STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145319	A. Building B. Wing	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arc at El Paso	555 East Clay El Paso, IL 61738

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49187 Based on interview and record review, the facility failed to ensure a resident with new diagnoses of mental illness after admission was referred to the state agency for a level II PASARR (Preadmission Screening and Resident Review) evaluation for one of two residents (R7) reviewed for PASARR screening in the sample of 36. Findings include: The facility's Preadmission Screening and Annual Resident Review (PASARR) Policy, dated 3/2024, documents, It is the policy to screen all potential admissions on an individualized basis. As part of the preadmission process, the facility participates in PASARR level I for all new and readmissions per requirements to determine if the individual meets the criterion for mental disorder (Severe Mental Illness/Severe Mental Disability), intellectual disability or related condition. Annually and with any significant change of status, the facility will complete the PASARR level one screen for those individuals identified per the Level II screen requiring specialized services. R7's Admission Record, dated 3/25/25, documents, R7 admitted to the facility on [DATE]. R7's most recent Level 1 PASARR evaluation, dated 1/23/2023, documents Diagnoses: Mental Health Diagnoses: No mental health diagnosis is known or suspected. This same Level 1 PASARR evaluation documents Review date: 1/23/23. PASARR Level 1 Determination: No Level II Required- No Suspected Mental Illness, Intellectual Disability, or Related Condition. R7's Current Medical Diagnoses list, dated 3/25/25, documents R7 has been diagnosed with the following diagnoses at or after admission: Major Depressive Disorder 3/17/23 and Psychotic Disorder with Hallucinations due to known Physiological Condition 1/26/23. R7's medical record does not document R7 had any further PASARR screening or evaluation since admission to the facility or after R7's new diagnoses of Major Depressive Disorder and Psychotic Disorder with Hallucinations due to known Physiological Condition. On 3/25/25 at 11:20 AM V3/Social Service Director verified that R7 has not had a PASARR re-screen since admission or a level II screening. V3 stated, (R7) was actually on my list to submit for a new screening due to her new diagnoses after she admitted to the facility. I just did an audit and realized she does need a new PASARR screening done.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 50627 Based on observation, interview, and record review the facility failed to follow a Physician's Wound Order for one of two residents (R47) reviewed for wound care in a sample of 36. Findings Include: The Facility's Pressure Injury and Skin Condition Assessment Policy, dated/revised 01/2018, documents, Physician ordered treatments shall be initialed by the staff on the electronic Treatment Administration Record after each administration. Other nursing measures not involving medications shall be documented in the weekly wound assessment or nurses noted. R47's Physician Order Sheet, dated 3/19/2025, documents Non-Pressure Wound of the Right Second toe. Dressing Treatment Plan, Primary Dressing: Betadine apply once daily for 23 days. Secondary Dressing: Gauze Island with border apply once daily for 23 days. On 3/25/2025 at 11:06 AM, V11 (RN/Registered Nurse) entered R47's room. V11 removed R47's right foot sock. A pea sized black, dry, and crusted area was noted to R47's right 2nd toe knuckle. V11 used 4x4 gauze saturated with normal saline and cleansed R47's wound. V11 then opened a package with a cotton swab saturated in Betadine and wiped R47's right toe wound. V11 then placed R47's right sock back on her foot without placing the physician ordered dressing. On 3/25/2025 at 11:30 AM, V11 confirmed she did not place any protective island dressing on R47's wound after the Betadine. V11 stated, I followed the wound order in R47's chart, I was not aware this was incorrect. On 3/25/2025 at 11:40 AM V13 (Licensed Practical Nurse/Infection Preventionist) stated, I am the one who reviews wound orders and enters them into resident's charts. I did not see the updated order, and the previous order was entered wrong. I missed this.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49187 Based on observation, interview and record review the facility failed to date oxygen tubing and bag when not in use, place an oxygen sign on resident doors, and ensure a nebulizer facemask and tubing was changed weekly for four of five residents (R2, R6, R7, R11) reviewed for respiratory care in a sample of 36. Findings include: The facility's Oxygen and Respiratory Equipment-Changing/Cleaning Policy, dated 10/2024 documents Purpose: 1. To provide guidelines to employees for changing all disposable respiratory supplies. 2. To ensure the safety of residents by providing maintenance of all disposable respiratory supplies. 3. To minimize the risk of infection transmission. Procedure: 1. Handheld Nebulizer and Mask, if applicable: a. The handheld nebulizer should be changed weekly and as needed. b. A clean plastic bag with a zip lock or draw string, etc. (etcetera). should be changed weekly and as needed. 2. Nasal Cannula. a. Nasal cannulas are to be changed once a week and as needed. b. Whenever possible, residents using a portable oxygen tank, will be switched to a room oxygen concentrator while in their room. c. A clean plastic bag with a zip lock or draw string, etc. will be provided to store the cannula when it is not in use. It will be dated with the table the tubing was changed. 1. R6's Order Summary Report, dated 3/25/25, documents an order for Ipratropium Bromide Inhalation Solution 0.2% (percent) one vial as needed. On 3/23/25 at 10:00 AM R6 was sitting in her chair in her room. R6's nebulizer mask and tubing were lying on R6's bed undated and un-bagged. 2. R7's Order Summary Report, dated 3/25/25, documents an order for R7 to receive Oxygen at 3 liters via nasal route continuous every shift. On 3/23/25 at 12:15 PM R7's room had an oxygen concentrator with a nasal cannula tubing connected that was lying on R7's bed. The nasal cannula was un-dated and un-bagged. No oxygen sign was observed outside of R7's room. R7 was sitting in the hallway right outside of her room. R7 had on a nasal cannula hooked to a portable oxygen tank flowing with oxygen. R7's nasal cannula tubing was undated. 3. R11's Order Summary Report, dated 3/25/25, documents an order for R11 to receive Oxygen at 2 to 4 liters per nasal cannula to keep oxygen above 91% every shift. This same report documents an order for R11 to receive Albuterol Sulfate Inhalation Nebulization Solution (2.5mg (milligrams)/3ml (milliliters) 0.083% one dose inhale orally via nebulizer four times a day. On 3/23/25 at 9:49 AM R11 was sitting in her wheelchair in her room eating breakfast with oxygen flowing via nasal cannula. R11's nasal cannula was undated. Behind R11's bed was a nebulizer machine with a nebulizer mask/tubing attached to the machine lying on the floor un-dated and unbagged. No oxygen sign was observed outside of R11's room. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/23/25 at 10:58 AM V8/Agency Licensed Practical Nurse (LPN) verified R6's nebulizer tubing/mask was un-dated and un-bagged, R7's room had no oxygen sign outside of the door, R7's oxygen tubing was un-dated and un-bagged when not in use, R11's room had no oxygen sign outside of the door, R11's oxygen tubing was un-dated, and R11's nebulizer tubing/mask was un-dated and un-bagged. V8 stated, All respiratory equipment should be changed and dated every seven days and bagged in-between uses and anytime a resident is on oxygen an oxygen sign should be place outside of the residents room. 32875 4. R2's Face Sheet documents R2 is a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus without Complications, Sleep Apnea, Dysthymic Disorder, Diverticulum of Esophagus, Acquired, Pneumonitis due to Inhalation of Other Solids and Liquids. R2's Physicians Orders printed 3/24/25, documents Oxygen at three liters every night shift related to Other Specified Chronic Obstructive Pulmonary Disease. Order date 2/17/25. Change humidifier bottle and nasal cannula weekly on Sunday night shift. Start date 2/9/2025. On 3/23/25 at 9:35 AM, R2 was sitting in her wheelchair with her head resting on the overbed table. R2's oxygen tubing was not labeled with the date or initials. On 3/23/25 at 10:50 AM, V8/Agency Licensed Practical Nurse/LPN verified R2's oxygen tubing were not labeled with the date or initials.

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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. 38396 Based on interview and record review, the facility failed to provide eight consecutive hours of a Registered Nurse, daily. This failure has the potential to affect all 49 residents residing in the facility. Findings include: The facility's Facility Assessment Tool, dated 7/1/2024, documents the facility will provide a Registered Nurse (RN) as required with CMS (Centers for Medicare and Medicaid Services) minimum staffing requirements (eight consecutive hours per day). The facility's nursing staff schedule for March 2025, documents on 3/23/25 the facility did not have eight hours of an RN staffed in the facility. The facility's daily staff posting documents on 3/23/25, the facility was staffed with Licensed Practical Nurses (LPN) and documents no Registered Nurses provided resident care throughout 24 hours. On 3/25/25 at 1:45 PM, V1 (Administrator) confirmed the daily staff postings provided for March 2025 are accurate. On 3/26/25 at 11:16 AM, V13 (LPN/ Infection Control Preventionist) confirmed that she has been doing some nursing assistant schedules and Director of Nursing duties for an interim time period. V13 confirmed the facility did not have RN coverage on Sunday, 3/23/25. V13 stated, If the daily staff sheet documents no RN was working, that is accurate. We have been short an RN every other weekend on several occasions. The facility's Long-Term Care Facility Application for Medicare and Medicaid form dated 3/23/25 and signed by V1 (Administrator), documents 49 residents currently reside within the facility.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49187 Based on observation, interview and record review, the facility failed to ensure prepared refrigerated foods were labeled and dated with an expiration date, opened foods were stored in covered containers to prevent contamination, the kitchen floor/dry storage room floor were kept clean and free of debris, and kitchen surfaces were kept free from dust and debris. These failures have the potential to affect all 49 residents in the facility. Findings include: The facility's Food and Supplies: Storage Policy, dated 1/2024, documents, Policy: Food and supply storage areas shall be maintained in a clean, safe and sanitary manner. Procedures: 1. Food services will maintain clean food storage areas. 4. Prepared foods stored in the refrigerator until service will be covered, labeled, and dated with an expiration date. 6. All foods will be covered, labeled, and dated. If there is no expiration date on the package or container, a use-by date must be written on the product. The facility's Dry Storage Policy, dated 3/2025, documents, Dry storage areas will be kept neat, orderly, and in a condition which protects foods in a safe and sanitary manner. Procedure: 6. Floors will be swept daily and mopped at least weekly. The facility's Kitchen Sanitation Manual Policy, dated 9/2023, documents, Policy: The kitchen will be maintained in a clean and sanitary condition. The state and/or federal food code will be maintained on file within the food service department and will be the basis of all sanitation and food safety practices. 13. Sanitation is the entire departments responsibility. The facility's Cleaning and Sanitizing in Place Policy, undated, documents, Fixed equipment, utensils, and equipment too large to be cleaned in sink compartments will be washed manually or cleaned with a pressure spray method, rinsed, and then sanitized by spraying or swabbing with chemical sanitizer. Procedure: 1. Food service workers who use the equipment will be responsible for washing, rinsing, and preparation, food service areas, storage areas, and dish room. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/23/25 at 9:24 AM the kitchen was entered and toured with V6/Cook. In the walk in cooler there was a clear three liter container of green beans with a lid , pre made ham salad (according to V6) in a large metal container with a lid 1/2 full , two large cake pans of fruit crisp uncovered, a large metal pan 1/2 full of cooked cabbage with a lid, peeled potatoes in a square metal pan with a lid and a large metal pan 1/2 full of green gelatin with a lid. None of these items were labeled with an expiration date. V6 verified none of the prepared refrigerated items had a label with an expiration date and should have. V6 also verified the pans of fruit crisp were uncovered and anything prepared and stored in the refrigerator should be covered. In the dry storage room, the floor was covered in dirt and debris along with six cigarette butts scattered in the middle of the dry storage room floor. V6 verified the floors were covered with dirt and debris and cigarette butts were lying on the floor. V6 stated, I don't know why the floor is dirty like this, it should have been swept and mopped yesterday. The cigarette butts must be from a chair we take in and out from smoking. I didn't even notice them on the floor. The kitchen floor was observed to have dirt, debris, old food, and crumbs underneath the preparation tables. The four-burner stove had thick grease splatter built up on the stove and the inside of the left oven beneath the stove had black thick crusted matter built up inside of the stove. A shelf located above the kitchen stove was covered in dust and debris. The shelf underneath the steam table located in the kitchen had built up dust and debris where the pans were being stored. V6 verified the kitchen stove, the oven, the floors underneath the preparation table, the shelf above the stove, and the shelf underneath the steam table all needed cleaned. The facility's Long-Term Care Facility Application for Medicare and Medicaid form dated 3/23/25 and signed by V1 (Administrator), documents 49 residents currently reside within the facility.

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F 0847 Level of Harm - Potential for minimal harm Residents Affected - Many	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 32875 Based on interview and record review, the facility failed to explain the arbitration agreement to the resident, or their representative in a form or manner they could understand. This had the potential to affect all 49 residents residing in the facility. Findings include: On 3/26/25 at 1:22 PM, V1/Administrator stated that there is not an Arbitration Agreement policy. The Arbitration Agreement (not dated) documents, Binding Arbitration is private, less costly, and less time-consuming than traditional litigation. The parties agree to submit their dispute to an impartial arbitrator authorized to resolve the controversy(s) by rendering a final and binding decision(s). Which can be enforced by the court. On 3/23/25 at 11:44 AM V3/Social Service Director stated, I have done the admissions since around September of 2024. The resident and Residents Power of Attorney are shown a video and given the contract where they can sign or not sign. I tell them if there are any concerns we encourage them to use arbitration instead of a lawyer. No one has declined to sign the arbitration. V3 was asked if she tells the resident/resident representative that they are giving up the right to sue the facility. V3 stated, No, those words have never come from my mouth. On 3/24/25 at 11:46 AM, V9, R16's Power of Attorney/POA stated, I don't know what an arbitration agreement is and do not know if I signed it. V9 was asked if she would have wanted to sign it if she knew she was giving up the right to sue the facility if there was an issue. V9 stated, I would not have signed the agreement; I am not one to sue but you never know what may happen. R16's Contract between Resident and Facility, dated 3/8/24, documents that V9 (R16's Power of Attorney) signed the binding arbitration agreement. The Resident Council Meeting was held on 3/25/25 at 10:15 AM. R1, R2, R7, R14, R37, and R41 attended the meeting. They were asked if they knew what an arbitration agreement was. All six residents stated that they did not know what arbitration meant and it was never explained to them. R1 stated that she had just admitted within the last 30 days and if it was signed R1 wants it changed. R1's Contract between Resident and Facility, dated 2/27/25 documents that R1 signed the binding arbitration agreement. On 3/25/25 at 11:06 AM, V10/Ombudsman stated, (R1) was so shocked and upset when she heard what the Arbitration Agreement meant (R1) was ready to call her family to make sure it got changed because (R1) is still within her 30-day time frame. The facility's Centers for Medicare & Medicaid Services/CMS-671 Long Term Care Facility Application for Medicare and Medicaid signed by V1 (Administrator) and dated 3/23/25 documents 49 residents currently reside in the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49187 Based on interview, observation, and record review, the facility failed to ensure Enhanced Barrier Precautions were implemented for five of five residents (R2, R10, R17, R47, and R51) reviewed for infection control in a sample of 36. The facility's Enhanced Barrier Precautions Policy, dated 3/2024, documents, Statement of Purpose: Enhanced Barrier Precautions (EBP): recommendations now include 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. Personnel: Personnel providing direct care. Personal Protective Equipment: Gown and gloves. Policy: EBP may be considered and implemented for: Wounds and/or indwelling medical devices (central line, feeding tube, tracheostomy, drains etc. (Etcetera). Infection or colonization with a novel or targeted multi-drug resistant organism when contact isolation does not apply. At discretion of the Infection Preventionist. Personal Protective Equipment. Standard Precautions must be followed with all cares. 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. 1. R10's Order Summary Report, dated 3/26/25, documents the following order: Cleanse Deep Tissue Injury to buttocks with wound cleanser and pat dry. Apply (medicated honey gel) to wound bed and cover with dry dressing every day shift and as needed. On 3/25/25 at 9:45 AM V12/Registered Nurse performed wound care to R10's right buttock. R10's wound had a moderate amount of clear/pinkish drainage noted on the dressing and around the wound. V12 did not wear a gown during R10's wound care. 50627 2. R47's current electronic medical record documents R47 has a scabbed wound on her right foot, second toe. On 03/25/2025 at 11:06 AM, V11 (RN/Registered Nurse) entered R47's room without a gown or gloves. R47's room did not contain a sign or personal protective equipment outside of R47's room for EBP (Enhanced Barrier Precautions). V11 completed a physician ordered wound treatment to R47's right foot, second toe wound. Throughout the wound care, V11 did not wear a gown. 32875 3. R2's Face Sheet documents R2 is a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus without Complications, Sleep Apnea, Dysthymic Disorder, Diverticulum of Esophagus, Acquired, Pneumonitis due to Inhalation of Other Solids and Liquids. R2's Physicians Orders printed 3/25/25, documents an Enteral Feed Order to flush enteral tube every four hours with 150 milliliters of water. Order date 2/14/25. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/25/25 at 11:06 AM V11/RN entered R2's room, washed her hands and applied gloves. V11 did not wear a gown while flushing R2's feeding tube. 38396 4. R17's current Care Plan, dated 3/14/25, documents, (R17) has an actual skin impairment of pressure to right heel and right plantar posterior foot. Enhanced barrier precautions related to chronic wounds. On 3/24/25 at 10:27 AM, R17 was sitting in her room sleeping in a chair. R17's room did not contain a sign to display R17 is in Enhanced Barrier Precautions (EBP). R17's room or doorway did not contain any containers of Personal Protective Equipment (PPE) required for EBP precautions. On 3/25/25 at 10:05 AM, V12 (Registered Nurse) applied gloves and entered R17's room, then completed wound care to R17's right planter posterior foot. Throughout the wound treatment V12 did not wear a gown or any other PPE aside from gloves. 5. R51's current Care Plan, dated 3/11/25, documents a plan of care for Enhanced barrier precautions related to indwelling catheter. On 3/24/25 at 10:32 AM, R51 was sitting in his room, in bed. R51's indwelling urinary catheter drainage bag was hooked to his wheelchair at R51's bedside. R51 stated he has been in the facility for about a month and has had a urinary catheter for the majority of his stay. At this time R51's room, door and entry way did not contain a sign or storage of PPE to alert that R51 is in EBP isolation. On 3/26/25 at 10:45 AM, V13 (Licensed Practical Nurse/ Infection Control Preventionist) stated, EBP should be implemented for anyone who has a hole that isn't natural. Such as wounds, urinary catheters, feeding tubes, central lines etcetera. Staff should wear gloves, mask, and gown for close contact resident care such as changing clothes, incontinence care, ADLs (activities of daily living), wound dressing changes, urinary catheter care etcetera. V13 confirmed R2, R10, R17, R47 and R51 should all be in EBP isolation with door entry signs and PPE outside of their rooms and stated she isn't sure why they don't have those precautions in place.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 38396 Based on interview and record review, the facility failed to offer Covid-19 vaccinations and vaccination education to all employees. This failure has the potential to affect all 49 residents residing in the facility. Findings include: The facility's Interim Covid-19 Vaccination Guidelines - Residents and Employees policy, dated 10/2024, documents, To minimize the risk of residents acquiring, transmitting, or experiencing complications from Covid-19. The facility maintains documentation related to staff Covid-19 vaccination that includes at minimum the following: That staff were provided education regarding the benefits and potential risks associated with Covid-19 vaccine; Staff were offered the Covid-19 vaccine or information on obtaining the Covid-19 vaccine. On 3/26/25 at 10:40 AM V13 (Licensed Practical Nurse/ Infection Control Preventionist) stated she doesn't have documentation to show Covid-19 vaccinations are offered to all employees or to show they are given education related to the Covid-19 vaccination. V13 stated, Staff are told to go to the local pharmacy to get the Covid-19 vaccination if they want it. If we have extra Covid-19 vaccine after giving to the residents, we will offer those to staff but otherwise staff are not offered the Covid-19 vaccination in the facility. We don't ensure that staff get the Covid-19 vaccine offered here, they are expected to pay for it at the pharmacy if they choose to get it. The facility's Long-Term Care Facility Application for Medicare and Medicaid form, dated 3/23/25 and signed by V1 (Administrator), documents 49 residents currently reside within the facility.

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Arc at El Paso	555 East Clay El Paso, IL 61738

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 38396 Based on interview and record review, the facility failed to ensure Certified Nursing Assistants (CNA) were provided and completed Dementia training in a 12 month period. This failure has the potential to affect all 49 residents residing in the facility. Findings include: The facility's Facility Assessment tool, dated 7/1/24, documents the facility cares for residents with Cognitive loss/ Dementia. This policy also documents, Required in-service training for nurse aides. In-service training must: Be sufficient to ensure the continuing competence of nurse aides but must be no less than 12 hours per year. Include dementia management training and resident abuse prevention training. On 3/25/25 at 11:45 AM, V1 (Administrator) provided a 12 month yearly training report for V18, V19 and V20 (Certified Nursing Assistants, CNA). These reports do not include documentation that V18, V19 or V20 have completed Dementia training from March 2024- March 2025. On 3/25/25 at 1:45 PM, V1 confirmed several residents in the facility have a diagnosis of Dementia and he does not have documentation to show that CNAs have been provided Dementia training. V1 stated I just started in January, and I wasn't aware of the lack of training but it appears none of the CNAs have had Dementia specific training in the past 12 months. The facility's Long-Term Care Facility Application for Medicare and Medicaid form dated 3/23/25 and signed by V1 (Administrator), documents 49 residents currently reside within the facility.