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 _____	09/26/2025

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 Annual Licensure Survey entered on 9/25 and exited on 9/26/25 Violation(s) cited: 295.3030 a) b) c) d) e) 1) 2) 295.4000 a) b) c) g)	A 000		
A3030	Section 295.3030 Initial Health Eval for Dir Care and FS empl This Regulation is not met as evidenced by: Section 295.3030 Initial Health Evaluation for Direct Care and Food Service Employees a) Each direct care and food service employee shall have an initial health evaluation, which shall be used to ensure that employees are not placed in positions that would pose undue risk of infection to themselves, other employees, residents, or visitors. b) The initial health evaluation shall be conducted not more than 30 days prior to and no later than 30 days after the employee's initial employment in the establishment. c) The initial health evaluation shall include the employee's immunization status. d) The initial health evaluation shall include a physical examination. The examination shall include a determination that the employee appears to be physically able to perform the job functions that the establishment intends to assign to the employee.	A3030		

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 _____	09/26/2025

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
A3030	Continued From page 1 e) Each employee shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696). The test must meet one of the following time frames: 1) The test must be completed no more than 90 days prior to the date of initial employment in the establishment; or 2) The test must be commenced no more than ten days after the date of initial employment in the establishment. Type 2 Violation These requirements were not met as evidenced by: Based on interview and record review the Establishment failed to ensure four employees obtained a Health Evaluation and three employees received Tuberculosis skin testing and annual TB symptom screening. These failures have the potential to affect all 19 residents residing in the Establishment. This failure creates a substantial probability of harm to a resident or residents. Findings include The Establishments Employee Initial Health Evaluation Policy, dated 2/1/25 documents "All employees must complete an initial health evaluation before or within 30 days of hire to confirm fitness for duty and identify any conditions requiring workplace accommodations or infection-control precautions." "Baseline TB risk assessment plus IGRA (Interferon-Gamma Release Assay) or two-step TST (Tuberculin Skin Test) or documentation of prior positive and chest	A3030		

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 _____	09/26/2025

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
A3030	Continued From page 2 X-ray clearance." 1. The employee file for E5 RN (Registered Nurse) documents E5's hire date as 2/4/25 and does not include a Health Evaluation completed by a physician. 2. The employee file for E7 TA (Tenant Assistant) documents E7's hire date as 7/11/25 and does not include a Health Evaluation completed by a physician. 3. The employee file for E8 TA documents E8's date of hire as 7/16/25 and does not include a Health Evaluation completed by a physician. 4. The employee file for E10 CNA (Certified Nursing Assistatnt) documents E10's hire date as 8/22/25 and does not include a Health Evaluation completed by a physician. 5. The employee file for E1 ED (Executive Director) documents E1's hire date as 11/1/24 and does not include a TB screening or TB skin test having been completed. 6. The employee file for E9 Housekeeper/CNA documents the last TB testing was completed on 12/29/22 and no annual symptom screening has been completed. 7. The employee file for E3 BOM (Business Office Manager) documents the last TB testing was completed on 12/26/22 and no annual symptom screening has been completed. On 9/26/25 at 3:00 pm, E1 ED confirmed the Establishments policy and procedures require staff to have a Health Evaluation, TB screening, and testing and they are not being done.	A3030		

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 _____	09/26/2025

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
A4000	Section 295.4000 Physician/s Assessment This Regulation is not met as evidenced by: Section 295.4000 Physician's Assessment a) No more than 120 days prior to admission of a resident to any establishment, a comprehensive assessment that includes an evaluation of the prospective resident's physical, cognitive, and psychosocial condition shall be completed by a physician. The physician's assessment shall include documentation of the presence or the absence of tuberculosis infection in accordance with the Control of Tuberculosis Code. At the time of admission, the physician's assessment must reflect the resident's current condition. b) At least annually, once a resident has moved into the establishment, a comprehensive assessment shall be completed by a physician. c) A physician's assessment shall be completed by a physician upon identification of a significant change in the resident's condition. g) Establishments may develop their own tools for evaluating their residents; however, the establishment evaluation does not replace the requirement for a physician's assessment. Documentation of evaluations and re-evaluations may be in any form that is accurate, that addresses the resident's condition, and that incorporates the physician's assessment. Type 2 Violation These requirements were not met as evidenced	A4000		

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 _____	09/26/2025

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
A4000	Continued From page 4 by: Based on interview and record review the Establishment failed to ensure Physician Assessments were completed by a Physician for three (R1, R2, and R3) of three residents reviewed for Physician Assessments in the sample of three. This failure creates a substantial probability of harm to a resident or residents. Findings include: The Physician assessment Policy, dated 2/1/25 documents "Every resident shall undergo a physician assessment on admission and at least annually thereafter, or whenever there is a significant change in condition." The attending physician "completes comprehensive assessments and updates as required." The initial assessment includes "full medical history, physical exam, medication review, cognitive and functional status, allergies, and special dietary or therapeutic needs." The annual assessment is to be conducted every 12 months. "The assessment findings are recorded on the facility's approved Physician Assessment Form; Signed and dated by the provider and filed in the resident's clinical record." On 9/26/25 at 2:40 pm, E1 ED (Executive Director) stated she was told by corporate that the Physician Assessment and Certification is all the same and provided a Physician Certification/ Recertification for Extended Care Services form for R1 through R3. E1 ED stated this is what the Establishment uses for the Residents Physician Assessment and confirmed there is not a separate Physician Assessment completed for residents.	A4000		

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 _____	09/26/2025

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
A4000	Continued From page 5 The Physician Certification Recertification for Extended Care Services form documents "Certification on or before resident's SNF (skilled nursing facility) admission. I certify that post hospital skilled nursing facility services and required to be given on an in-patient basis because of the residents need for (blank box to check) Skilled Rehabilitation and/or (blank box to check) Skilled Nursing services on a continuing basis." A line for the physician to sign and date. There are four "Recertification" spaces below the initial. There is no physician assessment included with this document and no places for an assessment to be documented. 1. On 9/25/25 and 9/26/25 R1 was residing in the Establishments Memory Care unit. The Physician Certification Recertification for Extended Care Services form for R1, dated 8/25/25, documents R1 admitted to the Establishment on 11/8/24 and resident requires "skilled Nursing services on a continuing basis." There is no physician assessment completed by R1's physician. R1's clinical record does not include a Physician Assessment having been completed for R1. 2. On 9/25/25 and 9/26/25 R2 was residing in the Establishments Memory Care unit. The Physician Certification Recertification for Extended Care Services form for R2, dated 3/14/25, does not document an admission date for R2. The form does document "skilled Nursing services on a continuing basis." There is no physician assessment completed by R2's physician.	A4000		

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 _____	09/26/2025

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
A4000	Continued From page 6 R2's clinical record does not include a Physician Assessment having been completed for R2. 3. On 9/25/25 and 9/26/25 R3 was residing in the Establishments Memory Care unit. The Physician Certification/ Recertification for Extended Care Services form for R3 documents R3 admitted to the Establishment on 11/1/24 and the form was initially completed on 7/18/24, four months prior to R3's admission. There is no physician assessment completed, and no level of care documented. The Recertification for R3 was completed on 7/8/25 and 8/22/25 for R3 to reside in the Memory Care unit with no completed physician assessments for R3. R3's clinical record does not include a Physician Assessment having been completed for R3.	A4000		