STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510103	A. BUILDING: _____ B. WING _____	C 01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF SHILOH	429 S MAIN ST SHILOH, IL 62269

(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 Complaint # 2640188 / IL199431 No violations cited Complaint # 2640609 / IL199681 Violations cited: 295.4010 a) d) e) 295.5000 a) d) h) 1) 2) 4) j) 295.6000 a) 5) Complaint # 2640694 / IL199683 Violations cited: 295.4010 a) d) e) 295.5000 a) d) h) 1) 2) 4) j) 295.6000 a) 5)	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: TYPE 2 VIOLATION Section 295.4010 Service Plan a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the Act) The establishment shall respect and accept the resident's choices regarding the service plan. d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change,	A4010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510103	A. BUILDING: _____ B. WING _____	C 01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF SHILOH	429 S MAIN ST SHILOH, IL 62269

(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
A4010	Continued From page 1 shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act) e) The service plan shall be reviewed and revised if necessary immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000). Based on interview and record review the facility failed to ensure service plans are updated to reflect current needs of residents, specifically, failed to ensure a Memory Care resident's skin changes is addressed in the service plan with treatment/intervention/s in place. This failure creates a substantial probability of harm to resident/s in the facility. Findings include: On 1/20/26 at 10:40 AM, E8/Licensed Practical Nurse (LPN) stated she works from 8AM until 4 PM twice a week. E8 stated she cannot recall administering any topical treatment to any resident in the facility but mentioned that R1 who was in the hospital had redness under the breast. When asked if she could show where the topical treatments are stored E8 pulled out 2 plastic totes from an upper storage cabinet inside the Memory Care medication room containing opened packages of bandages and gauzes, and a small tube of triple antibiotic topical ointment, medi honey sachets, all without labels. On 1/20/26 at approximately 11:05 AM, E10 (Resident Assistant/RA) was observed taking a container of Nystatin (indicated for fungal infection) Topical Powder,100,000 units per gram 15 gram bottle, and a tube of baza cream (moisture barrier cream), both with no resident's	A4010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510103	A. BUILDING: _____ B. WING _____	C 01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF SHILOH	429 S MAIN ST SHILOH, IL 62269

(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
A4010	Continued From page 2	A4010		

name from R4's bathroom and brought it out for review. E10 stated that the powder had always been there in R4's bathroom and she would apply it under R4's breasts after cleaning her up in the mornings. E10 stated she used to work at a sister facility Memory Care unit where R4 was also a resident and recalled R4 had the same problem with redness under her breast area and the same powder treatment. E10 stated she then worked at this facility and continued applying the powder which was kept in R4's bathroom when R4 moved in when the other facility closed down.

On 1/20/26 at 10:50 AM, E9/Certified Nursing Aide/CNA, stated R4 was overweight and when she started working at the facility in 8/2025 and noted R4's underbreast area was reddened and smelled and E9 tried to keep the area clean and dry and applied antifungal powder per nurse instruction. E9 stated the powder was kept in R4's bathroom and if she happened to give R4 a shower then she would apply it under the breast area.

On 1/20/26 at 11:28 AM, E11/RA stated R4 used to have showers twice a week then she started refusing showers and stated she was afraid of water so staff would give her a sponge bath in her bathroom. E11 stated R4 had redness like eczema or yeast with a particular smell under her breast and E11 would apply antifungal powder in the area and between her abdominal folds after wiping her down. E11 stated the redness was already there when R4 moved in. E11 stated she tries to keep the area dry often times by putting a hand towel under the breast. E11 stated the powder is kept in R4's bathroom and if it runs out staff would ask the nurse to request for it.

On 1/20/26 at 12:14 PM, E4/LPN, stated that she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510103	A. BUILDING: _____ B. WING _____	C 01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF SHILOH	429 S MAIN ST SHILOH, IL 62269

(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
A4010	Continued From page 3	A4010		

was familiar with R4's skin condition under the breasts and between her abdominal folds when R4 was still a resident at a sister facility and E4 a floor nurse until the place closed down almost a year ago and both relocated to the current location around the same time. E4 stated she recalled R4 had an order for the antifungal cream to be applied by the nurse twice a day and added she does not know if it was reordered since she now works regularly at the Assisted Living side.

On 1/21/26 at 9:21 AM, Z4/R4's Husband and Power of Attorney/POA, stated he knew R4 had on and off redness under her breasts for a long time which was treated with an antifungal powder and this was going on when R4 still lived at another facility. Z4 stated R4 used a shower gel that got rid of the redness but since R4 refused to have showers in the current facility, he stopped buying the shower gel. Z4 stated he was at the ER when R4 was transferred on 1/16 for weakness and the nurse showed him how red R4 was under her breasts and it made him very upset. Z4 stated it was pretty bad and showed how staff ignored and paid no attention to R4's care.

On 1/21/26 at 4:00 PM, when a request for R4's Shower Sheets for the last 3 months was placed, E1/Executive Director stated the facility could not find them. E1 also confirmed there were no documentation of R4's skin condition, nor any order for evaluation and treatment for R4's skin condition.

Review of R4's record indicate the following:

a.Current Medication List:
No topical treatment order is on the list.
Physician Order Form: No topical treatment order

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510103	A. BUILDING: _____ B. WING _____	C 01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF SHILOH	429 S MAIN ST SHILOH, IL 62269

(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
A4010	Continued From page 4	A4010		

has been documented.

b.R4's Service Plan dated 6/9/25 documents:
R4 needs physical assist with showers, dressing, undressing, wash, shampoo and with all required physical assistance into shower and on to shower chair.
Resident requires assist with medication administration up to 3x per day with more than 4 medications per pass.

Service Plan did not address any skin condition and intervention for skin condition including redness/excoriation under the breasts or between abdominal folds.

Unlicensed staff stated they are administering treatment without physician's order to undocumented skin condition on R4, a Memory Care resident.

c.R4's Assessment dated 6/9/25
Integumentary (Skin): Box left unmarked under Rash, Inflammation, Discoloration, Ulcers, other.

d.No shower sheets for R4 in the last 3 months could be found when requested.

e.R4's Care History from 9/1/25 thru 1/16/26 do not document any changes in skin condition or skin changes and related evaluation and treatment.

A Run Report Record of the Shiloh Emergency Medical Services for R4's ER transport on 1/16/26 was requested by IDPH on 1/20/26. No report has been received yet.

An IDPH release for R4's 1/16/26 ER records was requested on 1/20/25. No report has been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510103	A. BUILDING: _____ B. WING _____	C 01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF SHILOH	429 S MAIN ST SHILOH, IL 62269

(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
A4010	Continued From page 5 received so far. The Facility Policy on Alert Charting dated 6/13/24 documents, "Policy: Alert Charting will be implemented for residents who have had a recent change in their expected or customary function or other reason that initiates a need for closer monitoring. Procedure: 1. Alert charting procedures will be initiated if a resident: a. Is new to the Community. b. Exhibits a change in condition. c.Is returning from the hospital, Emergency Room, or Urgent Care. d. Has eloped form the community. f.Exhibits a change in the resident's expected or customary physical, emotional, behavioral, or mental function. g. Any other reason deemed appropriate by the Director of Health and Wellness. Includes: c. Care staff will immediately notify the Director of Health and Wellness or designee if the resident is exhibiting a change in condition or other reason for concern. e. Changes in the resident's service plan will be made as appropriate."	A4010		
A5000	Section 295.5000 Medication Reminders, Supervision of Self Med This Regulation is not met as evidenced by: TYPE 2 VIOLATION Section 295.5000 Medication Reminders, Supervision of Self-Medication, Medication Administration and Storage a) An establishment may provide medication reminders, supervision of self-administered medication, and medication administration as an	A5000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510103	A. BUILDING: _____ B. WING _____	C 01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF SHILOH	429 S MAIN ST SHILOH, IL 62269

(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
A5000	Continued From page 6 optional service. d) Medication administration refers to a licensed health care professional employed by an establishment engaging in administering routine insulin and vitamin B-12 injections, oral medications, topical treatments, eye and ear drops, or nitroglycerin patches. Non-licensed staff may not administer any medication. (Section 70 of the Act) h) Any medication stored by the establishment shall meet the following requirements: 1) Medication shall be stored in a locked container, cabinet, or area that is inaccessible to residents; 2) Medication shall not be left unattended by an employee; 4) A bathroom or laundry room shall not be used for medication storage; and j) A separate medication record shall be maintained for each resident receiving medication administration and shall include: 1) Name of resident; 2) Name of medication, dosage, directions, and route of administration; 3) Date and time medication is scheduled to be administered; 4) Date and time of actual medication administration; and 5) Signature or initials of the employee	A5000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510103	A. BUILDING: _____ B. WING _____	C 01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF SHILOH	429 S MAIN ST SHILOH, IL 62269

(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
A5000	Continued From page 7 administering medication. Based on observation, interview and record review the facility failed to ensure resident skin condition is evaluated by a physician and treatment ordered; failed to prevent unprescribed topical medications to be administered by unlicensed staff; and failed to keep topical medication in proper storage. These failures create a substantial probability of harm to residents in a Memory Care unit of the facility Findings include: On 1/20/26 at 10:40 AM, E8/Licensed Practical Nurse (LPN) stated she works from 8AM until 4 PM twice a week. E8 stated she cannot recall administering any topical treatment to any resident in the facility but mentioned that R1 who was in the hospital had redness under the breast. When asked if she could show where the topical treatments are stored E8 pulled out 2 plastic totes from an upper storage cabinet inside the Memory Care medication room containing opened packages of bandages and gauzes, and a small tube of triple antibiotic topical ointment, medi honey sachets, all without labels. On 1/20/26 at approximately 11:05 AM, E10 (Resident Assistant/RA) was observed taking a container of Nystatin Topical Powder,100,000 units per gram 15 gram bottle, and a jar of baza cream, both with no resident's name from R4's bathroom and brought it out for review. E10 stated that the powder had always been there in R4's bathroom and she would apply it under R4's breasts after cleaning her up in the mornings.	A5000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510103	A. BUILDING: _____ B. WING _____	C 01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF SHILOH	429 S MAIN ST SHILOH, IL 62269

(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
A5000	Continued From page 8 E10 stated she used to work at a sister facility Memory Care unit where R4 was also a resident and recalled R4 had the same problem with redness under her breast area and the same powder treatment. E10 stated she transferred to this facility and continued applying the powder which was kept in R4's bathroom when R4 moved to the current facility when the other facility closed down. On 1/20/26 at 10:50 AM, E9/Certified Nursing Aide/CNA, stated R4 was overweight and when she started working at the facility in 8/2025 and noted R4's underbreast area was reddened and smelled and E9 tried to keep the area clean and dry and applied antifungal powder kept in R4's bathroom per nurse instruction. E9 stated if she happened to give R4 a shower then she would apply it under the breast area. On 1/20/26 at 11:28 AM, E11/RA stated R4 used to have showers twice a week then she started refusing showers and said she was afraid of water so staff would give her a sponge bath in her bathroom. E11 stated R4 had redness like eczema or yeast with a particular smell under her breast and E11 would apply antifungal powder in the area and between her abdominal folds after wiping her down. E11 stated the redness was there already when R4 moved in. E11 stated she tries to keep the area dry often times by putting a hand towel under the breast. E11 stated the powder is kept in R4's bathroom and if it runs out staff would ask the nurse to request for it. On 1/20/26 at 12:14 PM, E4/LPN, stated that she was familiar with R4's skin condition under the breasts and between her abdominal folds when R4 was still a resident at a sister facility and E4 a floor nurse until the place closed down almost a	A5000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510103	A. BUILDING: _____ B. WING _____	C 01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF SHILOH	429 S MAIN ST SHILOH, IL 62269

(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
A5000	Continued From page 9	A5000		

year ago and both relocated to the current location around the same time. E4 stated she recalled R4 had an order for the antifungal cream to be applied by the nurse twice a day and added she does not know if it was reordered since she now works regularly at the Assisted Living side. E4 stated that unlicensed staff are not allowed to apply topical treatments to MC residents.

On 1/21/26 at 9:21 AM, Z4/R4's Husband and Power of Attorney/POA, stated he knew R4 had on and off redness under her breasts for a long time which was treated with an antifungal powder and this was going on when R4 still lived at another facility. Z4 stated R4 used a shower gel that got rid of the redness but since R4 refused to have showers in the current facility, he stopped buying the shower gel. Z4 stated he was at the ER when R4 was transferred on 1/16 for weakness and the nurse showed him how red R4 was under her breasts and it made him very upset. Z4 stated it was pretty bad and showed how staff ignored and paid no attention to R4's care.

On 1/21/26 at 4:00 PM, when a request for R4's Shower Sheets for the last 3 months was placed, E1/Executive Director stated the facility could not find them. E1 also confirmed there were no documentation of any order for evaluation and treatment for R4's skin condition.

R4's record documents a move in date to the facility Memory Care unit on 2/11/25 with diagnoses significant for Alzheimer's disease and a SLUMS (St Louis University Mental Status exam score of 25 (Mild Neurocognitive disorder).

Review of R4's record indicate the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510103	A. BUILDING: _____ B. WING _____	C 01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF SHILOH	429 S MAIN ST SHILOH, IL 62269

(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
A5000	Continued From page 10 a.Current Medication List: No topical treatment order is on the list. Physician Order Form: No topical treatment order has been documented. b.R4's Service Plan dated 6/9/25 documents: 1. R4 needs physical assist with showers, dressing, undressing, wash, shampoo and with all required physical assistance into shower and on to shower chair. 2. Resident requires assist with medication administration up to 3x per day with more than 4 medications per pass. Service Plan did not address any skin condition and intervention for skin condition including redness/excoriation under the breasts or between abdominal folds. Unlicensed staff stated they are administering medicated topical medication with no documented physician's order to undocumented skin condition on R4, a Memory Care resident. c.R4's Assessment dated 6/9/25 Integumentary (Skin): Box left unmarked under Rash, Inflammation, Discoloration, Ulcers, other. d.No shower sheets for R4 in the last 3 months could be found when requested. e.R4's Care History from 9/1/25 thru 1/16/26 does not document any changes in skin condition and related evaluation and treatment. A Run Report Record of the Shiloh Emergency Medical Services for R4's ER transport on 1/16/26 was requested by IDPH on 1/20/26. No report has been received yet.	A5000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510103	A. BUILDING: _____ B. WING _____	C 01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF SHILOH	429 S MAIN ST SHILOH, IL 62269

(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
A5000	Continued From page 11 An IDPH release for R4's 1/16/26 ER records was requested on 1/20/25. No report has been received so far. The Facility Policy on Narrative Charting dated 6/13/24, documents,"Policy: Narrative Charting will be maintained to promote clear communication regarding resident care. It is (corporate's name) policy to chart to the exception." The Facility Policy on Alert Charting dated 6/13/24 documents, "Policy: Alert Charting will be implemented for residents who have had a recent change in their expected or customary function or other reason that initiates a need for closer monitoring. Procedure: 1. Alert charting procedures will be initiated if a resident: a. Is new to the Community. b. Exhibits a change in condition. c.Is returning from the hospital, Emergency Room, or Urgent Care. d. Has eloped form the community. f.Exhibits a change in the resident's expected or customary physical, emotional, behavioral, or mental function. g. Any other reason deemed appropriate by the Director of Health and Wellness. Includes: c. Care staff will immediately notify the Director of Health and Wellness or designee if the resident is exhibiting a change in condition or other reason for concern. e. Changes in the resident's service plan will be made as appropriate."	A5000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: TYPE 2 VIOLATION	A6000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510103	A. BUILDING: _____ B. WING _____	C 01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF SHILOH	429 S MAIN ST SHILOH, IL 62269

(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
A6000	Continued From page 12 Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 5) The right to receive the services specified in the service plan, to review and renegotiate the service plan at any time; and to be informed of the cost of the changes; Based on interview, record review and observation, the facility failed to provide evaluation and treatment of a resident's skin condition; failed to address the skin condition in the service plan; and allowed unlicensed staff to administer topical treatment to a Memory Care resident with an undocumented skin condition in the facility. These failures create a substantial probability of harm to a resident and to other residents in the facility. Findings include: On 1/20/26 at 10:40 AM, E8/Licensed Practical Nurse (LPN) stated she works from 8AM until 4 PM twice a week. E8 stated she cannot recall administering any topical treatment to any resident in the facility but mentioned that R1 who was in the hospital had redness under the breast. When asked if she could show where the topical treatments are stored E8 pulled out 2 plastic totes from an upper storage cabinet inside the Memory	A6000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510103	A. BUILDING: _____ B. WING _____	C 01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF SHILOH	429 S MAIN ST SHILOH, IL 62269

(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
A6000	Continued From page 13	A6000		

Care medication room containing opened packages of bandages and gauzes, and a small tube of triple antibiotic topical ointment, medi honey sachets, all without labels.

On 1/20/26 at approximately 11:05 AM, E10 (Resident Assistant/RA) was observed taking a container of Nystatin Topical Powder,100,000 units per gram 15 gram bottle, and a jar of baza cream, both with no resident's name from R4's bathroom and brought it out for review. E10 stated that the powder had always been there in R4's bathroom and she would apply it under R4's breasts after cleaning her up in the mornings. E10 stated she used to work at a sister facility Memory Care unit where R4 was also a resident and recalled R4 had the same problem with redness under her breast area and the same powder treatment. E10 stated she transferred to this facility and continued applying the powder which was kept in R4's bathroom when R4 moved to the current facility when the other facility closed down.

On 1/20/26 at 10:50 AM, E9/Certified Nursing Aide/CNA, stated R4 was overweight and when she started working at the facility in 8/2025 and noted R4's underbreast area was reddened and smelled and E9 tried to keep the area clean and dry and applied antifungal powder kept in R4's bathroom per nurse instruction. E9 stated if she happened to give R4 a shower then she would apply it under the breast area.

On 1/20/26 at 11:28 AM, E11/RA stated R4 used to have showers twice a week then she started refusing showers and said she was afraid of water so staff would give her a sponge bath in her bathroom. E11 stated R4 had redness like eczema or yeast with a particular smell under her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510103	A. BUILDING: _____ B. WING _____	C 01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF SHILOH	429 S MAIN ST SHILOH, IL 62269

(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
A6000	Continued From page 14	A6000		

breast and E11 would apply antifungal powder to the area and between her abdominal folds after wiping her down. E11 stated the redness was there already when R4 moved in. E11 stated she tries to keep the area dry often times by putting a hand towel under the breast. E11 stated the powder is kept in R4's bathroom and if it runs out staff would ask the nurse to request for it.

On 1/20/26 at 12:14 PM, E4/LPN, stated that she was familiar with R4's skin condition under the breasts and between her abdominal folds when R4 was still a resident at a sister facility and E4 a floor nurse until the place closed down almost a year ago and both relocated to the current location around the same time. E4 stated she recalled R4 had an order for the antifungal cream to be applied by the nurse twice a day and added she does not know if it was reordered since she now works regularly at the Assisted Living side.

On 1/20/26 at 1:10 PM, E3/Former Director of Health and Wellness stated that any topical medication ordered by the physician for residents in the Memory Care should be administered by a licensed nurse not by unlicensed staff.

On 1/21/26 at 9:21 AM, Z4/R4's Husband and Power of Attorney/POA, stated he knew R4 had on and off redness under her breasts for a long time which was treated with an antifungal powder and this was going on when R4 still lived at another facility. Z4 stated R4 used a shower gel that got rid of the redness but since R4 refused to have showers in the current facility, he stopped buying the shower gel. Z4 stated he was at the ER when R4 was transferred on 1/16 for weakness and the nurse showed him how red R4 was under her breasts and it made him very upset. Z4 stated it was pretty bad and showed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510103	A. BUILDING: _____ B. WING _____	C 01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF SHILOH	429 S MAIN ST SHILOH, IL 62269

(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
A6000	Continued From page 15	A6000		

how staff ignored and paid no attention to R4's care.

On 1/21/26 at 4:00 PM, when a request for R4's Shower Sheets for the last 3 months was placed, E1/Executive Director stated the facility could not find them. E1 also confirmed there were no documentation of any order for evaluation and treatment for R4's skin condition.

R4's record documents a move in date to the facility Memory Care unit on 2/11/25 with diagnoses significant for Alzheimer's disease with a SLUMS (St Louis University Mental Status exam score of 25 (Mild Neurocognitive disorder).

Review of R4's record indicate the following:

a.Current Medication List:
No topical treatment order is on the list.
Physician Order Form: No topical treatment order has been documented.

b.R4's Service Plan dated 6/9/25 documents:
1. R4 needs physical assist with showers, dressing, undressing, wash, shampoo and with all required physical assistance into shower and on to shower chair.
2. Resident requires assist with medication administration up to 3x per day with more than 4 medications per pass.

Service Plan did not address any skin condition and intervention for skin condition including redness/excoriation under the breasts or between abdominal folds.

Unlicensed staff stated they are administering medicated topical medication with no record of physician's order to undocumented skin condition

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510103	A. BUILDING: _____ B. WING _____	C 01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF SHILOH	429 S MAIN ST SHILOH, IL 62269

(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
A6000	Continued From page 16 on R4, a Memory Care resident. c.R4's Assessment dated 6/9/25 Integumentary (Skin): Box left unmarked under Rash, Inflammation, Discoloration, Ulcers, other. d.No shower sheets for R4 in the last 3 months could be found when requested. e.R4's Care History from 9/1/25 thru 1/16/26 do not document any changes in skin condition and related evaluation and treatment. A Run Report Record of the Shiloh Emergency Medical Services for R4's ER transport on 1/16/26 was requested by IDPH on 1/20/26. No report has been received yet. An IDPH release for R4's 1/16/26 ER records was requested on 1/20/25. No report has been received so far. The Facility Policy on Narrative Charting dated 6/13/24, documents,"Policy: Narrative Charting will be maintained to promote clear communication regarding resident care. It is (corporate's name) policy to chart to the exception." The Facility Policy on Alert Charting dated 6/13/24 documents, "Policy: Alert Charting will be implemented for residents who have had a recent change in their expected or customary function or other reason that initiates a need for closer monitoring. Procedure: 1. Alert charting procedures will be initiated if a resident: a. Is new to the Community. b. Exhibits a change in condition. c.Is returning from the hospital, Emergency Room, or Urgent Care. d. Has eloped form the community. f.Exhibits a change in the	A6000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510103	A. BUILDING: _____ B. WING _____	C 01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF SHILOH	429 S MAIN ST SHILOH, IL 62269

(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
A6000	Continued From page 17 resident's expected or customary physical, emotional, behavioral, or mental function. g. Any other reason deemed appropriate by the Director of Health and Wellness. Includes: c. Care staff will immediately notify the Director of Health and Wellness or designee if the resident is exhibiting a change in condition or other reason for concern. e. Changes in the resident's service plan will be made as appropriate."	A6000		