STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145290	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belleville Healthcare Center	727 North 17th Street Belleville, IL 62226

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33110 Based on interview and record review, the facility failed to locate and or replace missing clothing for 5 of 5 residents (R13, R64, R70, R100, R103) reviewed for loss of property in the sample of 59 Findings Include: 1. R13's Minimum Data Set (MDS), dated [DATE], documented that R13 was moderately cognitively impaired. On 8/9/24 at 9:00 AM, R13 stated, I'm missing all my underwear. R13's Grievance form, dated 3/28/24, documented, (R13) was losing her clothes down to her last three underwear. Moving forward making sure all clothes are properly labeled and legible. On 4/11/24 at 3:00 PM, V28, Housekeeping Supervisor, stated, We go and talk to them and asked them what is the item that is missing. The Psych Social will do a grievance and I basically follow up I let them know (psych social) if I can't find them (the clothes) in one week. We ask them to reimburse. On 4/15/24 at 1:00 PM, V9, Social Service Designee, stated, We did find some of her (R13) underwear. 2. On 4/09/24 at 9:00 AM, R103 stated, I like it here but, my clothes are missing underwear, 2 pair of blue jeans and two t-shirts, one is a Bronco, and one is a [NAME]. R103's MDS, dated [DATE], documented that R103 was cognitively intact. On 4/10/24 at 3:00 PM, the laundry room had a note hanging on the wall stating what clothing items R103 was missing. It was Two T-shirt, 2 pairs of jeans, and underwear. R103's Inventory of Personal Effects form, undated, documented that she had 3 shirts and 3 blouses. R103's undated Inventory of personal items did not have a category for panties. No slacks were listed. There wasn't a category for jeans. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/15/24 at 1:00 PM, V9, Social Service Designee, stated, We have found all of her (R103) clothing except for her blue jeans and we will look into it more. 35156 On 4/11/24 at 10:00 AM, during the group meeting, R103 stated that the facility was always losing clothes in laundry and half the time the stuff never comes back. They will just say they can't find it. It's a big problem. R103's MDS dated [DATE] documents she was cognitively intact for decision making. Resident Council Meeting Minutes dated 12/28/2023 documents, Not getting clothes in a timely manner. Wrote grievance. 3. On 4/11/24 at 10:00 AM, during the group meeting R70 stated she was missing clothes, underwear, socks, and pants and when she told (V9, Social Service) she said they would look for them and they never found it and it has been three weeks now. R70's MDS dated [DATE] documents she was cognitively intact for decision making. Grievance form, dated 1/20/2024, documented, Resident expressed another resident had on her fuzzy socks. Fuzzy socks are black and red. Steps of Investigation: SSD (Social Service Director) asked resident if they were her personal items and did, they belong to her. Resident stated they were hers. SSD checked laundry for socks. 34964 4. On 4/12/24 at 10:25 AM R64 was lying in bed. He had two pair of slippers, a pair of brown hiking boots, and a pair of brown tennis shoes under his bed. He had multiple shirts and pants hanging in his closet. R64 stated he is missing clothes and they have found some of them. He stated the staff do put his clothes on his roommate sometimes. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/11/2024 at 4:16 PM, V26, Family of R64, stated, The facility keeps losing (R64's) stuff. I bought him a big package of black socks, and they are now missing. I bought him white socks, those are missing. I bought him 12 pair of grey speckled socks, those are missing. He has a pair of black jeans that are missing. A pair of black boots, hiking boots, and his underwear, and he has but one pair of underwear and I had bought him a pack of underwear and I went to Target and bought him four or five and a bedspread and it's missing. I purchased another one and it has been missing since Christmas. I asked the nurse where was his bedspread because he got a really nice bedspread for Christmas, and she said she will go down and look for it. I called yesterday and they had not found any of these things. There have been so many shirts, short sleeved, long sleeved, and they all go missing. (V9) told me it was not a sure thing that those items were in the facility, and they would find them. I have pictures of everything, and I should not have to constantly be replacing his items without being reimbursed. Every time I come up there his roommate has on my son's clothes. I did not buy those clothes for his roommate. (R90) was even wearing my son's clothes and they scratched off my son's name and made into his roommate initials and I have pictures. They had bed bugs in there and they took all the clothes and then he had a lot of his stuff missing including his cell phone. I stayed on them, and they said they would give him one of the phones, and I said I have a contract with mobile company, and I made a copy of the outstanding balance that I still have to pay regardless if they give him a new phone. I went there on 2/9/2024 and they made a copy of the statement and gave back to me. They never paid the balance like they said they would. I got (R64) coat on sale on for $49.99 and I sent them copies of it. He never wore the coat, and it went missing. They said they were going to find his stuff, and this was back in January. I still have not got any of those items found or replaced. I would like for these items to be replaced. They know he had these items. They gave him a phone and he does have a phone now. He lost a lot of stuff because of the bed bugs; they went to laundry they found some stuff but not everything. The bedspread the nurse took a photo of on the 1/6/2024 and everyone knows that is his bedspread and nobody has found it or replaced it, and they keep saying we are still looking for it, we are still looking for it. They don't find it. I usually go and try and talk with them and try and see if they can find the stuff. I have talked with (V2) and the lady that is over the facility and I think her name is (V9) and she called me, and I talked with the former administrator about his stuff missing multiple times. They can't keep an administrator, and nobody really knows or cares that my son's stuff is missing. On 12/22/2024, I talked with (V15) the state lady a few weeks ago and told her about everything and she said to give them time to replace everything but that didn't mean anything. They told the state lady they would replace everything and give me my money for the contract for the cell phone and they have never replaced it. I would like them to replace his clothes too. Putting names on the clothes does not do any good. His clothes should be replaced and his bedspread sheet. His shoes were brand new, and they are lost now too. This is getting out of control. On 4/12/24 at 10:30 AM V19, Certified Nursing Assistant (CNA), entered R64's room to wake him up because he had not eaten any of his breakfast which was still sitting on his bedside table. R64 asked her to warm up his breakfast which she did and brought it back to him. After setting up R64's breakfast, V19 went to check on his roommate, R90, and looked at the name on the pants R90 was wearing and they were R64's pants and were marked with R64's name. The shirt R90 was wearing did not have a name in it. V19 stated R90 is not able to dress himself and he is dressed by the night shift staff. V19 stated that when R90 needs clothes during the day, she just goes down to laundry to get him some clothes. V19 stated all the clothes in the closet in R64's and R90's room belong to R64. She stated when she comes in to give R90 care she will take off R64's pants that R90 is wearing and get some of R90's own pants to put on him. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/10/24 at 1:00 PM, V9, Social Service Designee, stated that she did receive a grievance from R64's family a few months ago regarding him missing some clothes and boots and a cell phone. V9 stated his family was directed to provide receipts for the missing clothes and the facility will reimburse them. R64's MDS, dated [DATE] documented that R64 was alert and oriented. R90's MDS, dated [DATE], documented that he was moderately cognitively impaired. 5. On 4/09/24 at 10:35 AM, R100 stated that all her clothes are missing. She also stated the only clothes she has is the clothes she is wearing right now. On 4/10/24 at 2:47 PM, V9, Social Service Designee, went into R100's room to ask about R100's missing clothes. V9 reminded R100 that she took her some clothes from unmarked/ unclaimed clothes in laundry. R100 stated she does remember V9 giving her some clothes but stated they are all gone along with all her underwear and socks. V9 looked in R100's closet and there were no clothes other than R100's roommate's clothes. R100 asked V9 if she could please find some of her clothes because she wants to take a shower and put on fresh clothes. V9 stated she will check with laundry and try to find some of R100's clothes. On 4/12/24 at 10:15 AM, R100 was lying in bed dressed in different clothes than she was wearing on 4/10/24. R100 stated that they did not find the clothes she was missing but they did give her some more clothes and put her name in them including some pants, shirts, socks and underwear. She stated they are still looking for her clothes. R100's MDS, dated [DATE], documented that she was moderately cognitively impaired. The facility's policy, Missing Items, reviewed 9/2021, documented, General: It is the policy of the facility to take seriously all issues of missing items and take the necessary measure to locate items. Guideline: 1. All reports of missing items shall be discussed with the resident. 2. A search for the missing items will occur. 3. If the item is located, it will be returned to the resident. 4. If the item is not located, then the Administrator will discuss the possible options with the resident. 5. The resident contract contains verbiage regarding resident items. 6. If it is believed that the missing items meet the definition of theft as defined in the abuse policy, then an abuse investigation will occur as required. The facility's undated policy, Notification of Policy Regarding Personal Property documented, Lost or Misplaced Personal Items: This facility understands the value and importance of everyone's personal property. Because we care, we make every effort to assure that your possessions are not lost, misplaced, or stolen. However, the ownership, administration, staff and residents in this facility also recognize the need to address the problem of missing personal items, whenever the situation might occur. The loss of valuable personal property is an unfortunate event and a very difficult task to manage in a long-term care facility where many diverse residents reside and employees work. There are multiple occupancy rooms, visitation by friends and relatives, residents frequently leaving the facility, etc. Investigating Lost Personal Items: By defining an approach to investigate complaints of theft or misplaced personal property, the administration wishes not only to discover lost items, but also to gather information and determine potential patterns that may lead to the reduction and eventual prevention of lost items or theft.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35156 Based on observation, interview and record review, the facility failed to ensure allegations of abuse, neglect, or mistreatment were thoroughly investigated and interventions were put into place to prevent further potential abuse, neglect exploitation or mistreatment for 7 of 25 residents (R30, R36, R39, R50, R63, R85 and R88) reviewed for abuse in the sample of 59. This failure had the potential to affect all 112 residents residing in the facility. Findings include: 1. R30's Initial Incident Report, dated 2/1/2024 at 8:30 AM, documented, Resident (R30) and (R50) entered a verbal disagreement about (R50) working for a seed company that (R30) used to work for. The verbal argument became physical and (R30) bit (R50) on the right hand. Puncture wound/bite marks that drew blood to right hand of resident (R50). An Incident Report, dated 2/14/2024, documented, (R50) got into a verbal disagreement with roommate (R30) about working at the same seed company in the past then (R30) bit him on the right hand. Root cause: Both residents are cognitively impaired and became agitated resulting in (R50) being bit by (R30) on the right hand. Intervention: Residents were moved to separate rooms on a different hall. Supervision provided to both residents for change in status. On 4/9/2024 at 8:04 AM, all abuse investigations for the past year were requested from the facility. On 4/9/2024 at 10:30 AM, V1, Interim Administrator, stated We are working on the abuse investigations. I have only been here for a little while and we are working on them. On 4/9/2024 at 5:20 PM, V21, Corporate Nurse, stated, We have been looking everywhere and we cannot find all of the abuse investigations. We have given you everything we could find. We are not sure where all of the investigations went. We believe they were completed, we just cannot provide them, or prove that they're done. The Facility was unable to provide a Final Report for R30 and R50 for 2/14/2024. There were no investigations documenting staff or residents' interviews related to the altercation. The Facility was unable to show evidence of the incident and how the altercation was thoroughly investigated. The facility was unable to provide what protective actions were taken to ensure residents were being protected and safe aside from separating R30 and R50 and placing them on different halls. There was no evidence of the interaction between R30 and R50 and no documentation related to if R50 was or was not threatening R30 prior to the altercation. There was no evidence of the facility conducting observations of R30 and R50, the interactions and relationships between them and other residents. No corrective actions were documented from the incident except the Intervention: Residents were moved to separate rooms on a different hall. Supervision provided to both residents for change in status. 2. R85's Incident Report dated 8/19/2024 documents, As told by the 400 hall (Certified Nurse Assistant) CNA, resident was thrown out of his wheelchair by another resident to the floor. Both residents were separated by staff. Abrasion to left ear, upper left arm, and face. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R85's Nurse Notes, dated 8/19/203 at 4:53 PM, documented, As told by the 400 hall CNA, resident was thrown out of his wheelchair by another resident to the floor. As told by the resident he was thrown out of his wheelchair by another resident. Both residents separated from each other by staff. 911 was called. The Facility was unable to provide a Final Report for R85 and R39 for the altercation on 8/19/2023. There were no investigations documenting staff or residents' interviews related to the altercation. The Facility was unable to show evidence of the incident and how the altercation was thoroughly investigated. The facility was unable to provide what protective actions were taken to ensure residents were being protected and safe. There was no evidence of the interaction between R85 and R39. There was no evidence of the facility conducting observations of R85 and R39, the interactions and relationships between them and other residents. No corrective actions were documented from the incident on 8/19/2023. There were no interviews documented if R85 felt safe in the facility. On 4/17/2024 at 4:14 PM, V21, Corporate Nurse stated, We realize it is serious that we could not find the abuse investigations. We are not sure what happened to all of the abuse investigations, or where they went to. 33110 3. R36's Resident to resident Initial Investigation, dated 2/26/24, documented that V34, Licensed Practical Nurse (LPN), heard yelling coming from the dining area. She went to assess and noted R36 laying on her back against a chair with staff in between her and a peer. R36 voiced that R35 had taken her bag from a table in the dining room. When R36 attempted to retrieve her belongings R35 had pushed her away and hit her (R36). R35 voiced that she grabbed R36's hair, resulting in them falling back on to chair. During this investigation, attempted to call V34 was unable to reach her and R36 refused interview. R35, when interviewed, didn't remember the incident. An Investigation was requested from the facility, and V1 stated I have called the former staff, and they were not helpful this is the only investigation we have. The final report staff and resident interviews were not provided. R36's Initial Report, dated 5/9/23, documented, This writer was made aware by the Assistant Administrator that resident reported being physically touched by a staff member. Resident states a staff member physically touched her. Bruising noted with bright red blood to right lower extremity. Resident refused care at this time. R36's Clinical Record was reviewed and an investigation into this injury of unknown origin was not found, and when requested, an investigation into the injury of unknown origin was not provided by the facility. 4. R88's Nurses Note, dated 8/12/23, documented, Resident complained of lower back pain, NP (Nurse Practitioner) notified. N.O (New Order) for lidocaine patch and Xray- Lumbar and sacral spine 4 view. R88's Nurses Note, dated 8/13/23, documented, Resident returned to facility with new orders for (Hydrocodone/Acetaminophen 5milligrams (mg)-325mg as needed every 6 hours due to) Cat Scan results fracture vertebrae. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R88's Nurses Note, dated 8/14/23, documented, Resident came to nurses station and stated that she is having back pain. R88's Clinical Record was reviewed during this investigation and there was not an investigation for injury of unknown origin found and no investigation to injury of unknown was provided by V1 Administrator or V2 Director of Nursing when they were asked for it. The facility policy Abuse Prevention program, dated 2/2017, documented, For resident injuries not involving an allegation of abuse or neglect, the administrator will appoint a person to gather further facts to make a determination as to whether the injury should be classified as an injury of unknown source. an injury should be classified as an injury of unknown source when both of the following conditions are met. The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident. The injury is suspicious because of the extent of the injury, or the location of the injury is located in an area not generally vulnerable to trauma or the number of injuries observed at one particular point in time or the incidence of injuries over time. 34964 5. R39's Progress Note, dated 8/19/2023 at 5:38 PM, documented, Approximately 1530 (3:30 PM) this said RN (Registered Nurse) was down the hall when I heard a loud voices coming from the 300 hall. I ran to assist, and that is when I saw (R85) on the floor with CNA holding (R85's) wheelchair. CNA stated that he stopped (R39) from hitting (R85) with the wheelchair, and that (R39) had thrown/knocked (R85) out of his wheelchair. I assessed the situation and called 911 believing that (R39) was still a threat to others. While on the 911 call, I notified the Administrator, DON, NP (Nurse Practitioner) for DR (doctor). The Facility's Incident Report, dated 8/19/24 at 4:19 PM, documented, Nursing Description: As told by the 400 Hall CNA resident, (R85) was thrown out of his w/c (wheelchair) by another resident (R39) to the floor. Resident Description: As told by the resident he was thrown out of his w/c by another resident. Immediate Action Taken: Both residents were separated from each other by staff. No other information regarding investigation of this resident-to-resident altercation were provided by the facility when requested. On 04/12/24 at 12:57 PM, V1, Administrator, stated that he has not been able to locate the investigations surveyors have requested of the resident-to-resident abuse investigations and abuse investigations. He continued to state that he has reached out to the two previous administrators, who stated the investigations should be here, but he has looked in all the file cabinets and closets and the abuse investigations are not here anywhere. 6. On 4/11/24 at 11:18 AM, R50 was lying on his bed. He had a crusty yellow scab at the base right first finger with no dressing or drainage noted. R50 shook his head when asked if he had any pain in his right hand from being bit. R50's Progress Note, dated 2/1/2024 at 12:08 PM, documented, Resident noted with blood stains on his coat. Resident assessed for injuries and noted abrasion to right hand. MD (Medical Doctor) notified new orders clean with wound cleaner and apply Triple Antibiotic Ointment daily until healed. Resident is own responsible party. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R50's Progress Notes, dated 2/9/2024 at 2:50 PM, documented, Resident changed rooms; resident notified and aware; resident own responsible party; attempted to call (R50's family) but the number was disconnected; called placed to (R50 family) with no answer; (R50 family) called and notified of room change; said he would let the family know; no concerns voiced. On 4/10/24 at 3:00 PM, V2, Director of Nurses, stated that she has not been able to find any abuse investigations regarding abuse allegations or resident to resident physical altercations involving R50. Incident Report, dated 2/1/24 at 8:30 AM, documented, Nursing Description: Resident was bit by peer (R30). Refused to go to the hospital. Resident Description: Resident unable to give description. Immediate action taken: Description: Immediately separated, both refused to go to the hospital. Both skin assessed. NP (Nurse Practitioner) notified. Injuries Type: No injuries observed at time of incident. This incident report documented that R50 was alert and ambulatory without assistance. Incident Report, dated 9/30/23, documented, Nursing Description: Resident was seen in bed laying down with his roommate standing over him yelling about being hit. Resident description: Stated he did not do anything to that man. Immediate Action Taken: Resident was put on a one to one; and rooms are being changed. Mental status: Oriented to person; Predisposing Environmental Factors: Other; Predisposing Physiological Factors: Non-compliant with safety guidance, recent change in cognition, and Predisposing Situation Factors: Recent room change. R50's Incident Report, dated 9/28/24 at 2:01 AM, documented, Nursing Description: CNA (Certified Nursing Assistant) shouted out to this nurse that they were fighting. This nurse entered the room and observed this resident and another punching each other in the face and chest area while in the bathroom. I attempted to close the bathroom door to cease the fighting and this resident put his feet in the door in attempts to reopen. The other resident has sat down and calmed himself at this this time. This resident was then screaming, I said turn off the lights, turn them off. I asked the resident to if he could stop screaming in attempts to not awake other sleeping residents. He then responded, F**k you, you, you, you I will kill all you guys. Several attempts were made to redirect/calm this resident by it only agitated him even more, so I allowed him space to calm himself. Resident still at this time continued screaming, making gestures and threats. Resident Description: Unable to give description. Immediate Action Taken: Residents were separated. The aggressor was escorted from the room to ensure safety of other residents. MD called/texted. Management contacted. EMS (Emergency Medical Services/Police contacted. Resident sent to Gateway for a psych eval. This incident report documented that R50 was ambulatory without assistance, oriented to person, place, time and situation. Predisposing Environmental Factors: other, poor lighting. Predisposing Situation Factors: Dislikes roommate, recent room change. Incident Report, dated 9/9/24 at 4:00 PM, documented, Nursing Description: resident was seen by a staff member blood on resident masked. This nurse examines all that I could. Resident was angry yelling. A scratch examined on resident nose and under eye. Resident description: Resident states a guy hit him, and he fell . Resident stated he does not know who hit him. Immediate Action Taken: Skin assessed. 2 small scratches noted under his eye near his nose. Skin cleansed with normal saline. Physician, police, and resident's responsible party resident sent to ER (emergency room) for eval and treatment. Predisposing Environmental Factors: other. Predisposing Physiological Factors: confused, gait imbalance. Predisposing Situation Factors: Ambulating without assist. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R50's Progress Note, dated 9/9/2023 at 3:07 PM, documented, Note Text: resident was seen by a staff member blood on resident masked. This nurse examined all that I could. Resident was angry, yelling. A scratch was examined on resident nose and under eye. R50's Progress note, dated 9/30/23 at 7:11 AM, documented, Resident roommate c/o being physically assaulted by him. Resident denied allegations of abuse. Resident was yelling w/ roommate; roommate stated that he was struck by Rusty; MD was notified, order was given to send resident to ED for eval of altered mental status; [NAME] PD were called to assist EMS; resident's roommate filed report; this resident refused to go to ED for eval; residents were separated immediately, this resident remains on one to one; MD made aware of changes. During this investigation, V2, DON, could not provide incident report for this incident when she provided other incident reports for him (V50) on 4/10/24. On 4/11/24 at 11:08, V16, LPN/Scheduler stated that she did the incident report on 2/1/24 when R30 bit R50 on his hand but she did not witness what happened and could not remember who she reported it to her. She continued to state that she did not know anything about R50 being hit by another resident on 9/9/23 causing facial fractures. On 4/11/24 at 11:25 AM, V21, Corporate Nurse and V22, Corporate Traveling Administrator, both stated that they do not have any investigations for abuse allegations or resident to resident altercations for R50. V21 also stated, We have given you (surveyors) everything we can find. We have looked everyplace for investigations and have not found them. On 04/12/24 at 12:57 PM, V1, Administrator, stated that he has not been able to locate the investigations surveyors have requested of the resident-to-resident abuse investigations and abuse investigations. He stated he has reached out to the two previous administrators who stated the investigations should be here, but he has looked in all the file cabinets and closets and the abuse investigations are not here anywhere. 7. The facility reportable to the State Agency, dated 3/30/24 at 12:23 PM documented, Resident/ Victim/Perpetrator(R63/R24) Initial Incident Description: Resident reported that he got into an argument with another resident over the food cart and the other resident poked him and hit him. Residents were separated and assessed for injury and minor injury was treated. Residents monitored to prevent recurrence. The Initial Report documented that R63, as the victim and R64, as the perpetrator. (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 Follow-up Investigation Report, undated, documented, The victim describes the incident as a disagreement over the access to the hallway meal cart during lunch. The victim states that he asked the other party to close the door to the cart and not to take food out of it. This discussion escalated to a verbal argument followed by the other resident approaching the victim and, with cupped hands, shoving his hands into the neck area of the victim and lightly poking him with a fork. Victim said there were no staff or residents present as the location was out of view of the nursing staff at the time. The victim stated that the other resident said he was allowed to access the cart. The victim displayed no expression of distress after the incident and during the follow up discussion with the Administrator on 4/1 and 4/2. He appeared to be in good spirits and expressed understanding of the other residents' initial actions due to the misunderstanding of the access allowed to the meal cart by residents. It continues, The resident is not cognitively able to express himself as to the intent of his actions due to a past brain injury but is alert. It continues, Based on staff interviews there were no additional reports of similar incidents uncovered involving these or other residents. A staff member did indicate that the victim has a history of directing other residents and that the alleged perpetrator coincidentally does not take direction well from other resident. Conclusion statement, Not verified. Unsubstantiated. It continues, The facility residents have diagnosis of bipolar, depressive disorders and behavior histories. The investigation uncovered the source of the altercation as a misunderstanding of the facility procedures for access to the hallway meal cart rather than a deliberate attempt by the alleged perpetrator to willfully harm the victim. The victim expressed this in his statements as well. The injury sustained by the victim were relatively minor and required basic first aid and apparently resulted from an initial verbal disagreement. Upon further discussions, the victim expressed no fear or feelings of being unsafe. Based on review of the medical records, resident history, as well as the disagreement involved and related to his need for behavior intervention plan, which is in place. At this point the police report has not been received but has been requested by the facility. If there are changes to the results of the investigation based on the content of the police report, the final report will be adjusted. On 4/17/24 at 2:55 PM, V1, Administrator stated that he did not feel abuse was substantiated in regard to the incident between R63 and R64 because, based on the facility's population, there was no willful intent to cause harm. V1 also stated that R63 likes to tell others what to do and R64 does not like anyone to direct him. V1 stated that there was superficial harm when R64 scratched R63 on the right cheek, but due to there being no intent, abuse is not substantiated. The Facility Abuse Policy and Prevention Program, dated 2022, documented, This facility affirms the right of our residents to be free from abuse, neglect, exploitation, and misappropriation of property, deprivation of goods, and services by staff or mistreatment. The facility will take steps to prevent potential abuse while the investigation is underway. Residents who allegedly abused another resident shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement considering his and her safely as well as the safety of other residents and employees of the facility. In addition, the facility shall take all steps necessary to ensure the safety of residents including but not limited to the separation of residents. The Long-Term Care Facility Application for Medicare and Medicaid form, dated 4/9/24, documented that there are 112 residents that reside in the facility.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 35156 Based on interview and record review the Facility failed to ensure there was sufficient qualified nursing staff available at all times to ensure timely medication administration for five of five residents (R27, R61, R63, R64, R102) reviewed for sufficient staffing in the sample of 59. Findings include: On 4/16/2024 at 8:00 AM, schedules and timecards were requested for all staff working in the facility on Sunday 4/14/2024 on the day shift. On 4/16/2024 at 2:02 PM, R102 stated, On Sunday 4/14/2024 there was no nurse on my hall. I live on the 100-hall. In fact, my buddy, (R63) needs insulin, and he did not get his insulin on Sunday because there was no staff passing out medications on the 100-hall. Nobody on my hall got any medication until the lunch service because we did not have a nurse. There was no nurse working on the 100-hall. On 4/16/2024 at 2:25 PM, R63 stated, On this past Sunday (4/14/2024) there was no nurse on the 100-hall. I am diabetic, I did not get my insulin or any medication on Sunday morning. I am not sure why there was no nurse passing out medications in the morning. I am diabetic and they are supposed to be checking my blood sugar levels. Good thing my sugar levels were good because there was no nurse around if I would have needed one. On 4/16/2024 at 2:32 PM, R27 stated, I am diabetic, and staff are supposed to check my sugar levels and give me the right amount of insulin. I am supposed to get the insulin at meals. On Sunday there was not any nurse on our hall. I live on the 100-hall. Nobody got their medicine Sunday morning because we did not have a nurse. On 4/16/2024 at 2:35 PM, V16, Licensed Practical Nurse (LPN) stated, I was on vacation on Sunday, and I am in charge of the schedule, but I was not working Sunday. I was on vacation. I expect staff would be contacting (V2) and (V30) if staff were a no show or did not show up for the scheduled time. I know there was something about not having enough staff on Sunday but again, I was not here. On 4/16/2024 at 2:42 PM, V34, LPN stated, I was working Sunday and we were short staffed. We only had two nurses working the entire building. It was only me and (V52). I did not get to the 100-hall until the afternoon, and I was not able to pass out any AM mediations. (V3, ADON) finally came in to help us but she did not get here until after 1:00 PM. (V52) was working downstairs and I was the only nurse covering upstairs, 100, 200 and 300 halls and we were both going back and forth. On 4/16/2024 at 2:52 PM, V3, Assistant Director of Nursing (ADON) stated, I know the facility was short staffed on Sunday and I came into help. I did not get here until maybe 1:20 PM. I did not pass out any, AM medications. I talked with (V32) and (V52) and they told me they were behind in their morning medications. On 4/16/2024 at 2:59 PM, V1 stated V52 forgot to clock in but she worked a double shift and worked 6 AM to 10:30 PM on 4/14/2024. V3 is salary and does not have a timecard. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staffing schedules were reviewed for 4/14/2024 and document V34 for the 100 and 400 halls, V3 for the 300 hall and V52 working the 200 and 500 halls. R27's, R61's, R63's, R64's and R102's April 2024 Medication Administration Records were reviewed and document on 4/14/2024 medication and blood glucose monitoring were given late or not given. Grievance dated 3/28/2024 documents, Nurse always are late to give meds. The Facility Assessment with a revision date of 4/1/2024 documents, Is licensed for 180 beds with and average daily census of 115. Facility Resources needed to provide competent support and care for our resident population every day and during emergencies, Nursing services, DON (Director of Nursing), RN. The Facility Staffing Policy with a revision date of 8/2022 documents, To have appropriate number of staff available to meet the needs of the residents.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35156 Based on interview and record review, the facility failed to ensure a Registered Nurse (RN) was working in the facility seven days a week, for 8 consecutive hours. This failure has the potential to affect all 112 residents living in the facility. Findings include: On 4/9/2024 at 8:03 AM, staffing schedules were requested from the facility for the past 14 days. On 4/9/2024 at 8:25 AM, V1, Interim Administrator, stated he was filling in as the administrator, but he was not aware of any issues with not having enough Registered Nurses (RN) working in the facility. On 4/10/2024 at 10:13 AM, the staffing scheduled provided were reviewed for RN coverage every day, for 8 consecutive hours for the past 14 days. No RN coverage was documented as working on 3/7/2024. On 4/11/2024 at 10:39 AM, timecards or documentation was requested for any RN coverage for 3/7/2024. On 4/11/2024 at 10:44 AM, RN staffing was provided and documents there was no RN coverage on 3/7/2024. On 4/11/2024 at 10:49 PM, V2, Director of Nursing stated, I have given you all of the timecards for all of the RN coverage for the past 14 days. On 4/11/2024 the timecards provided for RN coverage document there were no RN coverage on 3/1/2024, 3/4/2024 and 3/7/2024. The Facility assessment dated [DATE], documents, (Facility) is licensed for 90 bed Skilled Nursing Facility with the average daily census of 50 residents. RN of LPN Charge Nurse: 1 for each shift. 1-59 residents DON may be Charge Nurse. Licensed Nurses: RN, LPN providing direct care. The undated Staffing Policy documents, It is the policy of (Facility) to provide sufficient licensed and unlicensed nursing staff on each shift of the day to attain or maintain the highest practical physical, mental, and psychosocial well-being of each resident. Nurse staffing shall be based upon resident evaluation by the Administrator and Director of Nursing as specified by the Illinois Department of Public Health. The Facility's Long-Term Care Facility Application for Medicare and Medicaid form, dated 4/9/2024, documented the facility had a census of 112 residents.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 34964 Based on interview and record review, the facility failed to administer medications and perform blood glucose monitoring as ordered by the physician for 5 of 5 residents (R27, R61, R63, R64 and R102) reviewed for Pharmacy Services in the sample of 59. Findings include: 1. R27's Medication Administration Record (MAR) dated April 2024 documents the orders for the following medications to be administered during the morning medication pass: Humulin R Insulin to be administered per sliding scale order before meals at 7:00 AM, 11:00 AM, 4:00 PM and 8:00 PM. R27's blood glucose monitoring flow sheet documents he did not get his 7:00 AM blood glucose monitoring on 4/14/24 as ordered. 2. R61's Medication Administration Record dated April 2024 documents the orders for the following medications to be administered during the morning medication pass: Insulin Aspart FlexPen Subcutaneous-Inject 15 units three times a day for diagnosis of Type 2 DM. R61's Treatment Administration Record documents his blood glucose monitoring was not performed on 4/14/24 at 8:00 AM as ordered. 3. R63's Medication Administration Record dated April 2024 documents the orders for the following medications to be administered during the morning medication pass: Amlodipine 10 milligrams (mg), Aspirin Enteric Coated 81 mg, Lexapro 20 mg , Lipitor 20 mg, Buspirone 5 mg, Docusate Sodium 100 mg, Metformin 500 mg, Symbicort Inhaler 2 puffs, Torsemide 40 mg, Gabapentin 600 mg, and Insulin Lispro 14 units SQ, and also Insulin Lispro per sliding scale. The MAR does not document that R63 received any of his AM medications or his blood glucose monitoring that was ordered for 8:00 AM on 4/14/24. 4. R64's Medication Administration Record dated April 2024 documents the orders for the following medications to be administered during the morning medication pass: Olanzapine 5 mg, Lidoderm Patch 5% to be put on in morning, Ferosol 325 mg, Multivitamin, Famotidine 20 mg , Vitamin B 12, Sodium Chloride 1 Gram, Flonase Nasal Spray one spray each nostril, Metformin 1000 mg, Depakote 750 mg, Levetiracetem 1000 mg, Metoprolol 12.5 mg, Fluoxetine 30 mg, Vimpat 200 mg, and Insulin Lispro per sliding scale. The MAR does not document R64 received any of his medications ordered at 8:00 AM on 4/14/24 and did not document R64 received his blood glucose monitoring at 8:00 AM or 11:00 AM on 4/14/24 as ordered. 5. R102's Medication Administration Record dated April 2024 documents the orders for the following medications to be administered during the morning medication pass: Bupropion 150 mg, Celexa 20mg, Lisinopril 5 mg, Omeprazole 20 mg, Metformin 500 mg, Buspirone 7.5 mg, and Hydroxyzine 50 mg. The MAR does not document R102 received any of his ordered medications at 8:00 AM as ordered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/16/24 at 1:54 PM R102 stated there was no nurse on the 100-Hall on Sunday, April 14, 2024, and he did not get his medications until after lunch. R102 came and requested to speak to surveyors on 4/16/24 at 1:54 PM stating he had some concerns. R102 stated there was no nurse on the 100-hall on Sunday and he did not get his medications until after lunch, around 1:00 PM, when a nurse from the other hall came to administer his medications and other residents' medications on the hall. R102 stated he heard one of the other residents, (R63) arguing with the nurse because he had not gotten his blood glucose monitoring or insulin in the morning like he was supposed to. On 4/16/24 at 2:16 PM V7, Licensed Practical Nurse (LPN), stated she worked the afternoon shift on Sunday, 4/14/24 on the 200-Hall and could not recall what nurse she relieved. V7 stated there was another nurse who came in for the afternoon shift for the 100-hall, but she did not know who worked days on the 100-hall. On 4/16/24 at 2:21 PM V16, LPN, stated she is working the 100-Hall today and no residents complained to her about not getting their medications on the weekend. She stated she would usually be notified if a nurse did not show up to work, but she was on vacation so they wouldn't bother her. She stated she didn't know anything about a nurse not showing up for day shift on the weekend. On 4/16/24 at 2:25 PM R63 stated he did not get his medications on Sunday morning, including not getting blood glucose monitoring to see if he needed insulin. R63 stated the day shift nurse did not show up and he didn't get any medications. He stated a nurse came over to the 100-Hall at 10:30 AM or 11:00 AM to administer his medications and he told her it was too late for his blood glucose monitoring and insulin and stated he did not take any medications at that time because they were so late. R63 stated his blood sugar was not checked until 10:30 PM that night. R63 stated he was upset about not getting his medications like he was supposed to. On 4/16/24 at 2:35 PM V55, Nurse Practitioner-Cardiac Division stated she would expect medications to be given as ordered. She stated she monitors cardiac conditions, including congestive heart failure, and watches residents' weights. She stated if a resident had a weight gain noted day to day, she would want to know if that resident was receiving their blood pressure medications and diuretics as ordered or if that could be the cause of the weight gain. On 4/16/24 at 3:25 PM V34, LPN stated she worked a double shift from Saturday 4/13/24 at 10:30 PM to Sunday through the day shift. She stated she was working on the 400-Hall and no nurse showed up to work the 100-Hall or 200-Hall on day shift on Sunday. V34 stated she and one other nurse, V52, LPN were the only two nurses in the facility, and V52 was working downstairs. V34 stated after she finished passing medications on her own hall (400) she went over to the other side and tried to get some of the medications done over there. V34 stated R63 was upset about his medications being late and refused to take them for her at about 10:30 AM. On 4/16/2024 at 2:52 PM, V3, Assistant Director of Nursing (ADON) stated, I know the facility was short staffed on Sunday and I came into help. I did not get here until maybe 1:20 PM. I did not pass out any, AM medications. I talked with (V32) and (V52) and they told me they were behind in their morning medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's policy, Medication Administration, reviewed 4/2024, documents, General: All medications are administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms, and help in diagnosis. 6. Check medication administration record prior to administering medication for the right medication, dose, route, patient/resident, and time.