manager), a trash dumpster was observed outside of the kitchen service hall door with the lid open and garbage bags inside, and one garbage bag sitting on top of a discarded recliner chair outside of the dumpster. At that same time, V6 (Dietary Manager) stated "all staff use the dumpsters," verified the dumpster lid should be closed, and there was a recliner chair with garbage on top of it that had been there for a while. (C) Statement of Licensure Findings 13 of 13:			S9999			

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S9999	Continued from page 25 300.3260L) Section 300.3260 Resident's Funds L.) Unless otherwise provided by State law, the facility shall upon the death of a resident provide the executor or administrator of the resident's estate with a complete accounting of all the resident's personal property, including any funds of the resident being held by the facility. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to return one (R21) of one residents reviewed for resident funds upon death in a sample of 22. Findings include: undated, documents "It is the policy of the management company that the resident trust fund is managed and accounted for in accordance with state regulations. Per state regulations, a completed discharge/trust fund accounting form reflecting (resident) discharge date and monies to be disbursed must be sent to the Medicaid caseworker within five business days. If death should occur, the facility shall convey within 30 days the balance of the residents' personal funds account. If the facility does not receive notification of a claim for deceased residents' funds, the unclaimed funds will be sent to the Unclaimed Property Section, Secretary of Revenue for the state, next of kin, and the amount of funds will be handled per the guidelines." Facility "RFMS/Resident Fund Management System," balance as of 3/10/26, documents R21 is deceased as of 11/18/25 and their RFMS currently has \$1105.70 of R21's money. R21's electronic medical record documents R21 expired/deceased on 11/18/25. On 3/12/26 at 2:42PM, V1 Administrator stated "(R21) is deceased as of 11/18/25 (four months), he had no family listed to notify of his funds, and I need to contact social security to return his funds." At that time, V1 verified that the facility still had in their possession \$1105.70 of R21's money. (C)	S9999					