STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510504	A. BUILDING: _____ B. WING _____	C 05/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENS OF KEWANEE	141 ACORN ST SOUTH KEWANEE, IL 61443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comment Original Complaint Investigation #2626206/IL201958 Violation 295.4060h)3)A) Original Complaint Investigation #2626207/IL201959	A 000		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Section 295.4060 Alzheimer's and Dementia Programs h) An establishment that offers to provide a special program for persons with Alzheimer's disease and related disorders shall: 3) Develop and implement policies and procedures that ensure the continued safety of all residents in the establishment including, but not limited to, those who: A) May wander; Type 1 Violation Based on interview and record review the establishment failed to follow their abuse policy and procedures for an injury of unknown origin for one (R1) of three residents reviewed for abuse in the sample of three. This failure creates a substantial probability of severe harm to a resident or residents. Findings include: The establishments Abuse Prevention and Reporting policy and procedure dated 3/2026 documents the nursing staff is responsible for "reporting on a facility incident report the	A4060		

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A4060	Continued From page 1	A4060		

appearance of suspicious bruises, lacerations, or other abnormalities as they occur. Upon report of such occurrences, the nursing supervisor is responsible for assessing the resident, reviewing the documentation, and reporting to the administrator or the person designated to act on behalf of the administrator in the administrator's absence. " This policy also documents "An injury should be classified as an 'injury of unknown source' when both of the following conditions are met: The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incident of injuries over time. If classified as an 'injury of unknown source,' the person gathering facts will document the injury, the location and time it was observed, any treatment given and notification of the resident's physician, and responsible party."

The establishments Resident Roster dated 5/8/26 documents there are currently 17 residents residing in the establishment.

The establishments investigation for R1's bruising of unknown origin was initiated on 5/11/26 by E2 HWD (Health and Wellness Director). Signed and dated interviews were obtained from staff who had contact with R1 between 5/4/26 through Monday 5/11/26. E5 TA (Tenant Assistant) reported that (E5) saw a bruise on R1's forehead on Friday 5/8/26 and asked E7 TA about it. E7 TA told E5 TA that R1's bruise had already been reported and was from a previous fall on 4/18/26. E8 TA reported seeing yellow discoloration to R1's left forehead on the evening of 5/10/26 and

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A4060	Continued From page 2	A4060		

reported it to E9 LPN/Licensed Practical Nurse. E9 reported she assessed R1's bruise but did not report it to anyone. E10 TA reported seeing discoloration to R1's left forehead on 5/10/26 and did not report it to anyone.

The Progress Notes for R1 do not document any new bruising on 5/8/26 through 5/10/26 and the establishment was unable to provide any prior incident reports or documentation of the bruising to R1's left forehead.

On 5/22/26 at 9:45 am E2 HWD stated she was passing medications on the morning of 5/11/26 and noticed a fading yellow bruise to the left side of R1's forehead. E2 stated she had not received an incident report for the bruising, so she completed an incident report, notified R1's family and R1's physician, and started an investigation.

On 5/26/26 at 12:41 pm E5 TA stated she saw a yellow bruise on R1's left forehead on 5/8/26 and reported it to E7 TA because (E5) was still in training, and E7 TA said the bruising had already been reported from previous incident, so (E5) did not report to the nurse. E5 TA stated she did not fill out an incident report.

On 5/26/26 at 11:04 am E10 TA stated she worked on 5/9/26 and 5/10/26 and did not notice bruising to R1's forehead on 5/9/26. E10 stated she assisted R1 to the bathroom on 5/10/26 and saw bruising to R1's left forehead and that "(E10) forgot to mention it to the nurse." E10 TA confirmed she did fill out an incident report.

On 5/26/26 at 1:00 pm E8 TA stated she got R1 up and dressed on morning of 5/10/26 and noticed yellow, purple bruising on R1's left forehead and reported it to E9 LPN two times on

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A4060	Continued From page 3 5/10/26. E8 TA stated she asked E9 LPN if she should fill out an incident report and E9 said no because she thought it was old bruising from previous incident. E8 TA confirmed she did not complete an incident report. On 5/26/26 at 11:11 am E9 LPN stated E8 TA reported R1 with bruising to (R1's) left forehead. E9 stated she assessed R1's forehead and due to the yellow green color, she thought the bruising was old and E8 TA did not report any incidents having occurred, so she did not report it or document it. On 5/26/26 at 9:23 am Z3 Hospice RN (Registered Nurse) stated while she was at the establishment on 5/11/26 she saw a fading yellow bruise to R1's left forehead near the hairline. Z3 stated an unknown Tenant Assistant (TA) reported to (Z3) that the TA thought R1's bruise was there on Saturday 5/9/26. On 5/26/26 at 1:15pm E2 HWD confirmed E5, E7, E8, and E10 TAs and E9 LPN were aware of R1's bruise of unknown origin to (R1's) left forehead prior to 5/11/26, did not complete an incident report or document the bruise, and did not report the bruising to E2 HWD. E2 HWD confirmed staff should have reported and all staff have been educated on reporting and completing the incident reports.	A4060		