STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145058	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arc at Chillicothe	1028 Hillcrest Drive Chillicothe, IL 61523

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident with a risk for skin breakdown received accurate skin assessments to identify a newly acquired pressure injury, provide a pressure injury treatment and physician notification promptly and ensure interventions were implemented timely and followed to prevent further injury to an unstageable pressure ulcer for one of four residents (R28) reviewed for pressure ulcers in the sample of 35. This failure resulted in R28 returning from the hospital with an unstageable pressure injury and going five days without a wound treatment order, physician notification, or any wound assessments. Findings include:R28's Census sheet documents R28 is an [AGE] year-old female who admitted to the facility on [DATE].R28's Medical Diagnosis List documents Acute Respiratory Failure, Morbid Obesity, Heart Failure, Anxiety and Depression, Difficulty in Walking, Localized Edema, Acute Kidney Failure, and Osteoarthritis in both feet.R28's Minimum Data Set (MDS) assessment dated [DATE] documents R28 is cognitively intact and is dependent on staff for toileting, showers and bathing, upper and lower body dressing and transfers. This same MDS documents R28 is cognitively intact.R28's admission care plan did not include any interventions to prevent pressure ulcers.R28's Treatment Assessment Record (TAR) dated an order with a start date of 2/26/26 and discontinued 4/3/26 to apply a liquid film-forming wipe (Skin Prep) to R28's Right Heel three times a day and as needed.R28's Medical Record does not include any skin assessment for R28's right heel area, when a treatment was obtained on 2/26/26 through when R28 was transferred to the hospital on 3/28/26.R28's hospital records contained a physician progress note dated 3/30/2026 that documented R28 had an unstageable pressure ulcer to the right heel present on admission (to the hospital), with corresponding wound care orders to cleanse with normal saline and apply moisture wicking dressing and cover with a foam dressing every 48 hours.R28's Hospital Discharge Orders, dated 4/1/26, documents a Physician order for R28 to receive treatment to R28's right heel as follows: Cleanse with normal saline and apply moisture wicking dressing and cover with a foam dressing every 48 hours.R28s admission Skin assessment dated [DATE] documents R28 does not have any skin concerns or pressure ulcers identified. R28's care plan initiated on 4/3/2026 documents a pressure blister to R28's right heel but was not revised to reflect the unstageable pressure ulcer and did not contain appropriate interventions for pressure relief and wound management.R28's Treatment Administration Record dated 4/1/26 through 4/5/26 (5 days after being admitted back to the facility from the hospital) does not contain treatment to R28's right heel to cleanse with normal saline and apply moisture wicking dressing and cover with a foam dressing every 48 hours as ordered from the hospital discharge orders.R28's Medical Record dated 4/1/26 through 4/5/26 does not include any documentation or skin assessment of R28's unstageable right heel pressure ulcer.R28's Wound Note dated 4/6/26 documents that V21 (Wound Doctor) was notified by the facility Medical Director that R28 had a wound on her right foot that needed evaluation by V21. This wound note further documents R28 has an unstageable pressure ulcer to her right heel with dead skin. This note documents the pressure ulcer measures 2.9 centimeters (cm) x 2.6 cm and the depth is unmeasurable due to presence of nonviable tissue and necrosis. V21 documents to use a pressure-reliving boot to the right foot and keep R28's heels offloaded. This note contains a new order (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	for R28's right heel to apply foam dressing every two days and as needed: if saturated, soiled, or dislodged for 30 days.On 4/21/2026 at 9:30 AM, R28 was lying in her bed with both heels resting directly on the bed. R28 stated she has a wound on her right heel and does not remember how long she has had it.On 4/22/2026 at 9:00 AM, observation of R28's right heel revealed a dime-sized pressure ulcer with surrounding redness, yellow dead tissue at the edges, and a darkened brown area approximately the size of a pencil eraser in the center of the pressure ulcer.On 4/22/2026 between 9:00 AM and 10:00 AM, intermittent observations revealed the R28 did not have a low air loss mattress in place, R28's heel boot was not in use, and R28's heels were resting directly on the bed without offloading. R28's call light was on from 9:20 AM and still on at 10:00 AM.On 4/22/26 at 9:20 AM, V17 stated that prior to R28 going to the hospital on 3/28/26 R28 had a fluid filled blister on her right heel. V17 stated she could not find documentation of a blister on R28's heel or any assessment including a skin assessment or measurements of the blister. V17 stated there should have been a skin assessment in R28s chart regarding R28's right heel area prior to R28 going to the hospital on 3/28/26. V17 verified R28 does not have a low air loss mattress on her bed because R28 refused one. V17 stated R28's heels should not be laying directly on the bed to prevent further deuteriation of wound or additional wounds. V17 stated the facility received an order from the hospital on 4/1/16 for R28s right heel and nobody caught it until an audit was performed of the readmission by V17 on 4/7/26.R28s current Care Plan does not include documented interventions for R28 to receive a right heel boot to offload right heel at all times or an intervention of a low air loss mattress.R28's electronic medical record does not contain documentation that R28 refused a low air loss mattress or a right heel boot. On 4/22/2026 at 12:15 PM, V21 (Wound Physician) stated he was not notified of the wound until 4/6/2026 and confirmed that failure to implement pressure-relieving interventions and assess and identify timely could result in worsening of the pressure ulcer.The facility's Pressure Injury and Skin Assessment Policy, revised 1/2018, documents the purpose of the policy is to establish guidelines for assessing, monitoring, and documenting skin breakdown and pressure injuries, and to ensure appropriate interventions are implemented. The policy requires that a skin condition assessment and a pressure ulcer risk assessment (Braden Scale) be completed upon admission and readmission. It further requires that residents identified as at risk receive ongoing monitoring, including weekly skin assessments by a licensed nurse. The policy states that when a pressure injury or skin breakdown is identified, a wound assessment must be initiated and documented in the clinical record, including measurements and characteristics of the wound. The policy also requires that, at the earliest sign of skin impairment, the resident, the attending physician, and the resident's representative be notified. Additionally, the initial observation must be documented in the nursing progress notes, and the resident's care plan must be revised to reflect the change in condition, including appropriate goals and interventions. The policy further states that wound assessments are to be completed at least weekly and documented in the medical record.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, record review and interview, the facility failed to provide readily available grievance forms and failed to post grievance/complaint procedures in a prominent location throughout the facility. This has the potential to affect all 89 residents residing in the facility. The facility's CMS (Centers for Medicare and Medicaid Services) Form 671 dated 4/20/26 and signed by V1 (Administrator), documents 89 residents reside within the facility.On 4/21/2026 at 10:37 AM R15, R27, R37, R84, and R87 all stated they have never been shown how to fill out a grievance, where the grievance forms are located, how to fill one out anonymously, or who the grievance official is to turn the forms into.On 4/21/26 at 11:00 AM a tour was conducted with V1/Administrator asking V1 to show where the grievance forms are located for the residents and where prominent locations(s) are for the grievance procedure in the building. V1 could not locate the grievance forms herself and thought they may be located at each nurse's desk but was unable to locate them at this time. V1 stated, I am not aware of the grievance procedure posted anywhere. (V10) would be our Grievance Official. The residents should know they can ask anyone to fill out a grievance for them and that the staff member filling it out would turn it in for them. I think the residents are just used to telling us issues instead of filling out a grievance form.On 4/21/26 at 11:04 AM V10/Social Service Director verified she is the grievance official. V25 stated, Grievance forms are located at the nurse's station behind the desk in a binder. Residents would have to ask for a grievance form. I do not have anything located around the facility how to fill out a grievance or who to turn the grievance paper into. There is no grievance forms located where a resident can grab one anonymously.The facility's Grievance Policy, dated 9/17/26, documents Purpose: To ensure prompt resolution of all grievances with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their stay at this campus. Guidelines: Grievances may be filed orally (meaning spoken), in writing, or anonymously. This same Grievance Policy documents, An appointed Grievance Official (usually Social Service Director) is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusion, leading any necessary investigations and maintaining the confidentiality of all information associated with grievances.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on Record Review and Interview, the facility failed to ensure residents and/or resident families are provided with a written notice of transfer when being transferred to the hospital. This failure has the potential to affect all 89 residents residing in the facility.Findings include:On 4/20/26 at 11:00 AM, R13 stated she has been sent back and forth to the hospital multiple times for numerous reasons, while in the facility.R13's current electronic medical record documents, R13, was most recently transferred out of the facility to the hospital on 1/4/26 and again on 2/28/26. This same medical record does not document that written notice of transfer was provided to the resident at the time of transfer.On 4/22/26 at 10:58 AM, V2 (Director of Nursing) confirmed that R13 does not have any written notices of transfer, with a reason for why R13 was being sent to the hospital. V2 stated, We (facility) do not have a formal transfer form that is provided to the residents or their families. We notify the resident's family via telephone, but we do not have a form with the reason for transfer that we provided to (R13) or any resident or family members of residents sent to the hospital. It has not been practiced due to us (facility staff) being unaware it's required.The facility's CMS (Centers for Medicare and Medicaid Services) Form 671 dated 4/20/26 and signed by V1 (Administrator), documents 89 residents reside within the facility.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on interview and record review, the facility failed to offer bedtime snacks to six of six residents (R15, R27, R37, R84, and R87) reviewed for bedtime snacks in the sample of 35.Findings include:R15, R27, R37, R84, and R87 electronic health records do not contain documentation of R17, R18, R27, R30, R38, and R52 being offered or receiving bedtime snacks.On 4/21/26 at 10:45 AM R15, R27, R37, R84, and R87 were in the resident council meeting. R15, R27, R37, R84, and R87 all stated they are not offered bedtime snacks and would like them to have offered them.On 4/21/26 at 2:05 PM V12/Certified Nursing Assistant stated, I have worked at the facility since October 2025. I do not go around and offer snacks at bedtime to all residents who can have them. They can ask for one and we would get them for them, but we don't go around and offer them.On 4/22/26 at 10:58 AM V2/Director of Nursing stated Dietary staff provide a drawer of snacks located at each nurse's station where a resident can ask for a snack.On 4/22/26 at V3/Dietary Manager stated that a dietary aide is scheduled to distribute ice cream to the Medicare hallway nightly at 6:15 PM. Following this, the aide leaves snacks at both nurses' stations. Regarding the North/South hallway, the manager noted that snacks and ice cream are not actively offered or distributed by dietary staff; however, these items are available to those residents upon request.The facility's Snacks and House Supplements Policy, dated 2022, documents House Snacks provide additional calories and meet a resident's individualized nutritional and care plan needs. Any type of food may be served as a snack as long as it is not contraindicated to the physician's diet order and the food item is handled employing all proper safe food handling practices. HS (bedtime) Snack Suggestions: HS Snacks should provide a minimum of a starch or bread serving and fruit drink.The facility's Bedtime Care Policy, dated 1/2018, documents Purpose: To promote comfort and relaxation before sleep. Guidelines: Provide bedtime snack and/or fluids as appropriate.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on Observation, Interview and Record review, the facility failed to report allegations of staff to resident mental abuse and neglect to the facility's abuse coordinator and the state agency for three of four residents (R13, R39, R72) reviewed for abuse in the sample of 35.Findings include: 1. R13's current Care Plan, dated 3/26/26, document R13 has a self-care deficit and requires assistance of one staff member for bed mobility and two staff members for transfers. This same care plan documents a plan initiated on 12/19/24 (R13) is at a high risk for abuse/neglect as noted from abuse screening related to depression. On 4/20/26 at 11:00 AM, R13 was sitting in her wheelchair in common area of the facility. R13 stated about three weeks ago she had an incident with a CNA (Certified Nursing Assistant) being mean to her and she felt like after she complained that the whole crew of staff was upset with her. R13 stated she cannot remember the CNA's name, but she knows it was in the afternoon time. R13 stated I asked her to help me get up and she refused to help. She said No. It hurt my feelings, and I didn't know how long I was going to be left there. I was crying and I felt upset about that for a couple weeks. I think she refused to help me because she doesn't like me. The main lady (V1, Administrator) came and talked to me. I don't know if the employee still works here but she is not allowed to take care of me anymore. On 4/20/26 at 1:30 PM, V1 provided the facility's reported abuse allegations and investigations for the past six months which did not include any reported allegations or investigations for R13. On 4/21/26 at 1:12 PM, V2 (Director of Nursing) confirmed that V9 (CNA) is no longer being assigned to R13's hall when working. V2 confirmed she was notified by V4 (CNA) of some conflict that R13 expressed. V2 stated (R13) feels like (V9) rushes when she is in there and complained that she felt like the CNA rushed her roommate (R39). We didn't prohibit (V9) from caring for (R13) we just have her off of (R13's) hall for preference and to avoid conflict. On 4/21/26 at 1:30 PM, V1 (Administrator) confirmed that V9 does not get assigned to R13's hallway to work anymore. V1 stated, (R13) doesn't overly like (V9) for whatever reasons. V1 confirmed she was informed of a complaint from R13 at the end of March 2026. V1 stated, There was a complaint relayed to us around 3/31/26 and the allegation was that (R13) didn't want to come back to the facility from the hospital, and she had made a statement that the CNA (V9) had possibly caused harm to her roommate (R39). V1 confirmed there is no documentation in the resident's record to explain the encounter and that she did not initiate an abuse investigation. V1 stated I did not report anything to the state. 2. On 4/20/2026 at 12:00 PM, R72 reported concerns regarding alleged verbal abuse by a night shift nurse identified as (V7, Registered Nurse). R72 stated that V7 was disrespectful and aggressive during an interaction that occurred on third shift on 04/17/2026. R72 reported that she has taken Meclizine for years to manage hand tremors and following a recent hospitalization, the medication order was changed from scheduled to as needed (PRN). R72 stated that on the night of the incident, she requested Meclizine due to significant shaking. R72 stated, V7 responded in an aggressive manner, questioning the need for the medication and stating, Why do you need this? what is this about? This drug makes you shake not take it away. R72 reported that despite explaining her history with the medication, V7 did not acknowledge her input, left the room, and returned with printed material disputing her claims. R72 stated the interaction escalated into a yelling exchange, during (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	which she felt humiliated and dismissed. R72's Nurse Progress Note dated 4/17/26 at 4:42 AM, V7 (Registered Nurse) documents Resident (R72) asked for cough syrup approx. 15 minutes ago from. This nurse was in another room with G-tube meds, etc. When I (V7) got out, I (V7) pulled her (R72) am meds along with her cough syrup. When I (V7) got in her (R72) room, she (R72) said I asked for that 1-1/2 hour ago. I (V7) told her maybe 15 minutes or at the longest 30 minutes. I (V7) was in another room when your light went off. It was 4:25 AM because I looked at the clock. Then when I (V7) was done, I pulled your morning meds and got you cough syrup. I (V7) am sorry, but I was busy with another resident and he takes a few minutes when I go in there. She (R72) said well you are wrong it was over 1-1/2 hours ago. I just left the room. On 4/20/2026 at 2:10 PM, V22 (Certified Nursing Assistant/CNA) stated R72 has declined functionally since admission and now requires total assistance. V22 stated that R72 reported that third shift staff were mean and verbally rude the other night, but the V22 did not report the concern at that time because V22 didn't want to involve herself in the drama. On 4/20/2026 at 2:00 PM, V2 stated she had received prior communication from a nurse expressing concern about R72's use of Meclizine and requested the nurse practitioner to change the order to PRN every 12 hours. V2 acknowledged she had not spoken directly with R72 prior to the change. Upon review of a nurse progress note dated 04/17/2026 by V7, V2 stated the documentation was inappropriate and confirmed she was unaware of the note. On 4/20/22 at 2:15 PM, V1 (Administrator/abuse Coordinator) stated that she had not been made aware of the verbal abuse allegations. The facility's Abuse Prevention and Reporting policy, dated 3/2026, documents This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. This will be done by: identifying occurrences and patterns or potential mistreatment; identifying concerns of residents' allegations of deprivation of goods and services by staff; immediately protecting residents involved in identified reports of possible abuse, neglect, exploitation, mistreatment, and misappropriation of property; implementing systems to promptly and aggressively investigate all reports and allegations of abuse, neglect, exploitation, mistreatment, and misappropriation of property and mistreatment, and making the necessary changes to prevent further occurrences; filing accurate and timely investigative reports. This policy also documents Verbal Abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance, regardless of an individual's age, ability to comprehend, or disability. Mental Abuse includes but is not limited to, humiliation, harassment, threats of punishment or deprivation. Retaliation means when there is a hinderance of a resident's involvement in one or more of the protected activities and that interferes with a resident's quality of life at the facility or results in either the imposition of selective restrictions or the resident's neglect or reduced access to services. Neglect means the failure to provide goods and services to a resident that are necessary to avoid physical harm, pain, or mental anguish. Neglect means a facility's failure to provide, or willful withholding of, adequate medical care, mental health treatment, psychiatric rehabilitation, personal care, or assistance with (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	activities of daily living that is necessary to avoid physical harm, mental anguish or mental illness of a resident, including deprivation of goods and services by staff. This policy further documents Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, retaliation, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, or to an immediate supervisor who must then immediately report it to the administrator. In absence of the administrator, reporting can be made to an individual who has been designated to act as administrator's absence. Reports should be documented and a record kept of the documentation. Upon learning of the report, the administrator or a designee shall initiate an incident investigation. Any allegation of abuse, retaliation, or any incident that results in serious bodily injury will be reported to the (state agency) immediately, but not more than two hours after the allegation of abuse. Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on Observation, Interview and Record review, the facility failed to ensure an abuse investigation was conducted and residents were protected from alleged perpetrators of mental abuse and neglect for three of four residents (R13, R39, R72) reviewed for abuse in the sample of 35.Findings include:1. R13's current Care Plan, dated 3/26/26, document R13 has a self-care deficit and requires assistance of one staff member for bed mobility and two staff members for transfers. This same care plan documents a plan last updated on 6/12/25: (R13) is at a high risk for abuse/neglect as noted from abuse screening related to depression. On 4/20/26 at 11:00 AM, R13 was sitting in her wheelchair in common area of the facility. R13 stated about three weeks ago she had an incident with a CNA (Certified Nursing Assistant) being mean to her and she felt like after she complained that the whole crew of staff was upset with her. R13 stated she cannot remember the CNA's name, but she knows it was in the afternoon time. R13 stated, I asked her to help me get up and she refused to help. She said, No. It hurt my feelings, and I didn't know how long I was going to be left there. I was crying and I felt upset about that for a couple weeks. I think she refused to help me because she doesn't like me. The main lady (V1, Administrator) came and talked to me. I don't know if the employee still works here but she is not allowed to take care of me anymore. R13's electronic medical record does not document any investigations or progress notes related to staff and resident conflicts, refusal to get R13 transferred or updates to R13's care plan related to the alleged incident. On 4/20/26 at 1:30 PM, V1 provided the facility's reported abuse allegations and investigations for the past six months which did not include any reported allegations or investigations for R13. On 4/20/26 at 2:10 PM, V4 (CNA) confirmed she has known in the past that there have been issues with staff on the evening shift and R13 not meshing well. V4 stated, (R13) has told me this without much specifics, but that the staff member was moved to a different floor and no longer cares for (R13). I believe it was a third shift CNA, and this was about 2 weeks ago. When I came the next morning, she told me and had already told (V2, Director of Nursing) and (V1) that she does not want that staff in her room anymore. On 4/21/26 at 1:12 PM, V2 confirmed that V9 (CNA) is no longer being assigned to R13's hall when working. V2 confirmed she was notified by V4 of some conflict that R13 expressed. V2 stated, (R13) feels like (V9) rushes when she is in there and complained that she felt like the CNA rushed her roommate (R39). We didn't prohibit (V9) from caring for (R13) we just have her off (R13's) hall for preference and to avoid conflict. V2 confirmed that V1 is the facility's abuse coordinator and stated she does not have any documentation from this incident. V2 stated, When we meet with someone with stuff like that, I leave the documentation to (V1). We did not talk with any other residents besides (R39), in that situation that I can recall, and I do not have any staff members written statements. On 4/21/26 at 2:05 PM (V2) provided a report that documents verbal warning was given to V9 on 4/13/26 for customer service issues. V2 then stated she does not have a written statement from V9 and stated the conversation took place over the phone. On 4/21/26 at 1:30 PM, V1 (Administrator) confirmed that V9 does not get assigned to R13's hallway to work anymore. V1 stated, (R13) doesn't overly like (V9) for whatever reasons. V1 confirmed she was informed of a complaint from R13 at the end of March 2026. V1 stated, There was a complaint (continued on next page)

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	145058	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arc at Chillicothe	1028 Hillcrest Drive Chillicothe, IL 61523

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	relayed to us around 3/31/26 and the allegation was that (R13) didn't want to come back to the facility (from the hospital) and made a statement that the CNA (V9) had possibly caused harm to the roommate (R39). (R13) does not like (V9), I don't know why. So, we moved (V9) to a different hall since there is an issue there. V1 confirmed there is no documentation in the resident's record to explain the encounter and that she did not initiate an abuse investigation, suspend the employee while investigating or keep a file with statements and interviews conducted. V1 stated, I don't see anything. I may have just had paper notes. (V2) and I both met with (R39). I may have got rid of them (notes), because it didn't amount to anything. I didn't get a statement from (V9). I did not talk to any other residents. 2. On 4/20/2026 at 12:00 PM, R72 reported concerns regarding alleged verbal abuse by a night shift nurse identified as (V7, Registered Nurse). R72 stated that V7 was disrespectful and aggressive during an interaction that occurred on third shift on 04/17/2026. R72 reported that she has taken Meclizine for years to manage hand tremors and following a recent hospitalization, the medication order was changed from scheduled to as needed (PRN). R72 stated that on the night of the incident, she requested Meclizine due to significant shaking. R72 stated, V7 responded in an aggressive manner, questioning the need for the medication and stating, Why do you need this? What is this about? This drug makes you shake not take it away. R72 reported that despite explaining her history with the medication, V7 did not acknowledge her input, left the room, and returned with printed material disputing her claims. R72 stated the interaction escalated into a yelling exchange, during which she felt humiliated and dismissed. On 4/20/2026 at 2:00 PM, V2 (Director of Nursing) stated she had prior knowledge of concerns related to R72's use of Meclizine and had requested a medication change; however, she acknowledged she had not spoken directly with R72 regarding the concern. V2 further stated she was unaware of the nurse progress note dated 04/17/2026, authored by V7(Registered Nurse), which documented an argumentative interaction with the resident. Upon review, V2 identified the documentation as inappropriate. On 4/20/2026 at 2:10 PM, V22 (Certified Nursing Assistant/CNA) stated R72 had expressed concerns the other day that third shift staff were mean and verbally rude; V22 stated that she did not report to V1 (Administrator/Abuse Coordinator) because V22 didn't want involved in the drama. V22 confirmed she did not investigate or question any further with other residents or staff. On 4/20/2026 at 2:15 PM, V1 (Administrator/Abuse Coordinator) V1 confirmed there was no evidence that the facility had initiated an investigation at the time the allegation was reported to V22 and stated she does not know how often V7 has provided care to R72 since the new incident. The facility's Abuse Prevention and Reporting policy, dated 3/2026, documents This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. This will be done by: identifying occurrences and patterns or potential mistreatment; identifying concerns of residents' allegations of deprivation of goods and services by staff; immediately protecting residents involved in identified reports of (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	possible abuse, neglect, exploitation, mistreatment, and misappropriation of property; implementing systems to promptly and aggressively investigate all reports and allegations of abuse, neglect, exploitation, mistreatment, and misappropriation of property and mistreatment, and making the necessary changes to prevent further occurrences; filing accurate and timely investigative reports. This policy also documents Verbal Abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance, regardless of an individual's age, ability to comprehend, or disability. Mental Abuse includes but is not limited to, humiliation, harassment, threats of punishment or deprivation. Retaliation means when there is a hinderance of a resident's involvement in one or more of the protected activities and that interferes with a resident's quality of life at the facility or results in either the imposition of selective restrictions or the resident's neglect or reduced access to services. This same policy also documents The facility will take steps to prevent potential abuse while the investigation is underway. Employees of this facility who have been accused of abuse, neglect, retaliation, exploitation, mistreatment or misappropriation of resident property will be removed from resident contact immediately. The employee shall not be permitted to return to work until the results of the investigation have been reviewed by the administrator and it is determined that any allegation of abuse, neglect, exploitation, mistreatment or misappropriation of resident property is unsubstantiated. All incidents will be documented, whether or not abuse, neglect, retaliation, exploitation, mistreatment or misappropriation of resident property occurred, was alleged or suspected. Any incident or allegation involving abuse, neglect, exploitation, retaliation, exploitation, mistreatment or misappropriation of resident property will result in an investigation. Investigation procedures; the appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident, if interviewable. Any written statements that have been submitted will be reviewed, along with any pertinent medical records or other documents. Residents to whom the accused has regularly provided care, and employees with whom the accused has regularly worked, will be interviewed to determine whether any one has witnessed any prior abuse, neglect, exploitation, mistreatment or misappropriation of resident property by the accused individual.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on Observation, Interview and Record review, the facility failed to ensure a residents Minnimum Data Set (MDS) assessments were completed accurately to reflect insulin usage for one of 24 residents (R2) reviewed for MDS accuracy in the sample of 35.Findings include:On 4/20/26 at 1:55 PM, R2 was sitting in her room watching television. R2 stated she does have a diagnosis of Diabetes, but she is able to control it with oral medication. R2 stated she does not have to take insulin injections.R2's Physician Order sheet, dated 12/26/25 through 4/22/26 and includes current and discontinued medications, does not document R2 is prescribed an insulin category medication.R2's MDS assessments dated 1/2/26, 1/22/26 and 3/16/26 all document that R2 received one insulin administration in the last seven days.On 4/22/26 at 11:10 AM, V18 (Licensed Practical Nurse/ MDS coordinator) confirmed that R2's MDS assessments have been coded for insulin, and that R2 does not receive insulin. V18 stated, It was marked due to her order for Trulicity (injectable glucagon-like peptide-1 (GLP-1)) which is a GLP-1, and not an insulin. (R2's) assessments will need corrected.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident's fingernails were kept clean and trimmed for one of one resident (R60) reviewed for ADLs (Activities of Daily Living) in the sample of 35.Findings include:R60's admission Record documents R60 is a [AGE] year-old female who admitted to the facility on [DATE], with the following but not limited to, diagnoses: Senile Degeneration of Brain, Age-Related Osteoporosis, Frontotemporal Neurocognitive Disorder, Hypertension, Chronic Kidney Disease, Dementia, and Major Depressive Disorder.R60's MDS (Minimum Data Set) Assessment, dated 2/25/26, documents R60 is severely cognitively impaired and receives hospice services.R60's current Care Plan documents R60 requires assistance of one staff assistance with personal hygiene.On 4/20/26 at 11:32 AM R60 was sitting in the dining room in her wheelchair at a table. All R31's fingernails were long (past fingertips), jagged, and had brown debris underneath. On 4/20/26 at 11:35 AM V4/CNA (Certified Nursing Assistant) verified R60's were long past fingertips, jagged, with brown debris underneath and stated R60's nails needed trimmed and cleaned. On 4/22/26 at 10:58 AM V2/Director of Nursing stated resident's fingernails should be cleaned and trimmed with every shower or as needed.The facility's Nail Care Policy, dated 12/2025, documents Equipment: Nail Clippers. 1. Observe condition of resident nails during each time of bathing. Note cleanliness, length, uneven edges, and hypertrophied nails. 3. Perform hand hygiene.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to implement a range of motion program for two of two residents (R7 and R14), with known functional limitations, in a sample of 35. 1. R7's facility admission record documents that R7 was admitted to the facility on [DATE] with the following diagnoses: Relapsing-Remitting Multiple Sclerosis, Paraplegia, Muscle Wasting and Atrophy. R7's current Physician Order Sheet, dated April 2026 includes the following physician orders: No Weight Bearing to the right lower extremity; Ankle brace to the right ankle. R7's current Restorative Assessment, dated 2/9/26 documents R7 requires staff assistance for all activities of daily living, would benefit from a range of motion program, has a functional limitation in the bilateral upper and lower extremities and has paralysis in the bilateral upper and lower extremities. R7's current Minimum Data Set Assessment, dated 2/9/26 documents R7 is alert and oriented with a brief interview for mental status as a 13 out of 15. On 4/20/2026 at 11:05 A.M., R7 was up in a wheelchair in his room, watching television. R7 was alert and oriented and able to answer questions appropriately. R7 stated he has multiple sclerosis. An ankle/foot brace was present to R7's right leg. R7 stated staff do not perform range of motion exercises for him. 2. R14's facility admission record documents R14 was admitted to the facility on [DATE] with the following diagnoses: Cerebral Infarction, and Hemiplegia and Hemiparesis Affecting Right Dominant Side. R14's current Physician Order Sheet, dated April 2026, includes the following physician orders: Evaluate and treat for new brace to the right forearm and right leg due to weakness from stroke. R14's current Restorative Assessment, dated 2/20/26 documents that R14 requires staff assistance for all activities of daily living, would benefit from a range of motion program, has a functional limitation in the right upper and lower extremities and has paralysis in the right upper and lower extremities. R14's current Minimum Data Set Assessment, dated 2/11/26 documents R14 is alert and oriented with a brief interview for mental status as a 13 out of 15. On 4/20/2026 at 11:02 A.M., R14 was lying in bed, in her room, watching television. R14 was alert and oriented and able to answer questions appropriately. R14 stated she had a stroke. A black splint was present to R14's right wrist and to R14's right leg. R14 stated staff do not perform range of motion exercises for her. On 4/21/26 at 1:46 P.M., V15/Corporate MDS/Restorative Nurse stated that she oversees the restorative programs for the facility. V15 stated she recalled R7 and R14 and stated she is unsure why they did not have a passive range of motion program. At that time, V15 stated that both R7 and R14 could benefit from a passive range of motion program, due to contractures. On 4/21/26 at 2:30 P.M., V16/Certified Occupational Therapy Assistant stated in her opinion R7 and R14 would benefit from a range of motion program. The facility policy, Restorative Nursing Program, dated (approved) 12/2025 directs staff that the purpose of a restorative program is to promote each resident's ability to maintain or regain the highest degree of independence as safely as possible. To determine a restorative need for a resident during their stay, review range of motion assessments, looking for an improvement or decline in range of motion. Range of motion programs may include Active Assisted Range of Motion, Active Rage of Motion or Passive Range of Motion.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, the facility failed to check gastric tube feeding residual prior to administering an enteral feeding for two of two residents (R9 and R34) reviewed for gastric tube feedings in a sample of 35.Findings include:1. R9's current Physician Order Sheet, dated April 2026, includes the following diagnoses: Dysphagia Following Cerebral Infarction; Gastrostomy Status and the following physician orders: Check tube placement before feeding, flush(ng) and meds (medications). R9's current care plan includes the following interventions: Check for tube placement and gastric contents/residual volume per facility protocol and record. On 4/21/2026 at 8:42 A.M., V8/Registered Nurse (RN) prepared to administer medications for R9. V8/RN applied a gown and gloves and entered R9's room. V8/RN connected a 60 CC (Cubic centimeter) syringe to R9's gastronomy tube, and without checking tube placement, flushed R9's gastrostomy tube with 30 cc's of water, added pre- mixed medications and administered 325 cc's of a prescribed formula, followed by 50 cc's of water. At that time, V8 removed the syringe, reapplied the cap and left R9's room. V8/RN verified she did not check placement of R9's gastrostomy tube by checking for gastric contents, prior to administering medications, flushes and a feeding. 2. R34's current Physician Order Sheet documents to check residuals before beginning a feeding and before medication administration. This form documents if residual greater than 100ml hold feedings and recheck in one hour. If not resolved, call the MD (medical doctor). On 4/20/26 at 10:00am, V13, Licensed Practical Nurse, washed her hands and applied gloves. V13 opened the cap on the gastrotomy tube and flushed it with 30ml (Milliliter) of water. V13 then poured 60ml at a time of ordered enteral feeding to equal 240ml. V13 flushed the gastrostomy tube with 30ml of water after the enteral feeding was administered. V13 did not check for placement prior to feeding R34. On 4/22/26 at 8:50am, V13 verified that she did not check the placement of R34's gastrostomy tube prior to administering his enteral feeding. The facility policy, Gastrostomy Tube- Feeding and Care, dated (last) 01/2026 directs staff, Checking for Tube Placement: Aspirate to visually verify stomach contents. Gastric fluid normally appears clear or yellow with mucus or may appear milky if residual remains from previous feeding. Aspirated contents must be returned to the stomach to maintain pH, fluid and electrolyte balance.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to don the required personal protective equipment during high-contact care for two of five residents (R11 and R34) reviewed for infection control in a sample of 35.Findings include: 1.R34's current Physician Order Sheet documents EBP, enhanced barrier precautions. On 4/20/26 at 10:00am, V13, Licensed Practical Nurse, washed her hands and applied gloves. V13 opened the cap on the gastrotomy tube and flushed it with 30ml (Milliliter) of water. V13 then poured 60ml at a time of ordered enteral feeding to equal 240ml. V13 did not apply personal protective equipment before administering R34's enteral feeding. On 4/22/26 at 8:50am, V13 verified that R34 is on enhanced barrier precautions because of his gastrostomy tube. V13 stated that she did not put on a gown prior to administering R34's enteral feeding. On 4/22/26 at 11:30am, V17, Infection Preventionist, stated that the appropriate personal protective equipment is to be donned before any high-contact care. 2. R11's current Care Plan, dated 8/6/25, documents, (R11) has an actual skin impairment of pressure to coccyx. This same care plan documents Enhanced barrier precautions related to wounds. Educate staff/resident/family on enhanced barrier precautions as needed. Gown and glove during high contact resident care activities (such as dressing, bathing, showering, changing briefs, assisting with toileting, or wound care). On 4/22/26 at 8:55 AM R11 was in his room being cared for by V19 and V20 (Certified Nursing Assistants, CNA). V20 came to the door upon opening stated, We are just getting (R11) up right now. V19 and V20 were not wearing gowns while dressing R11 and providing a mechanical lift transfer. On 4/22/26 at 9:00 AM, V19 confirmed that R11 has a wound, is in Enhanced Barrier Precautions (EBP) and that V20 and V19 did not wear gowns when getting R11 out of bed. V19 stated We only have to wear the EBP gown during the (wound) dressing change, I believe. It is not required for just dressing with clothing and getting him transferred out of bed. On 4/22/26 at 12:25 PM, V17 (Registered Nurse/ Infection Preventionist) confirmed that facility staff should be wearing a gown and gloves during transfers for residents in EBP precautions. The facility's Enhanced Barrier Precautions policy, reviewed 12/2025, documents that enhanced barrier precautions (EHP) recommendations now include the use of EBP for residents with chronic wounds or indwelling medical devices during high-contact resident care activities, regardless of their multidrug-resistant organism status. EBP may be considered and implemented for wounds and/or indwelling medical devices (central line, feeding tube, tracheostomy, drains, AV fistulas, etc.) This form also documents that standard precautions must be followed with all care. Additionally, gown and gloves must be worn when providing the following cares: Dressing, bathing/showering, providing hygiene, changing linens, incontinence care, medical device care, and wound care.