STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145266	A. Building B. Wing	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fondulac Rehabilitation & Hcc	901 Illini Drive East Peoria, IL 61611

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to protect a resident (R2) from resident-to-resident sexual abuse for one of four residents (R2) reviewed for abuse in the sample of ten. This failure resulted in R1 a cognitively intact resident sexually assaulting R2 a cognitively impaired resident on more than one occasion. This failure resulted in an Immediate Jeopardy. The Immediate Jeopardy began on 5/3/25 when the facility failed to protect a resident (R2) from resident-to-resident sexual abuse. V2 (Director of Nursing) was notified of the Immediate Jeopardy on 5/24/25 at 9:00 AM. On 5/24/25 the surveyor confirmed through interview and record review that the facility took the following actions to remove the Immediate Jeopardy: While the immediacy was removed on 5/24/25, the facility remains out of compliance at a severity Level II as additional time is needed to evaluate the implementation and effectiveness of their removal plan and Quality Assurance monitoring. Findings include: On 5/21/25 at 9:25 AM, V6 (Certified Nursing Assistant/CNA), stated on Saturday 5/3/25 during breakfast V6 saw R1 sitting in the dining room at a table with R2. R1 had R2's toy in R1's right hand and R1's left hand was between R2's legs touching R2's vagina. V6 told R1 don't touch her like that and V6 moved R2 to the middle of the dining room away from R1.V6 stated she left the dining room and came back 20 minutes later and R1 was sitting next to R2 again, with R1's hand further up between R2's legs. V7 couldn't see R1's hand because it was all the way up R2's shorts. V7 stated she told R1 this is the second time I have told you not to do that. V7 stated V15 (Licensed Practical Nurse)/LPN called V1 (Administrator in Training) to report the abuse allegation. V6 stated V1 did not come to the facility and did not give the staff guidance on safety interventions to put in place to keep R2 from further sexual abuse from R1. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/21/25 at 10:16 am, (V7 CNA) stated Saturday morning on 5/3/25, V7 walked in the dining room and saw R1 and R2 sitting at the table, and R1 was sitting next to R2. R1 had R2's baby doll in R1's right hand and R1's left hand was in between R2's legs up R2's shorts and touching R2's private area. V7 stated V7 stopped R1 and told R1 it's not right to touch R2. V7 stated V7 immediately told V15 (LPN) of what V7 witnessed in the dining room. V7 stated we immediately removed R2, and R1 starting crying and said, I'm sorry. V7 further stated R2 has been having increased behaviors where R2 is crying out and pointing to her vagina since this incident happened. On 5/22/25 at 12:36 PM, V15 (LPN) stated V7 and V6 came up to V15 and stated they had witnessed R1 touching R2 between R2's legs and on R2's vagina. V15 stated V15 first contacted V5 (Assistant Director of Nursing) who told V15 to call V1 (Administrator in Training). V15 called V1 to report the sexual abuse between R1 and R2 to V1. V1 told V15 to leave it alone and not do anything until V1 came in to do the investigation. V15 stated V1 did not come to the facility that weekend to do the investigation. V15 stated V1 did not give any further interventions or instructions to keep R1 away from R2. On 5/20/25 at 4:00 PM, V4 CNA, stated one day after the occurrence between R1 and R2, R1 told V4 that R1 shouldn't have, but R1 touched R2. V4 stated R2 has the mindset of a four-year-old and is nonverbal. V4 stated R1 can self-propel in manual wheelchair around the facility. On 5/21/25 at 11:53 AM, V9 (Guardian), stated V9 was not made aware of an allegation of sexual abuse towards R2. V9 stated R2 would be so upset and scared that this happened to R2. R2 has been mentally and physically handicapped R2's entire life. On 5/20/25 at 4:01 PM, R2 was lying in bed in low position with a fall mat on the floor. R2 was alert but nonverbal. On 5/20/25 at 3:30 PM, R1 was laying in R1's bed watching television. R1 was alert and answered questions appropriately. R1 stated R1 didn't want to talk about what happened with R2. On 5/21/25 at 12:19 PM, R1 was observed in the dining room sitting two tables away from R2. R2's Minimum Data set (MDS) dated [DATE] documents R2 is severely cognitively impaired. R2's current Medical Diagnosis list documents R2 has diagnoses of cerebral palsy, intellectual disabilities, anxiety, and depression. R2's current care plan does not contain documentation of interventions to keep R2 free from sexual abuse. R2's current medical record does not include any documentation or assessment of R2 after being sexually abused by R1. R2's medical record does not include a completed trauma care assessment after the alleged sexual abuse on 5/3/25. R1's current care plan does not include interventions to address R1's sexual behaviors. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's current medical record does not include documentation of R1's sexual abuse allegation that occurred on 5/3/25. The facility's Abuse, Prevention, &Prohibition Policy dated 12/2024 documents each resident has the right to be free from abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, agency staff, family members or legal guardians, friends, or other individual. While the facility investigation is under way, steps will be taken to prevent further abuse. The person identified in the allegation of abuse will have no contact with residents or other employees during the investigation process. A licensed Nurse will assess the resident for injuries and notify the residents physician and responsible party. Social Services will complete a Trauma Informed care assessment and provide follow up care regardless of if allegation is substituted. This policy documents sexual abuse is defined as non-consensual sexual contact of any type with a resident. The Immediate Jeopardy began on 5/3/25 when the facility failed to protect a resident (R2) from resident-to-resident sexual abuse. V2 (Director of Nursing) was notified of the Immediate Jeopardy on 5-24-25 at 9:00 AM. On 5-24-25 the surveyor confirmed through interview and record review that the facility took the following actions to remove the Immediate Jeopardy: 1. R2 was assessed by V2 (Director of Nursing) with no changes noted 5/24/2025. 2. R2's trauma assessment was completed by V14 (Social Service Director) on 5/24/25. 3. R2's plan of care was reviewed by interdisciplinary team (IDT) and updated on 5/24/25, by minimum data set (MDS) to include to have R2 in staff visual when not in room. 4. R1's plan of care updated on 5/24/25 to include counseling 1:1 (one to one) with social services, educated to not be within proximity of R2, 15-minute visual checks plan to care updated on 5/23/2025 and reviewed with IDT again on plan of care updated by minimum data set on 5/24/2025. 5. V16 (Medical Director) in conjunction with interdisciplinary team (IDT) reviewed abuse policy and procedure and assured policy and procedure included steps to report to appropriate parties and agencies including state agency, police department, resident representative, and abuse coordinator as well as proper investigation on 5/24/2025. 6. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	All staff in-service initiated on Abuse by V2 (DON) to be done prior to next scheduled shift for all staff. Inservice to include emphasis on preventing abuse including sexual abuse and reporting requirements on 5/24/2025. 7. All residents reviewed by IDT for risk to be victim of sexual abuse and if identified to have been a high risk, plan of care reviewed, and new interventions added, if necessary, on 5/24/2025. 8. V1 (Administrator in Training) willfully resigned employment effective 5/24/2025. 9. Abuse Coordinator role assigned to V23 (Corporate Administrator), and staff educated on clear signs posted for Abuse Coordinator Contact Information on 5/24/2025.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 implement their abuse policy and procedures to identify and report resident to resident suspected crime and sexual abuse immediately to local law enforcement, resident representatives, and the state agency for two (R1, R2) of three residents reviewed for reporting abuse in the sample of ten. These failures resulted in R1 having unsupervised access to all 79 residents within the facility after R1 sexually assaulted R2. Findings include: The facility's Resident Listing dated 5-20-25 documents 79 residents currently reside within the facility. On 5/21/25 at 10:30 AM, V6 (Certified Nursing Assistant) stated on 5/3/25 V6 witnessed R1 putting R1's hand up R2's shorts, placing R1's hand on R2's vagina on two occasions. V6 stated she made V15 (Licensed Practical Nurse) aware after R1 touched R2 on the vagina for the second time. V6 stated V15 called V1 (Administrator in Training) while V6 was standing at the nurse's station. On 5/21/25 at 10:35 AM V7 (Certified Nursing Assistant) stated on 5/3/25 V7 witnessed R1 putting R1's hand up R2's shorts, placing R1's hand on R2's vagina on two occasions. V7 confirmed the first interaction between R1 and R2 was not reported to V1. V7 stated she and V6 made V15 aware of R1 touching R2's vagina after the second interaction and V15 called V1 to report the allegation. On 5/20/25 at 3:15 PM, V1 (Administrator in Training) stated a report was not sent to the state agency regarding V6 and V7 witnessing R1 putting his hand up R2's shorts and touching R2's vagina. V1 also verified that V1 did not report V6 and V7's allegations of R1 and R2 to the local police department, resident representative, or state agency. R1's was observed from 5/20/25-5/24/25 between 9:00 AM and 3:30 PM, self-propelling in R1's manual wheelchair throughout the facility. The facility's Abuse, Prevention, &Prohibition Policy dated 12/2024 documents each resident has the right to be free from abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, agency staff, family members or legal guardians, friends, or other individuals. Resident abuse must be reported immediately to the administrator. The facility Administrator will ensure a thorough investigation of alleged violations of individual rights and document appropriate action. The facility will complete summarized investigation within five business days and submit to required agencies. Resident to Resident abuse means the individual's action was deliberate, regardless of whether the individual intended to inflict injury or harm. This policy further documents Administrator will report all allegations of abuse to the mandated state agency and Law enforcement. The allegation will be reported no later than two hours, or per state regulations, after the allegation is made.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Respond appropriately to all alleged violations. Based on observation, interview, and record review the facility failed to implement their abuse policy and procedure to thoroughly investigate an allegation of resident-to-resident sexual abuse, implement measures to provide safety and supervision to prevent further abuse, and failed to submit a final report of the final investigation to the state agency within five working days for two of three residents (R1 and R2) reviewed for protection from abuse in the sample of ten. These failures resulted in R1 having unsupervised access to all 79 residents within the facility after R1 sexually assaulted R2. Findings include: The facility's Resident Listing dated 5-20-25 documents 79 residents currently reside within the facility. On 5/9/25at 10:30 AM, V6 (Certified Nursing Assistant) and V7 (Certified Nursing Assistant) stated they witnessed R1 putting R1's hand up R2's shorts, placing R1's hand on R2's vagina on two occasions. On 5/20/25 at 3:15 PM, V1 (Administrator in Training) stated there was not an investigation, and a report was not sent to the state agency regarding V6 and V7 witnessing R1 putting his hand up R2's shorts and touching R2's vagina. R1 and R2's electronic medical record did not include interventions or increased supervision to protect R2 from R1 further sexually abusing R2 or other residents in the facility. On 5/21/25 at 10:30 AM, V6 and V7 stated V15 Licensed Practical Nurse called V1 and made V1 aware of the allegations of R1 touching R2's vagina in the dining room. V1 did not provide any safety interventions for the staff and told V15 that V1 would be in the facility on Monday to start the investigation. On 5/21/25 at 12:19 PM, R1 was observed in the dining room sitting two tables away from R2. R1's was observed from 5/20/25-5/24/25 between 9:00 AM and 3:30 PM, self-propelling in R1's manual wheelchair throughout the facility. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Abuse, Prevention, & Prohibition Policy dated 12/2024 documents each resident has the right to be free from abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, agency staff, family members or legal guardians, friends, or other individuals. Resident abuse must be reported immediately to the administrator. The facility Administrator will ensure a thorough investigation of alleged violations of individual rights and document appropriate action. While the facility investigation is under way, steps will be taken to prevent further abuse. The person identified in the allegation of abuse will have no contact with residents or other employees during the investigation process. A licensed Nurse will assess the resident for injuries and notify the residents physician and responsible party. Social Services will complete a Trauma Informed care assessment and provide follow up care regardless of if allegation is substituted. Complete summarized investigation within five business days and submit to required agencies. Resident to Resident abuse means the individual's action was deliberate, regardless of whether the individual intended to inflict injury or harm.

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to initiate a resident head count once an exit door was alarming without known cause, failed to ensure a gait to the outside smoking patio was kept secure, failed to develop a care plan and implement interventions for residents at risk for elopement, and failed to provide adequate supervision for two of three residents (R6 and R7) reviewed for elopement risk in the sample of 10. These failures resulted in cognitively impaired resident (R6) who required assistance with ADL's (Activities of Daily Living) exiting the facility without staff knowledge or supervision on 4-22-25, and being found 2.2 miles away from the facility, on a concrete median, by a stop light, in the dark, with complaints of being cold. The road R6 traveled along was a busy main road that had numerous steep hills and curves. These failures resulted in an Immediate Jeopardy. The Immediate Jeopardy started on 4-22-24 at 2:00 AM when R6, a cognitively impaired resident, exited the facility without staff knowledge or supervision and was found 2.2 miles away from the facility, on a concrete median, by a stop light, in the dark, with complaints of being cold. V1 (Administrator-In-Training) and V18 (Assistant [NAME] President of Operations) were notified of the Immediate Jeopardy on 5-23-25 at 10:48 AM. While the immediacy was removed on 5-23-25, the facility remains out of compliance at a severity Level II as additional time is needed to evaluate the implementation and effectiveness of their removal plan and Quality Assurance monitoring. Findings include: 1. R6's MDS (Minimum Data Set) dated 4-4-25 documents R6 is cognitively impaired. R6's admission Record documents R6 was admitted to the facility on [DATE] with the diagnoses of Chronic Obstructive Pulmonary Disease, Hemiplegia and Hemiparesis following Cerebral Infarction affecting left non-dominant side, Type II Diabetes Mellitus, Obstructive Sleep Apnea, Chronic Pain, and Depression. R6's Elopement Risk assessment dated [DATE] documents R6 was a moderate risk for elopement and exit-seeks at times. R6's admission Care Plan dated 6-24-25 through discharge date d 4-24-25 documents R6 has impaired cognitive function or thought processes and requires staff assistance with transfers and toilet use. R6's Care Plan does not include any interventions to address R6's exit-seeking or risk for elopement as identified on R6's Elopement Risk assessment dated [DATE], until after R6 eloped on 4-22-25. R6's Fall Risk assessment dated [DATE] documents R6 was at high risk for falling and has intermittent confusion. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R6's Final Report dated 4-22-25 and signed by V1 (Administrator-in-Training) documents, Summary: (R6) noted off facility grounds by oncoming staff. Noted (R6) to have left facility without notification or staff knowledge. Staff Interviews: (V11/Licensed Practical Nurse/LPN) reported noting smoking patio alarm sounding. Did not note anyone around, assumed wind to have blown open. Stated did not enact facility procedure as this was not an exit and residents typically would not be able to exit facility grounds through this door or patio. R6's Social Service Progress Note dated 4-4-25 at 10:12 AM and signed by V14 (Social Service Director) documents, (V14) has reviewed (R6's) assess (assessment). (R6) initially kept saying he needed to get to the bank, transportation took (R6) to the bank, (and) it was not the correct bank. As I had noted before (R6) has poor cognition but doesn't feel he does. This has all recently started with (R6) wanting to go to the bank. R6's Social Services Progress Note dated 4-22-25 at 2:58 PM and signed by V14 documents, (R6) left the facility without alerting staff. (R6) was located and brought back to the facility. On 5-22-25 at 10:20 AM this surveyor observed the smoking patio where R6 exited the facility. The exit to this patio leads to a rocky embankment and then to a sidewalk that leads to the front parking lot. This surveyor drove from the front parking lot to the college campus where R6 was found. During the drive there was a steep hill that leads to the main road. From this main road to the local college where R6 was found per odometer reading was 2.2 miles from the facility and the road had many curves and hills. On 5-22-25 at 9:00 AM V12 (LPN) stated, I came into work early on 4-22-25 and came by the (community college) at 5:00 AM. I was at a stop light, and I saw (R6) standing with a wheeled walker in the middle of a concrete divider that separates two streets. I asked (R6) what he was doing, and he said he was going home. (R6) said he wasn't going back there (the facility). I tried several times to get (R6) to get in the car with me. I called the nursing home and (V1/Administrator-in-Training) and I had to turn around because I was at stop light. By the time I turned around (R6) was gone. It was dark and (R6) had dark colored clothes on. (V13/CNA/Certified Nursing Assistant) came and met with me to look for (R6). (R6) had gotten inside a college building and (V13) brought (R6) to my car and we were able to get (R6) in and bring him back to the facility. The weather was chilly and (R6) had a black jacket and stocking cap on. It was 47 degrees out. (R6) stated he was cold. (R6) stated he had left the facility around midnight. I called (V11/LPN) and (V11) was not aware that (R6) had left the facility unattended. I brought (R6) back to the facility. The road (R6) was found on is very busy with stop lights and lots of traffic from college students and other traffic. On 5-22-25 at 9:10 AM V13 (CNA) stated, (R6) was very quiet and had confusion. (R6) went out to the front parking lot around two months ago and threatened to leave and I was able to get (R6) back inside. (R6) was walking with a walker within the facility. On 4-22-25 I was told (R6) went out the door where the residents smoke. The alarm went off and the nurse (V11) thought the alarm was going off due to a resident going outside to smoke. (V11) shut the alarm off. V12 (LPN) called me and had me come and help find (R6). (R6) was over two miles away. (V12) lost sight of (R6). I found (R6) inside the college. It was 5:50 AM, dark, and cold. (R6) wanted to go home. (R6) was wanting to get on a bus to go home. (R6) would not be safe to by outside by himself. On 5-22-25 at 10:25 AM V14 (Social Service Director) stated, (R4) had poor cognition at times. (R4) was not safe to walk outside on the road by himself. (R4) needed a walker. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5-22-25 at 11:15 AM V2 (Director of Nursing) stated, (R4) had confusion and needed a walker. (R4) was not safe to leave the facility unattended and away from the facility 2.2 miles. A lot of the road (R4) used did not have sidewalks. On 5-22-25 at 1:00 PM V11 (LPN) stated, I was working the night of 4-22-25 and heard the smoking patio door alarming around 2:00 AM. I went to the alarm and thought the wind blew the door open and sounded the alarm. I did not see any residents outside, so I shut the alarm off. I should have done a resident head count and did not. Sometime after 5:00 AM that morning, (V12/LPN) called the facility and said she had found (R6) wandering around by the college. I had no idea (R6) was even missing from the facility. On 5-22-26 at 1:30 PM V10 (LPN) stated, (R6) has a lot of confusion and would try to exit-seek. Prior to (R6's) elopement, (R6) would set off alarms and try to leave the facility. (R6) would not be safe leaving the building unattended by staff, especially after dark. 2. R7's current Care Plan documents Potential risk for elopement related to cognitive deficits, history of wandering, walks, or wheels about aimlessly without a purpose. (R7) is at high risk. Interventions: Place electronic sensor device to alert staff of exit attempt (or if unavailable, place on 1:1 (one on one) observations). Routinely check device placement, check battery function, check door device functioning, and evaluate effectiveness. R7's Elopement Risk assessment dated [DATE] documents R7 is a high risk for elopement. On 5-22-25 from 12:45 PM to 1:05 PM R7 was wandering aimlessly up and down the hallways and the dining room. R7 did not have one on one staff supervision or and electronic sensor device in place during this time. On 5-23-25 at 9:45 AM R7 was lying in bed and V12 (LPN) and V13 were providing incontinence cares. R7 did not have an electronic sensor device in place. On 5-23-25 at 9:50 AM V12 (LPN) stated, (R7) has never had an electronic monitoring device on or one-on-one staff supervision that I am aware of. The facility's Elopement Policy dated 04/2025 documents, Policy: It is the policy of this facility that all residents are afforded adequate supervision to provide the safest environment possible. All residents will be assessed for behaviors or conditions that put them at risk for elopement. All residents so identified will have these issues addressed in their individual care plans. Responsibility: All staff is responsible. Definitions: For the purpose of this policy, missing resident or eloped if he/she is seen leaving the buildings or is seen walking away as a result of responding to a door alarm. 4. When a door alarm sounds, staff shall immediately respond to and determine the cause of the alarm. The staff person responding to the alarm will check the outside of the building to determine if a resident has exited the building. If, upon investigation, no reason can be found for the sounding off that alarm the charge nurse will initiate an accounting of all residents at risk for elopement. If, after all at-risk residents are accounted for, the cause of the alarm is still undetermined, a complete head count of all residents will be conducted. (continued on next page)

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	145266	A. Building B. Wing	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fondulac Rehabilitation & Hcc	901 Illini Drive East Peoria, IL 61611

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Immediate Jeopardy started on 4-22-24 at 2:00 AM when R6, a cognitively impaired resident, exited the facility without staff knowledge or supervision and was found 2.2 miles away from the facility, on a concrete median, by a stop light, in the dark, with complaints of being cold. V1 (Administrator-In-Training) and V18 (Assistant [NAME] President of Operations) were notified of the Immediate Jeopardy on 5-23-25 at 10:48 AM. On 5-24-25 this surveyor confirmed through interview and record review that the facility took the following actions to remove the Immediate Jeopardy: 1. R6 was assessed on 4-22-25, after the elopement, and no injuries were found. 2. On 4-22-25 V16 (R6's Physician) was made aware of R6's elopement and plan of care for a safe discharge back to home. 3. On 4-22-25 and 5-23-25 V16 and the Inter-Disciplinary Team reviewed facility policies and procedures to assure that processes are in place to supervise and prevent further residents from eloping. 4. On 5-23-25 all staff were in-serviced by V1 (Administrator-In-Training) on the facility's Elopement Policy and contacting all necessary parties, including law enforcement, when an elopement occurs. 5. On 5-23-25 V14 (Social Service Director) assessed all residents for elopement risk accuracy and completeness. 6. On 5-23-25 all residents deemed moderate or high risk on the Elopement Assessments were included in an elopement book located at the nurses' station. 7. On 5-23-25 V14 updated all residents at moderate to high risk for elopement care plans with interventions to increase safety. 8. On 5-23-25 V22 (Maintenance Director) checked all door alarms to ensure all door alarms were in proper working order. 9. On 4-22-25 V22 secured the smoking patio door with a padlock. 10. On 4-22-25 V11 (LPN) was provided one-on-one education and disciplinary action from V1 on the company's policy for responding to door alarms.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on record review and interview the facility failed to employ a licensed Administrator to ensure all residents were protected from abuse and all abuse allegations were investigated and reported to the police, State Agency, and residents' representatives, to ensure all staff received mandatory annual in-servicing, and to maintain positive staff feedback. These failures have the potential to affect all 79 residents residing within the facility. Findings include: The facility's Resident Listing dated 5-20-25 documents 79 residents currently reside within the facility. The facility's Job Description Manual (undated) documents, Job Title Variations: Acting Administrator. Position Description: Manages all business-related activity to achieve the company vision and supporting strategies and assures that the company image as an ethical and high-quality provider of health services is maintained. Assist in the overall operation of the facility in accordance with current applicable federal, state, and local standards, guidelines and regulations while completing the required training hours for skilled nursing and long-term care and achieving a proficient level of competency within all departments of the facility. Principle Responsibilities: Conduct continuing education programs and in-service training to all department managers and special in-services for all staff. Promotes and maintains pro-active, positive feedback to staff while they are working. Maintains frequent, daily, informal interaction, and provides positive feedback to staff while they are working. Resident Rights: Reports allegations of resident abuse, neglect, and/or misappropriation of resident property. Staff Development: Attends and participates in scheduled in-service training, educational classes, and meetings to maintain current certification as applicable and as managed by regulatory agencies and company policies. Qualifications: Bachelor's degree in nursing home administration or related field required. Master's degree preferred. License as required by state law. Current knowledge of local, state, and federal guidelines and regulations. V1's (Administrator-In-Training's/AIT's) Employee File documents V1 was hired on 6-1-24 as the Administrator of the facility. V1's Employee File does not include evidence of V1 having a bachelor's degree or a temporary license to act as the facility's Administrator at any time between 6-1-24 through 5-24-25. On 5-23-25 at 1:00 PM V2 (Director of Nursing/DON) provided all the facility's in-services provided to the employees within the last year. These in-services do not include the mandatory 12-hour CNA (Certified Nursing Assistant/CNA) annual trainings, staff trainings related to QAPI (Quality Assurance and Performance Improvement), staff trainings related to behavioral health services, staff training on the facility's infection control program and policies, and staff training regarding the facility's Compliance and Ethics Program. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5-21-25 at 9:25 AM, V6 (CNA) stated that V6 and V7 (CNA) witnessed R1 putting R1's hand up R2's shorts, placing R1's hand on R2's vagina on two occasions on 5-9-25. V6 stated that V1 (AIT) tried to make the sexual abuse incident between R1 and R2 seem like the staff were making it up and stated that V1 sweeps a lot of issues under the rug. V1 wrote witness statements in pencil and then changed what was wrote. On 5-20-25 at 3:15 PM, V3 (LPN/Licensed Practical Nurse) stated that V1 (AIT) is part of the problem, and you can't trust anything V1 says. On 5-20-25 at 4:00 PM, V4 (CNA) stated that V1 (AIT) has not investigated the sexual abuse allegations between R1 and R2 and V1 tries to cover stuff up. On 5-20-25 at 4:05 PM, V5 (Assistant Director of Nursing) stated that V1 (AIT) does not tell the truth and V1 can be intimidating towards staff. On 5-20-25 at 3:15 PM, V1 (AIT) stated that there was not an investigation and the state agency, resident representatives, or the police were not notified regarding V6 and V7 witnessing R1 putting his hand up R2's shorts and touching R2's vagina. On 5-21-25 at 9:35 AM, V10 (LPN) stated that V10 called V1 (AIT) on 5-3-25 to report the sexual abuse allegation between R1 and R2. V10 stated V1 did not provide any direction to the staff to remove R1 from having contact with R2 or other residents in the facility. On 5-21-25 at 10:16 AM, V7 (CNA) stated that V1 (AIT) wrote V7's witness statement in front of V7 in pencil. V7 stated the statement V1 documented is not what V7 told V1. V7 stated that V7 told V1 that R1 touched R2's private parts and V1 documented R1 touched R2's inner thigh. V7 stated that V1 is just trying to cover this situation up. On 5-23-25 at 1:20 PM V1 (AIT) stated, This company did not have a good training plan. Whatever (V2/DON) gave you for in-services is the only training the staff would have had. I have never received a temporary administrator's license from the state, and I am not a licensed administrator. I do not have a bachelor's degree. On 5-24-25 at 9:10 AM V2 (DON) verified the CNA's have not had the required annual 12-hour trainings, and the staff have not had annual training related to QAPI, behavioral health services, the infection program and policies, or the Compliance and Ethics Program.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. Based on record review and interview the facility failed to ensure all staff received annual QAPI (Quality Assurance and Performance Improvement) in-service training. This failure has the potential to affect all 79 residents residing within the facility. Findings include: The facility's Resident Listing dated 5-20-25 documents 79 residents currently reside within the facility. The facility's Annual In-Servicing Calendar Policy dated 09/2022 documents, March: QAPI All Staff. On 5/24/25 at 9:10 AM V2 (Director of Nursing) verified no staff received annual QAPI training.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. Based on record review and interview the facility failed to ensure all staff received annual Infection Control and Prevention in-service training. This failure has the potential to affect all 79 residents residing within the facility. Findings include: The facility's Resident Listing dated 5-20-25 documents 79 residents currently reside within the facility. The facility's Annual In-Servicing Calendar dated 09/2022 documents, April: Infection Prevention and Control All Staff On 5/24/25 at 9:10 AM V2 (Director of Nursing) verified no staff received Infection Control and Prevention Training.

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide training in compliance and ethics. Based on record review and interview the facility failed to ensure all staff received annual Compliance and Ethics in-service training. This failure has the potential to affect all 79 residents residing within the facility. Findings include: The facility's Resident Listing dated 5-20-25 documents 79 residents currently reside within the facility. The facility's Annual In-Servicing Calendar dated 09/2022 documents, April: Ethics and Corporate Compliance All Staff. On 5/24/25 at 9:10 AM V2 (Director of Nursing) verified no staff received annual Compliance and Ethics training.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on record review and interview the facility failed to ensure all staff received annual Behavioral Health in-service training. This failure has the potential to affect all 79 residents residing within the facility. Findings include: The facility's Resident Listing dated 5-20-25 documents 79 residents currently reside within the facility. The facility's Annual In-Servicing Calendar dated 09/2022 documents, January: Behavioral Health All Staff. October: Behavioral Management All Staff. On 5/24/25 at 9:10 AM V2 (Director of Nursing) verified no staff received annual Behavioral Health training.