

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145389	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2026
NAME OF PROVIDER OR SUPPLIER Arcadia Care Watseka		STREET ADDRESS, CITY, STATE, ZIP CODE 715 East Raymond Road Watsaka, IL 60970	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** Failures at this level required more than one Deficient Practice Statement. A. Based on observation, interview, and record review, the facility failed to protect the residents' right to be free from sexual abuse by another resident, failed to identify repeated sexual predatory behaviors and implement interventions to address these behaviors for R9, resulting in psychosocial harm of R10 and R11, who voiced expressions of fear of R9, and resulted in R9 sexually abusing R5 and R15, for six (R5, R9, R10, R11, R15) of 14 residents reviewed for abuse in the sample list 20. These failures also put other residents in the facility at risk for psychosocial impact, including not limited to emotional harm, loss of dignity, and feeling afraid, as well as being at risk for further abuse from R9. The Immediate Jeopardy began on 6/11/26, when R9 was witnessed with R9's hand up underneath R5's shirt and R5 was not wearing a bra. V1, Administrator In Training, and V3, Regional Administrator, were notified of the Immediate Jeopardy on 7/1/26 at 10:53 AM. The surveyor confirmed by observation, interview, and record review, the Immediate Jeopardy was removed on 7/7/26, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. B. Based on interview and record review, the facility failed to protect a resident's (R5) right to be free from sexual abuse by R4 and failed to protect a resident's (R2) right to be free from sexual exploitation and mental abuse by an employee (V32, Certified Nursing Assistant). R2 and R5 are two of 14 residents reviewed for abuse in a sample list of 20. These failures resulted in psychosocial harm of R5 and R2. A reasonable person would have feelings of fear and humiliation as a result of the abuse. Findings include: A. The facility's Abuse Prevention and Reporting policy, revised March 2026, documents the facility affirms the residents' right to be free from abuse and therefor prohibits abuse and mistreatment of residents. This policy documents abuse prevention measures including identifying, reporting, investigating occurrences and patterns of potential mistreatment and abuse. The Sexual Capacity to Consent Determination policy, dated January 2026, documents the following: Residents without the capacity to consent to sexual activity may not engage in sexual activity. The Interdisciplinary Team will assess and determine a resident's ability to consent to the sexual activity whenever there is an allegation of resident sexual abuse or other warranted situations. Sexual abuse is any non-consensual sexual contact with a resident, including unwanted intimate touching especially of breasts and perineal areas. The facility's Behavioral Health Services Program, dated March 2025, documents the purpose of the program is to establish a system to identify behaviors and implement appropriate interventions and individualized care plans to ensure each resident receives appropriate treatment and services to (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 - Some	R9's Care Plan, dated 4/9/26, documents R9 wanders into other resident rooms with no new interventions to address this behavior since 2/19/25. R9's care plan does not address any sexual behaviors or behaviors directed towards female residents or interventions to address these behaviors. R9's diagnoses include Unspecified Dementia with Behavioral Disturbances. R9's active behavior tracking does not identify sexual behaviors or predatory behaviors directed towards female residents as R9's targeted behaviors. R9's Nursing Notes document the following: On 12/11/2025 at 10:37 PM R9 had to be redirected out of other resident rooms and will not stop going into them. An unidentified Certified Nursing Assistant (CNA) had to sit in the hallway to keep R9 from going into resident rooms who are sleeping. On 12/12/26 at 10:53 PM R9 had to be redirected out of other resident rooms numerous times while CNA was providing care/showers on another resident. R9 also attempted to lay another resident down in bed. R9 was educated R9 is not allowed to assist other residents and R9 laughed. On 12/29/2025 at 10:57 PM R9 continues to try to lay other residents in bed and R9 was educated. On 2/10/2026 at 11:39 PM R9 continues to go into other resident rooms and R9 attempted to get an unidentified female resident out of her bed after waking her up. R9 was redirected to the television room but then had to be redirected again after entering another resident room. On 4/16/2026 at 10:08 PM R9 was told numerous times to stay out of female resident rooms, R9 continued to go into the rooms waking residents up and attempting to assist a female resident into her wheelchair. R9 opened another female's door after this resident asked R9 to leave her alone, R9 was educated but laughs in your face and continues to do what R9 wants. R9's Progress Note, dated 5/27/26, recorded by V33, Nurse Practitioner, documents R9 as stable with no new behavioral concerns. There is no documentation that R9's intrusive and predatory sexual behaviors were reported to V33 or V18, Physician. R9's Progress Notes recorded by V34, Psychiatry NP, document the following: On 4/28/26 R9 continued to be restless wandering in and out of resident rooms and will touch residents' hands while they are sleeping. R9 was easily redirected but only effective for short duration. An additional dose of Lorazepam (antianxiety) was prescribed in the morning and to continue the scheduled evening dose. On 5/12/26 no medication adjustments were made. On 6/9/26 R9 paces the hallways and enters female resident rooms, and no medication adjustments were made. The facility's abuse log dated January-June 2026 does not document any allegations involving R9. R5's Census documents R5 admitted on [DATE] and discharged on 6/26/26. R5's MDS, dated [DATE], documents R5 has severe cognitive impairment and a diagnosis of Unspecified Dementia with Behavioral Disturbances. R5 wandered daily during the one-week review period. R10's MDS, dated [DATE], documents R10 has moderate cognitive impairment and a diagnosis of Dementia. R10's Care Plan, dated 6/1/26, documents trauma informed care R10 experienced a traumatic event/circumstances of sexual assault when R10 was younger and R10 is at low risk of abuse/neglect per screening. Interventions include to provide a safe and secure environment and emotional support and evaluate interventions. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R11's MDS, dated [DATE], documents R11 has moderate cognitive impairment and a diagnosis of Alzheimer's Disease. R11's Nursing Note, dated 4/16/2026 at 10:22 PM, documents R11 was upset that male resident would not leave R11 alone, R11 pacing in hallway then went to lay in bed and male resident opened R11's door, R11 came out and began pacing again and told male resident to stop bothering R11 but male resident continued until CNA and nurse intervened and went to lay down in his bed. R15's Census documents R15 admitted on [DATE] and expired on 5/28/26. R15's MDS, dated [DATE], documents R15 had severe cognitive impairment and required substantial maximal staff assistance for transfers and bed mobility. R15's Care Plan, dated 6/1/26, documents R15 at high risk for abuse/neglect per screening. On 6/29/26 at 11:44 AM, V8, Certified Nursing Assistant/CNA, stated the following: V8 and V17 have reported R9's behaviors of going into female resident rooms R10 and R11, watching them undress and go to the bathroom, and R10 has expressed fear of R9. R9 sneaks in and watches staff when providing cares. Management, including V2, Director of Nursing/DON just tells us not to chart like that and to redirect R9. R9 has not been put on one to one or increased monitoring. Around 4-5:00 PM on 6/11/26, V8 found R5 and R9 in R9's room with the door shut. R9 had his hand up underneath R5's shirt and R5 was not wearing a bra. R5 was pretty confused and unable to consent to this. R5 was crying at the time of the incident; R5 cries only when R5 is upset about something. V8 removed R5 from R9's room. V24, Social Services called and asked V8 about the incident later that week. V8 stated these behaviors have been reported to the nurses as well as V1, Administrator in Training, and V3, Regional Administrator. V8 considered these behaviors as abuse. On 6/30/26 at 8:30 AM, V16, CNA, stated the following: V16 has worked in the facility since October and was told R9 had tried to undress R15, sometime prior to V16's employment. R9 likes to be physical with women, rubs staff's backs, and is persistent. R9 has to be watched closely at all times because R9 would try to get R15 out of bed. R10 has come to V16 to report R9 was in R10's bathroom and R11 has reported R9 standing over R11's bed watching R11. R10 will sit in the television room and has told V16 that R10 is uncomfortable with R9 being here and R10 wishes R9 wasn't here. R11 has yelled at R9 a few times to get R9 to leave R11 alone. R9 only goes into female resident rooms. These behaviors make V16 feel uncomfortable and management is aware of R9's behaviors. When staff try to chart these behaviors, management tells staff not to chart that way, or not to use certain words that make R9 sound like a predator. On 6/30/26 at 1:00 PM, V17, CNA, stated the following: R9 has a particular fascination with female residents, especially R10 and R11, including watching R11 and following R11 into the bathroom; and R10 has said R10 is afraid of R9 as R10 has woke up and found R9 standing over R10's bed and R9 has followed R10 into the bathroom. R9 waits to see if staff are watching and then enters these rooms when staff aren't looking and R9 does not do anything when staff are watching. Staff try to redirect R9, and V1 and V2 are aware of these behaviors. All the staff on the memory care unit know about R9's behaviors and talk about it. R9 has consistently had these behaviors since R9 admitted to the unit. Stop sign banners were supposed to be put across resident room doorways a long time ago but that hasn't happened yet. V17 doesn't think it is right that these female residents should have to put up with R9's predatory behaviors. R9 seems more alert than the other residents on the unit, and (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	person or by phone until 100% completion is obtained. Education will be provided to contracted agency for completion prior to the provider assigning shift. V1 verified staff were allowed to work between 7/1/26 and 7/6/26 without receiving this training, however as of 7/7/26 no additional staff worked without receipt of the training and V1 verified education will be ongoing for all agency staff prior to working. 12. V24 or designee will conduct rounds five times per week for 12 weeks on various shifts for all residents identified with sexually inappropriate or aggressive behaviors to verify required supervision and interventions are being implemented. V24 initiated these audits on 7/2/26. 13. V3, V65 Regional Nurse Consultant or designee will complete audits five times per week for 12 weeks then as determined by the Quality Assurance and Performance Improvement Committee to ensure continued compliance. These audits were initiated by V1 on 7/2/26. 14. V1 or designee will interview five residents per week for 12 weeks to ensure residents feel safe and have no abuse concerns. These audits were initiated by V1 on 7/2/26. 15. V1 or designee will use an audit tool related to Abuse/Abuse Reporting/Investigating and interview five staff members per week for 12 weeks to ensure staff know reporting requirements. V1 initiated these audits on 7/1/26 but did not complete the audit tool until 7/6/26. 16. The facility held a Quality Assurance meeting and reviewed the components of F600 immediate jeopardy on 7/1/26 with V67 [NAME] President of Clinical Services, V61 Chief Nursing Officer, V18 Medical Director, V3 Regional Administrator/Director of Operations, V68 Director of Social Services and Activities, V1 Administrator in Training, V2, V24, and V49. B1) The facility's Abuse Prevention and Reporting policy, revised March 2026, documents the facility affirms the residents' right to be free from abuse and therefor prohibits abuse and mistreatment of residents. This policy documents sexual abuse includes sexual harassment, sexual coercion, sexual assault, including non-consensual or non-competent to consent to sexual activity; mental abuse includes humiliation, harassment, threats of punishment or deprivation; and exploitation means taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats or coercion. This policy documents it is strictly prohibited for staff to photograph or record residents or their private space for other than medical or facility purposes, including sending recordings through multimedia messaging or social media, and this will be considered an allegation of abuse. The facility's Final Abuse Investigation Report, dated 6/24/26, documents the following: V1, Administrator in Training, was notified of an allegation of sexual abuse of R5 by R4 on 6/17/26 at approximately 7:10AM. The Certified Nursing Assistant (CNA V7) stated V7 briefly stepped away from the dining room and upon returning V7 observed R4 seated in a wheelchair with R4's hand inside the front waistband of R5's pants who was standing. R5's Census documents R5 admitted on [DATE] and discharged on 6/26/26. R5's Minimum Data Set (MDS), dated [DATE], documents R5 has severe cognitive impairment and a diagnosis of Unspecified Dementia with Behavioral Disturbances. R5 wandered daily during the one-week review period. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Arcadia Care Watseka		STREET ADDRESS, CITY, STATE, ZIP CODE 715 East Raymond Road Watseska, IL 60970	
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R4's MDS, dated [DATE], documents R4 has severe cognitive impairment. R4's Care Plan, dated 12/1/25, documents R4 has Alzheimer's disease and has behaviors of saying inappropriate things and being verbally aggressive to staff. R4's Psychiatry Progress Notes, dated 4/28/26 and 5/12/26, document R4 has sexually inappropriate behaviors. R4's Psychiatry Progress note, dated 6/9/26, documents staff reported concerns that R4 is making more sexual remarks and attempting to touch female staff during care. On 6/29/26 at 8:41 AM, V7, CNA, stated V7 witnessed the incident between R4 and R5 about a week ago, it was in the dining room just before breakfast. V7 went into the dining room to get trays and caught R4 with his hand down inside R5's pants and incontinence brief with palm up. R4 was seated and R5 was standing next to R4. R5 had no reaction and did not seem aware of what was going on. R4 is very hands on and likes to grab at staff and make sexual remarks. There was no other staff present in the dining room when this incident occurred. On 6/29/26 at 10:36 AM, V28, Registered Nurse, stated V7 reported to V28 that R4 and R5 were in the dining room and R4 had his hand down R5's pants. V28 stated V28 did a full assessment for R5, who was unable to communicate that anything had happened. V28 described R4 as alert/oriented to person, place and occasionally time, R4 knows right from wrong and is able to follow commands. V28 stated R4 is more cognitively intact and R5 does not have the capacity to consent to sexual activity/touch. V28 stated R4 has been verbally sexually inappropriate towards staff but not towards residents prior to this incident. On 6/30/26 at 9:56 AM, V22 (R5's Power of Attorney) stated it was reported that a few weeks ago a male resident (R4) was found with his hand inside R5's pants. V22 stated R5 has Dementia with short term memory loss and poor recall and R5 is mostly nonverbal. V22 stated R5 wouldn't be able to consent to being touched or be able to indicate no and R5 probably wasn't even aware of the situation. V22 stated if R5 did not have Dementia, R5 used to be feisty and would have fought the resident off. B2) The facility's abuse investigation, initially reported on 5/3/2026 at 4:09 PM, and the final investigation report submitted on 5/7/2026 at 4:08 PM documented an allegation that V32, Certified Nurse Aide (CNA), conducted a video call showing R2 during resident care. On 7/1/2026 at 9:31 AM, V31, Certified Nurse's Aide (CNA), stated that while assisting V32 with providing incontinent care to R2, V32 entered R2's room carrying a personal cellular phone. V31 stated V32 propped the phone against a stereo on the dresser and observed that the phone was engaged in a video call. During the provision of incontinent care, R2's back and buttocks were exposed and visible to the phone. V31 stated V32 told V31 that a friend wanted to become a CNA, and V32 showed the friend what the job was like. On 7/1/2026 at 1:16 PM, V37, R2's guardian, V37 stated R2 would not have wanted someone outside of R2's care to see R2's back and buttocks and that, prior to R2's cognitive decline, R2 was able to communicate R2's wishes. V37 stated the incident was unprofessional and unethical. (continued on next page)		

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Printed: 10/09/2026
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 7/1/2026 at 12:55 PM, V3, Regional Administrator, stated V31 reported observing V32 place her phone on a stereo in R2's room. V3 stated the facility expectation is that personal cell phones are not used in resident care areas.		

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident (R1) was free from physical restraints applied for staff convenience; failed to assess for the use of physical restraints; failed to identify the specific medical symptoms justifying the use of a physical restraint; failed to notify the resident's representative; and failed to obtain a physician's order for physical restraints for one (R1) of three residents reviewed for restraints in the sample of 20. These failures put R1 at risk for psychosocial impact that includes but is not limited to emotional harm, dehumanization, pain, loss of dignity, self-respect, feeling of imprisonment, increased agitation and restlessness and at risk for serious physical injury. The Immediate Jeopardy began on 6/11/26 at approximately 5:30 PM, when R1 was found sitting in the nurse's station in R1's wheelchair with a bed sheet that was rolled linear across R1's torso and tied behind R1's wheelchair, out of R1's reach, restricting R1 from getting out of R1's wheelchair. R1 also had on two hospital gowns, one frontward and one backward, which were tied behind R1 and restricted R1 from moving R1's arms as R1's arms were not through the sleeves. R1 was agitated as R1 tried to get his arms free. V1, Administrator in Training, and V3, Regional Administrator, were notified of the Immediate Jeopardy on 7/1/26. at 10:08 AM, the surveyor confirmed by observation, interview, and record review, the Immediate Jeopardy was removed on 7/7/26, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. Findings include: The facility's Restraints policy, revised May 2018, documents the following: Physical Restraints are any manual method, device, material, or equipment attached or adjacent to the resident's body that the resident cannot remove easily which restricts freedom of movement to normal access to one's body. Examples of restraints include vests or arm restraints the resident cannot easily remove and also may include tucking in or using fasteners to hold a sheet/fabric/clothing tightly which restricts a resident's movement, placing a resident in a chair that prevents a resident from rising. Residents with restraints shall have a physician's order, initial and quarterly assessments, and less restrictive interventions implemented prior to restraint use. The facility prohibits the use of restraints for discipline or convenience, and limits restraint use for management of medical symptoms that warrant the use of restraints. The facility's Abuse Prevention and Reporting policy, revised March 2026, documents abuse preventative measures includes assuring physical restraints are used sparingly and properly. R1's Minimum Data Set, dated [DATE], documents R1 has severe cognitive impairment, behaviors not directed towards others noted 4 to 6 days out of the 7 day review period, R1 did not use any physical restraints, and R1 required dependence on staff for transfers. R1's Care Plan does not identify any physical restraint use or interventions. R1's active Care Plan documents the following: R1 has Alzheimer's Disease, Anxiety Disorder, and transfers with one to two staff assist and gait belt. R1 can be agitated, physically aggressive towards staff and removes R1's clothing. R1 is at risk for falls and has poor safety awareness. Interventions include increased supervision when in common areas due to impulsiveness. The facility's Final Abuse Investigative Report, dated 6/16/26, documents the following: On 6/11/26 a staff to resident (R1) abuse allegation was reported. An unidentified Certified Nursing Assistant (CNA) was interviewed and reported being asked to watch R1 because R1 kept trying to get up from R1's chair, R1 was agitated and weak, and R1 could not stand up but kept trying. This CNA noticed a sheet tucked around R1 and the wheelchair, and two CNAs took R1 to be laid down in bed. The facility concluded based on staff interviews R1 experienced episodes of agitation (continued on next page)		

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and staff responded appropriately by providing one to one supervision until R1 could be laid down. The alleged abuse incident report, dated 6/11/26 for R1's abuse allegation, documents staff notified V3, Regional Administrator, that R1 had a sheet secured around R1's waist and wheelchair. This report does not document V30, R1's Power of Attorney, was notified of this allegation. This report documents a nurse statement, dated 6/11/26, as having two admissions who weren't doing well, R1 was weak and kept trying to get up, the nurse was next to R1 the entire time and asked a CNA to watch R1 so the nurse could take a break. The nurse securely tucked a sheet around R1's waist and chair. This report documents a CNA statement, dated 6/11/26, as being called by the nurse to sit with R1, and it took a few minutes for the CNAs to finish helping another resident. The CNAs walked into the room and found R1 tied to a chair and the other CNA said nice illegal restraint to the nurse. The nurse responded it was going to be undone when the nurse was done with her work, and the nurse wasn't going to keep R1 tied there. The CNAs untied R1 from the chair and assisted R1 to bed. The nurse also had R1 double gownned restricting R1 from using R1's hands as R1 normally does. Another CNA interview, dated 6/15/26, documents the same description as the 6/11/26 CNA interview, and mentions the nurse had her legs over R1's legs. The Corrective Action Form, dated 6/15/26, documents a verbal warning was given to V4, Licensed Practical Nurse (LPN), for misconduct regarding an incident on 6/11/26 at 4:20 PM that occurred on the facility's dementia unit/hall. This form documents it was reported that V4 failed to follow employee conduct in accordance with the facility's handbook and failed to follow safety policies, rules, or practices. R1's electronic medical record (EMR) does not document a physician's order for restraints prior to 6/29/26, an assessment for physical restraint use, medical symptoms justifying restraint use or alternative less restrictive measures implemented prior to restraint use. R1's electronic medical record does not document V30 was notified regarding restraint use to obtain consent for use or notified of the staff to resident abuse allegation on 6/11/26. R1's Physician Order, with created date of 6/29/26, documents an order for a soft restraint, release every hour and at meals with start date 6/12/26. This order was entered by V4, LPN, and documents V18, Physician, as the prescriber. R1's Physician Order, created 6/29/26 by V2, Director of Nursing, documents an order for a soft restraint, release every hour and at meals, with start date 6/11/26. This order documents V18 as the prescriber. These orders do not specify what device is used as the soft restraint. On 6/29/26 at 1:13 PM, R1 was self-propelling his wheelchair down the dementia unit hallway. R1 stood from his wheelchair and took a few steps. V5, CNA, instructed and assisted R1 to sit back down in the wheelchair. Attempts were made to interview R1 who was confused and did not respond to questions. On 6/29/26 at 11:10 AM, V4, LPN, was working on the dementia unit where R1 resides. V4 stated prior to R1's recent fall (6/5/26), R1 was impulsive with transfers and walking, R1 has weak and unsteady gait, and requires staff to walk with R1. V4 stated staff have to almost be right there to catch R1, R1 is still impulsive with transfers requiring close supervision and monitoring, and V4 feels like R1 needs a (lap cushion that loops through wheelchair arm rests). At 12:12 PM, V4 stated V4 did not have R1 tied up, V4 had a sheet across R1's lap that was tucked in at the side of R1's wheelchair, not tied, which was to help R1 feel the comfort of the blanket rather than trying to stand. V4 stated R1 had only one hospital gown on that was applied and tied normally. On 6/29/26 at 11:29 AM, V5, CNA, stated on 6/11/26, R1 returned from the hospital and at approximately 5:30 PM, V4 came out of the dementia unit nurses' station asking V5 and V8 CNA to watch R1 so V4 could take a break. V5 stated R1 was found sitting in a wheelchair with a sheet rolled linear across R1's torso and tied behind R1's wheelchair, out of R1's reach preventing R1 from getting out of the wheelchair. V5 stated R1 also had two hospital gowns on, one frontward and one backward, which were tied keeping R1's arms down and restricting movement as (continued on next page)		

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's arms were not through the sleeves. V5 was unsure how long R1 had been like that as V4 had been in the nurse's station with R1 with the door closed for about 30 minutes prior. V5 and V8 immediately removed the restraints and assisted R1 to bed and reported this to V1, Administrator in Training, at approximately 6:00 PM. On 6/29/26 at 11:44 AM, V8, CNA, described R1 as being restrained by V4 in the same way as described by V5. V8 stated V8 was unsure how long R1 had been restrained as V4 had been with R1 in the nurses' station with the door closed for 30 minutes prior. V8 stated V8 told V4 this was an illegal restraint, V8 considered this abuse and reported this immediately to V1 and then V3, Regional Administrator. V8 stated R1 was pretty annoyed and agitated as R1 was trying to get his hands free. V8 stated prior to this, V4 was sitting with her foot on R1's lap preventing R1 from standing and V4 has done this a few times before. On 6/29/26 at 2:08 PM, V3 stated R1 returned from the hospital during mealtime, R1 was not doing well, he was a mover and wanderer, and staff were trying to keep R1 busy so the staff could pass meal trays. V3 stated V3 was told V4 had a sheet draped across R1's lap, V8 reported the sheet was tied but V4 reported it wasn't. V3 stated whether the sheet was tied or not, R1 was in the restraint for less than two hours. V3 stated V3 would refer to the facility's restraint policy, but there should be a physician's order, skin checks, and that it is used appropriately. V3 stated there should be an assessment for restraints documented in the assessments section of the resident's EMR. V3 stated and V3 completed the initial report and handed the allegation over for V1 to complete the investigation. V1 stated V1 spoke to V4 who had two admissions that weren't doing well, V4 asked the CNAs to watch R1 so V4 could take a break, and V4 tucked a sheet around R1's waist and wheelchair. V1 stated V4 denied having the sheet tied or R1 double gowned. V1 stated V1 spoke to V8 and V5 who reported finding R1 tied to his wheelchair and double gowned by V4 so that R1 couldn't use R1's hands. V3 stated a physical restraint was in place as ordered so abuse was not substantiated. On 6/29/26 at 3:12 PM, V2, Director of Nursing, stated V2 was working the floor the day of R1's allegation and V2 was not involved in the investigation of this incident. V2 stated R1 had no prior order or assessments for restraints. On 6/30/26 at 10:12 AM, V2 stated restraints need consents from both the physician and the resident's family, which would be documented in the nursing notes. V2 stated the physician's order should specify the type of restraint used and confirmed it would not be acceptable or appropriate to use a sheet or hospital gown as a restraint. On 6/30/26 at 9:05 AM, V30 stated R1 has had several falls and requires assistance of two staff for walking. V30 stated the hospital had R1 in restraints but no one at the facility had contacted V30 about using restraints. V30 stated V30 was not aware of the allegation that a nurse had tied a sheet to R1's wheelchair or gowns used to restrict R1's movement. V30 stated if that happened it would have made R1 agitated. On 6/30/26 at 11:35 AM, V18, Physician, stated V18 was not made aware of R1's restraints until after the incident. V18 stated V18 had not given any orders to use restraints for R1 and would only order physical restraints if a resident were violent, otherwise V18 gives referral for psychiatry services to address behavioral needs. V18 stated the facility should be following its restraint policy and use the appropriate restraint devices which should be outlined in the policy. V18 stated restraints used in this manner (as described per R1's allegation) could cause increased confusion, agitation and risk for injury. The Immediate Jeopardy that began on 6/11/26 was removed on 7/7/26 when the facility took the following actions to remove the immediacy: R1's alleged restraint was removed on 6/11/26 by V5 and V8. On 7/2/26, V2 completed a Restraint Evaluation for R1. V1 and V3 interviewed V4, V5, and V8 on 6/11/26 and 6/15/26. R1 was assessed for physical/psychosocial effects by V49, Assistant Director of Nursing, on 6/11/26. R1's pain was assessed on 6/11/26 by V2. V18, R1's physician, was notified on 6/11/26 by V3. V30, R1's Power of Attorney, was notified on 7/6/26 by V3. On 7/1/26 V20 MDS/Care Plan (continued on next page)		

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Coordinator updated R1's care plan with individualized interventions to address R1's behaviors.V1 suspended V4 on 6/11/26 pending the investigation. V4 was given a verbal warning and education on the facility's restraint and abuse policy on 6/15/26 by V1 and V3. All residents currently in-house had completed skin assessments and observation for restraint use completed by V2, V20, and V49, Assistant Director of Nursing on 7/1/26. Family members of residents with Brief Interview for Mental Status score of 11 and below for all residents in-house were interviewed regarding abuse on 7/1/26 by V24 Social Services and V54 Medical Records.V24 completed abuse/neglect risk screening for all in-house residents on 7/1/26 and care plans were updated on 7/6/26. V1 and V3 initiated abuse and restraint in-service/education for all staff on 7/1/26. Staff members and contracted agency staff who were not present during the initial education will receive the training before working next shift provided by V1, V2 or designee for facility staff in person or by phone until 100% completion is obtained. Education will be provided to contracted agency for completion prior to the provider assigning shift. V1 verified staff were allowed to work between 7/1/26 and 7/6/26 without receiving this training, however as of 7/7/26 no additional staff worked without receipt of the training and V1 verified education will be ongoing for all agency staff prior to working. V1 verified staff who had not received this training worked between 7/1/26 and 7/6/26. Additional training was provided on 7/6/26 and as of 7/7/26 no additional staff worked without receipt of the training. V1 verified education will be ongoing for all agency staff prior to working. Facility Administrator or Designee will interview 5 residents per week for 12 weeks to ensure residents feel safe and have no concerns with abuse. These audits were initiated by V1 on 7/2/26. V1 or designee will use an audit tool related to Abuse/Abuse Reporting/Investigating and interview five staff members per week for 12 weeks to ensure staff know reporting requirements. V1 initiated these audits on 7/1/26 but did not complete the audit tool until 7/6/26. The facility held a Quality Assurance meeting and reviewed the components of F604 immediate jeopardy on 7/1/26 with V67 [NAME] President of Clinical Services, V61,Chief Nursing Officer, V18, Medical Director, V3, Regional Administrator/Director of Operations, V68, Director of Social Services and Activities, V1, Administrator in Training, V2, V24, and V49.		

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F 0605 Level of Harm - Actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident was free from chemical restraints, failed to implement and document individualized non-pharmacological interventions prior to psychotropic medication administration, and failed to administer medications according to physician's orders for one of three residents (R1) reviewed for unnecessary medications in the sample list of 20. This failure resulted in R1 sustaining a fall resulting in an acute subdural hematoma. Findings include: On 6/30/26 at 1:06 PM, R1 was lying in bed on R1's right side. The bed was in the lowest position, and a fall mat was positioned next to the bed. R1's admission Record, dated 2/20/26, documents R1 has diagnoses that include, but are not limited to Alzheimer's Disease, Generalized Anxiety Disorder, Mood Disorder, and Repeated Falls. R1's Minimum Data Set, dated [DATE], documents R1 is severely cognitively impaired. On 6/30/26 at 1:17 PM, V16, Certified Nursing Assistant (CNA), stated R1 rummages, attempts to fix items on the wall, and wanders into other residents' rooms. V16 reported when R1 first arrived at the facility, R1 was hostile toward staff due to frustration with a loss of independence. V16 stated R1 did not rest during the day and had no consistent sleep pattern, describing R1 as very active. On 6/30/26 at 1:20 PM, V5, CNA, stated R1's behavior varied depending on the situation. V5 reported R1 frequently attempted to get up and down, describing R1 as a busy body who was always on the go and could be redirected. V5 stated R1 did not have a sleep pattern. V5 also stated aggression toward others had not been personally observed, but V5 had heard that R1 had hit staff within the past few months. On 7/1/26 at 12:27 PM, V17, CNA, stated V17 had never seen any behaviors from R1 that were out of the ordinary. V17 reported R1 wanders frequently and attempts to stand up often, which V17 described as confusion rather than a behavioral concern. V17 stated when R1 was first admitted, R1 would kick and say rude things to staff, but R1 appeared to acclimate over time. V17 stated offering a snack or an activity usually occupied R1 and that R1 enjoyed having R1's back scratched. On 7/1/26 at 1:59 PM, V24, Social Services Director (SSD), stated R1 is impulsive. V24 reported R1 likes to tinker and fix things and attempts to stand up repeatedly despite weakness related to health concerns. When R1 was ambulatory, R1 would walk and roam the hallway. V24 reported when R1 was first admitted, R1 would sometimes disrobe and attempt to remove clothing, such as pants. V24 stated R1 can become agitated during care and may appear irritated or on edge when staff are providing care. V24 stated R1 has never been a harm to himself or others. On 7/1/26 at 4:29 PM, V19, Licensed Practical Nurse (LPN), stated upon R1's admission, the resident displayed significant behavioral concerns. R1 would hit and attempt to bite staff, wander throughout the unit, and try to fix items in the environment. According to V19, attempts to redirect R1 often resulted in biting, kicking, or spitting at staff. V19 reported R1 did not have any sleep supportive medications upon admission and demonstrated an extremely irregular sleep pattern, sometimes remaining awake for 48 to 72 hours, followed by sleeping for an entire day. V19 stated a tramadol order was eventually initiated and believed it was helpful, suspecting R1 was experiencing unexpressed pain. V19 stated R1's behaviors typically improved after tramadol administration. V19 further reported based on V19's experience, Lorazepam is not effective for elderly residents with dementia and R1's behaviors appeared to worsen when Lorazepam was administered. R1's Encounter Note, dated 5/12/26, documents R1 had increased agitation, physical combativeness, exit-seeking behaviors, and sleep disturbance. Staff reported R1 was up all night and restless. It further documents R1 appeared drowsy and asleep at the time of the (continued on next page)		

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F 0605 Level of Harm - Actual harm Residents Affected - Few	encounter. This encounter note goes on to document, to address the current instability and history of six falls since admission, an as needed (PRN) dose of Lorazepam (anti anxiety) 0.25 milligrams (mg) was added to R1's scheduled BID (twice a day) regimen and the dose of Divalproex (anti convulsant used for manic phases) previously lowered, will be re-increased for mood stabilization. This note also documents R1 is again receiving two antipsychotic medications after the restart of Quetiapine (anti psychotic) that medication will be marked for gradual dose reduction (GDR) while continuing Risperidone (anti psychotic) 1 mg BID for verbal and physical aggression. R1's Encounter Note, dated 5/14/26, documents a staff member called contracted psychological services because R1 had not been sleeping at night. It further documents that the staff member attempted to create a calm environment to reduce stimulation and R1's agitation did not respond, so Trazodone 25mg nightly was started. R1's Electronic Medical Record did not document any Physician's orders for Trazodone 25mg. R1's Physician Order Note, dated 5/14/26 at 3:06 PM, documents an order for Trazodone 50mg with directions to give one tablet by mouth at bedtime for sleep deprivation. This order was entered by V4, LPN. R1's Physician's Order Note, dated 5/18/26 at 4:30 PM, documents an order for Lorazepam 1mg with directions to give 1mg at bedtime for Insomnia. This order was entered by V4, LPN. On 7/1/26 at 12:06 PM, V4, LPN, reported R1 used to be more violent toward staff at night but had not demonstrated violent behaviors in several months. Regarding the trazodone order, dated 5/14/26 that V4 entered, V4 stated night shift staff might have asked V4 to reach out for medication to help R1 sleep. V4 stated V4 probably contacted psychological services but likely did not document the communication. Regarding the Lorazepam 1mg order, dated 5/18/26 that V4 entered, V4 could not recall who V4 received the order from or the circumstances surrounding the need for the order. On 7/2/26 at 8:59 AM, V18 (Medical Director) stated contracted psychiatry services manage medications for R1. V18 cannot recall or confirm whether R1's order for Trazodone 50mg and Lorazepam 1mg was issued by V18. V18 stated all psychotropic medication management is referred to contracted psychiatry services. On 7/6/26 at 1:33 PM, V2 stated no laboratory tests were obtained prior to R1's hospitalization on 6/5/26 to evaluate for potential underlying medical conditions that may have contributed to R1's behaviors. On 7/8/26 at 9:48 AM, V2, Director of Nursing (DON), stated the order for 25mg of Trazodone was never entered in R1's order. V2 stated R1's order for Trazodone 50mg entered on 5/14/26 by V4, LPN, was a transcription error. R1's Encounter Note by the contracted psychiatry services, dated 5/28/26, documents R1 continued to exhibit nighttime behavioral problems, including persistent behavioral disturbances and significant drowsiness. It also documents during the encounter, R1 was observed at bedside, sound asleep, was very drowsy upon awakening, and had difficulty remaining awake. This note documents staff and chart review indicate continued aggressive behaviors, labile mood symptoms, increased agitation, physical combativeness, exit seeking behaviors, and sleep disturbances. This note goes on to document the primary care provider also recently adjusted Lorazepam from 0.25 mg twice daily to 1 mg at bedtime and increased trazodone to 50 mg at bedtime. It also documents R1's POA (Power of Attorney) requested all bedtime medications be administered at 6:00 PM to help address sundowning behaviors and to avoid awakening R1 after falling asleep for nighttime administration. It also documents a new order for PRN Lorazepam 0.5mg. R1's Medication Audit Report, dated 6/1/26, documents a physician order for Lorazepam 0.5 milligrams (mg) stating to take 1 tablet by mouth every 6 hours as need for agitation for 14 days and do not give within 6 hours of bedtime dose. It also documents R1 received 1mg of Lorazepam at 4:48 PM and then received an as needed dose of lorazepam 0.5mg at 6:57 PM. R1's Medication Administration Note, dated 6/1/26 at 6:57 PM, documents Lorazepam 0.5mg was given because R1 restless, agitated, and no longer receives a nighttime dose of Lorazepam. It does not (continued on next page)		

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F 0605 Level of Harm - Actual harm Residents Affected - Few	document any nonpharmacological interventions attempted prior to the administration of this medication.R1's Medication Audit Report, dated 6/4/26, documents a physician order for Lorazepam 0.5 milligrams (mg) stating to take 1 tablet by mouth every 6 hours as needed for agitation for 14 days and do not give within 6 hours of bedtime dose. It also documents R1 received 1mg of Lorazepam at 5:15p.m. and then received an as needed dose of lorazepam 0.5mg at 6:54 PM by V12, LPN.R1's Medication Administration Note, dated 6/4/26 at 6:54 PM., documents Lorazepam 0.5mg was given because R1 was anxious. It does not document any nonpharmacological interventions attempted prior to the administration of this medication.R1's Medication Audit Report, dated 6/5/26, documents a physician order for Lorazepam 0.5mg stating to take 1 tablet by mouth every 6 hours as needed for agitation for 14 days and do not give within 6 hours of bedtime dose. It also documents R1 received 1mg of Lorazepam at 4:56 PM and then received an as needed dose of lorazepam 0.5mg at 6:30 PM by V12, LPN.R1's Medication Administration Note, dated 6/5/26 at 6:30 PM, documents Lorazepam 0.5mg was given because R1 was anxious. It does not document any nonpharmacological interventions attempted prior to the administration of this medication.R1's Nursing Note, dated 6/5/26 at 10:05 PM, documents R1 was found on the floor by a CNA during rounds. R1 was lying on the floor with R1's head on the floor mat. R1 was bleeding on R1's left forearm. No new head injuries were observed at this time, however, old scrapes and existing bandages, to the right arm and top of scalp were noted. R1 was sent to the local hospital for further evaluation and treatment.R1's Emergency Department Physician Report, dated 6/5/26, documents R1 presented with scattered bruising across the face and scalp. R1 was subsequently transferred to a larger hospital for management of a subacute subdural hemorrhage.R1's General Medicine Discharge summary, dated [DATE], documents R1 had a known chronic subdural hematoma with a small acute component. R1 was admitted to the neurological intensive care unit for monitoring and remained clinically stable throughout the hospitalization. The geriatrics team evaluated R1 for Delirium in the context of Advanced Dementia. Due to concern for possible paradoxical agitation, they recommended that the facility slowly taper R1's benzodiazepines.On 7/1/26 at 10:38 AM, V69, Pharmacist, reviewed R1's medications administered on 6/5/26 at 4:59 PM (Depakote 375 mg, mirtazapine 7.5 mg, lorazepam 1 mg, trazodone 50 mg, and risperidone 1 mg). V69 stated there are potential drug interactions among these medications. V69 reported trazodone and mirtazapine may increase the risk of serotonin syndrome, central nervous system (CNS) depression, or drowsiness. V69 further stated lorazepam and trazodone may also contribute to CNS depression and drowsiness, and the combination of Depakote and lorazepam may further increase CNS depressant effects. V69 stated that individuals may experience varying levels of CNS depression depending on their tolerability to this medication regimen. While discussing the additional PRN lorazepam 0.5 mg dose administered to R1 at 6:34 PM, V69 stated R1's PRN lorazepam order includes a specific instruction not to administer it within six hours of R1's evening lorazepam dose. V69 added this instruction was likely included by the provider out of concern for R1's safety.On 7/1/26 at 1:16 PM, V12, LPN, stated R1 used to be very active and would attempt to get up and walk independently, but R1 was very unsteady, so staff would walk with R1. V12 stated R1 is still anxious at times but is now primarily in a wheelchair and less mobile. V12 reported R1 has exhibited behaviors such as crawling on the floor and pinching R1's skin. V12 did not report any additional behaviors and stated the CNAs would be more familiar with R1's behavioral patterns, as V12's interactions with R1 are brief and primarily related to medication administration. V12 stated V12 has had no issues with R1 taking R1's medications. V12 reported when R1 exhibited behaviors, staff would typically redirect R1, and at one point, R1's scheduled Lorazepam and as needed dose helped soothe R1 and made R1 tired. V12 only recalls portions of R1's fall on 6/5/26. V12 stated V12 was (continued on next page)		

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F 0605 Level of Harm - Actual harm Residents Affected - Few	working on another hall when a CNA informed V12 that R1 had been found on the floor. The fall was unwitnessed. When V12 assessed R1, V12 observed bleeding on R1's left arm. V12 notified the physician, and R1 was sent to the hospital. R1's vital signs were stable at the time of transfer. V12 stated V12 does not recall any additional details. V12 cannot recall why V12 administered R1's as need Lorazepam so closely to R1's evening dose of Lorazepam. On 7/1/26 at 3:07 PM, V2, Director of Nursing/DON, stated n long-term care, staff are expected to chart by exception. V2 stated nursing staff are expected to document the specific behaviors observed rather than simply using a behavior descriptor. Documentation should clearly describe the signs and symptoms exhibited. When a medication is ordered for a specific behavior, the medication should only be administered when the resident is demonstrating that behavior. A re-evaluation is expected to be completed one hour after administration. V2 also stated staff should document any non-pharmacological interventions attempted in conjunction with medication administration. V2 stated R1 is impulsive with decreased safety awareness related to impaired cognition and does not demonstrate an understanding of safety risks. V2 reported when R1 was first admitted, R1 would hit staff and did not tolerate being touched during care. On 7/6/26 at 11:50 AM, V2 stated V2 could not provide behavior documentation to support R1's psychotropic medication changes. On 7/2/26 at 9:12 AM., V38, Physician, stated recalling R1's hospitalization. V38 reported R1 had a chronic subdural hematoma with a mild acute component. The acute portion represented a new bleed; however, it remained stable on multiple assessments, which is why no intervention was required. V38 stated being unable to determine the exact cause of the acute component but noted R1 is at very high risk for falls and had multiple bruises consistent with a history of prior falls. Based on clinical assessment, V38 stated the fall that occurred on 6/5/26 was the most likely cause of the new acute component of the bleed. On 7/2/26 at 11:48 AM, V34, Psychiatry Nurse Practitioner, stated when V34 began seeing R1 in March of 2026, staff reported R1 was physically and verbally aggressive and impulsive with self-transferring. V34 stated when rounding, R1 was usually asleep, but staff consistently reported R1's behaviors occurred at night, followed by sleeping during the day. V34 stated not knowing why the primary care provider initiated Trazodone and Lorazepam, noting that increasing Lorazepam from 0.25 mg twice daily to 1 mg every evening represented a significant dosage change. V34 stated R1's medications were moved to the evening based on R1's Power of Attorney concerns that R1 was not sleeping. The previous schedule required staff to wake R1 a few hours after falling asleep to administer additional doses, which raised concern R1 might awaken fully and then remain awake through the night. V34 stated an order was given for the PRN Ativan not to be administered due to concern for oversedation, particularly given R1's fall risk. V34 stated being unaware that PRN Ativan was administered earlier than ordered on 6/1, 6/4, and 6/5. V34 stated staff could have contacted the after-hours provider for approval but reported having no documentation that such communication occurred. On 7/2/26 at 12:30 PM, V2, DON, stated nurses are expected to receive, document, and follow physician orders accurately. R1's administration of scheduled and as needed Lorazepam on 6/1/26, 6/4/26, and 6/5/26 reviewed by V2. V2 stated these were medication errors and staff were not following the physician orders. V2 would be concerned with the administration of the as needed Lorazepam so closely to the scheduled Lorazepam because R1 is a fall risk. The facility's Behavioral Health Services Program policy, revised January of 2023, documents when inappropriate or distressed behaviors occur, interventions should be implemented by utilizing the least restrictive or least intrusive measures first, and evaluating the effectiveness of these interventions before utilizing more restrictive or intrusive interventions. The facility's Abuse Prevention and Reporting - Illinois policy, revised March of 2026, documents the facility should assure that chemical restraints are not used.		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on observation, interview, and record review, the facility failed to follow its abuse prevention policy by failing to ensure employee background checks were completed upon hire. This failure has the potential to affect 62 residents in the facility. Findings include: The facility's Abuse Prevention and Reporting policy, revised March 2026, documents abuse prevention measures include conducting pre-employment screening of employees. This policy documents the facility will check the Illinois Health Care Worker Registry for abuse and neglect, fingerprint results, and the sex offender website links on the registry for any new employees prior to starting work. On 6/29/26 at 11:10 AM and on 6/30/26 at 8:05 AM, V4, Licensed Practical Nurse, was working on the dementia unit/hallway of the facility. On 6/29/26 at 1:52 PM, V42, Human Resources (HR), provided V4's employee file which did not contain background checks and listed V4's hire date as 12/1/24. V42 confirmed V4's hire dated as 12/1/24 and confirmed V4 did not have background checks completed. V42 stated V42 took over as HR on 12/15/24 and background checks are to be completed for all employees prior to hire. On 7/7/26 at 8:15 AM, V2, Director of Nursing, stated the nurses do not have set assigned hallways and are expected to answer call lights for any/all residents (confirming nurses have the potential to interact with all residents in the facility). The facility's June 2026 Nursing Daily Schedules document V4 worked in the facility on the 300 and 400 hallways. The facility's Midnight Census Report dated 6/29/26 documents 62 residents reside in the facility.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Hire a qualified full-time social worker in a facility with more than 120 beds. Based on observation, interview, and record review, the facility failed to have a full-time qualified social worker. This failure has the potential to affect all 62 residents in the facility. Findings include: The Facility Assessment, revised 6/19/26, documents Social Services is included in the facility's resources/staffing needed to provide competent support and care of its residents. This assessment documents resident care/services include care of residents with cognitive impairment, mental health diagnoses, and behaviors. V24, Social Services Director (SSD), was working in the facility 6/29/26-7/2/26. On 7/2/26 at 9:25 AM, V24 stated V24 is the facility's SSD. V24 stated V24 is currently enrolled in courses to obtain a bachelor's degree as V24 does not meet the qualifications for a Social Worker for facility's with over 120 beds. V24 stated V68 (Regional SSD) has a degree and meets the qualifications but is only in the facility a couple times per month, not full time. The facility's Illinois Department of Public Health License, Permit, Certification, Registration issued 12/1/25 and expiring on 11/30/26 documents the facility has 123 licensed beds. The facility's Midnight Census Report, dated 6/29/26, documents a census of 62 residents.		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review, the facility failed to implement a Performance Improvement Plan (PIP) for identified problems with abuse, behavior monitoring, and falls. This failure has the potential to affect all 62 residents in the facility. Findings include: Record Review: Review of the facility's QAPI (Quality Assurance Performance Improvement) Binder revealed no Performance Improvement Projects (PIPs) had been completed for abuse or falls. Documentation for April, May, and June identified behaviors, abuse, and falls as ongoing areas of risk. There was no evidence that PIPs had been initiated or implemented to address these quality concerns. On 7/2/26 at 11:50 AM, V42, Regional Manager of Dietary, revealed that QAPI meetings included discussion of weekly weights, hospice residents with weight loss, infection prevention, wounds, falls, behavior logs, and monthly weight reports. V42 stated the Administrator, Director of Nursing (DON), Social Services, Dietary Manager, Minimum Data Set Coordinator, and Infection Prevention/Wound staff participated in the meetings and the Medical Director participated by telephone. On 7/2/26 at 11:53 AM, V1, Administrator, revealed that QAPI meetings had been held May 2026 and continued into June 2026. V1 stated the meetings included the Administrator, DON, Business Office Manager (BOM), and Assistant Director of Nursing (ADON). V1 stated reports were sent to the Medical Director by email and the information was reviewed; concerns were discussed during morning meetings. V1 further stated the consultant pharmacy and psychiatric consultant were not involved in the QAPI meetings and only completed medication reviews. V1 also confirmed no Performance Improvement Projects (PIPs) had been completed for approximately one year on behaviors, falls, or abuse. On 7/2/26 at 12:15 PM, V24, Social Services Director, revealed behaviors and grievances were discussed in morning meetings and during the QAPI meetings held monthly and provided to the Administrator for review. V24 stated there has been no Performance Improvement Projects (PIPs) in place for behaviors or abuse. The facility's Midnight Census Report, dated 6/29/26, documents a census of 62 residents.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 timely report an allegation of abuse to the Administrator and report abuse allegations to the State Survey Agency for six (R2, R5, R9, R10, R11, R15) of 14 residents reviewed for abuse in the sample list of 20. Findings include: 1.) The following resident to resident sexual abuse allegations were identified through staff (V8, V16, V17, Certified Nursing Assistants (CNA), and V19, Licensed Practical Nurse) and resident (R10) interviews conducted on 6/29/26 and 6/30/26 between 8:00 AM and 3:33 PM: R9 has predatory behaviors including going into female resident rooms R10 and R11, watching them undress and go to the bathroom, and R10 and R11 have expressed fear of R9. R9 rubbed R15's back and near R15's breasts, R9 attempted to get R15 out of bed and undressed which was reported to the former Administrator, V66. Around 4-5:00 PM on 6/11/26 V8 found R5 and R9 in R9's room with the door shut, R9 had his hand up underneath R5's shirt and R5 was not wearing a bra. These residents all resided on the Dementia unit. These behaviors and incidents were reported to management and administration throughout the last year. R10 stated R10 has had problems with another resident coming into R10's room and R10 identified R9 by R9's name and when R9 approached R10's doorway. R10 stated R10 tells R9 to get out of R10's room and R9 will just stand there, and R9 also goes into R10's friend's room (R11) located across the hall. R10 stated (R9) scares me (R10). The facility's Clinical and Order Alerts Listing Report dated 6/1/26-6/29/26 documents: On 6/10/26 at 11:23 AM, R9 is getting more touching with female staff and residents if they don't shake R9's hand and R9 will grab shoulders and arms. At 11:25 AM, R9 is going into female resident rooms while staff is providing cares, enters while residents are getting dressed/undressed or using the bathroom. On 6/11/26 at 10:27 AM, R9 is entering female resident rooms while staff are providing cares. At 10:28 AM, R9 is watching other residents get dressed/undressed and when using the bathroom. At 10:29 AM, R9 is getting upset when female staff and residents won't shake R9's hand right away and will grab onto their shoulders and/or arm. On 6/24/26 at 5:32 PM, R9 has been going into female bathrooms while in use, redirected but R9 goes right back. R9 follows females into their rooms and refuses to leave when asked. The facility's abuse log dated January-June 2026 does not include allegations involving R9 and there is no documentation the above allegations were reported to the state survey agency. On 6/29/26 at 2:08 PM, V1, Administrator In Training, and V3, Regional Administrator, stated nothing had been reported to them about R9's behaviors of watching female residents undress and toilet or touching female residents inappropriately. V1 and V3 stated the allegation of R9 having his hand up R5's shirt was reported today by V24, Social Services Director. V1 and V3 confirmed abuse allegations are to be reported to administration and the State Survey Agency. On 7/1/26 at 8:56 AM, V3 stated V66 (Former Administrator) was the facility's Administrator a year ago. V3 was not aware of any prior abuse allegations involving R9 and V3 will check the abuse allegation files. At 9:04 AM, V3 confirmed there were no abuse allegation files involving R9, besides an allegation of staff to resident verbal abuse regarding food. (continued on next page)		

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Form Approved OMB
No. 0938-0391

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. The facility's abuse investigation, initially reported on 5/3/2026 at 4:09 PM, and the final investigation report submitted on 5/7/2026 at 4:08 PM, documented an allegation that V32, Certified Nurse Aide (CNA), conducted a video call showing R2 during resident care. On 7/1/2026 at 9:31 AM, V31, Certified Nurse Aide (CNA), stated V31 observed V32 conduct a video call during R2's care and V31 reported it a few hours later. On 7/1/2026 at 12:55 PM, V3, Regional Administrator, stated the facility expects abuse allegations to be reported immediately upon becoming aware of the allegation. The facility policy titled Abuse Prevention and Reporting & Illinois, last approved March 2026, directed employees to immediately report any incident, allegation, or suspicion of abuse, neglect, retaliation, exploitation, mistreatment, or misappropriation of resident property to the Administrator or an immediate supervisor, who must then immediately notify the Administrator. The state agency will be notified of abuse allegations and notified of the findings of the abuse investigation.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to thoroughly document and thoroughly investigate abuse allegations, and implement appropriate corrective measures for seven (R1, R4, R5, R9, R10, R11, R15) of 14 residents reviewed for abuse in the sample list of 20. Findings include: The facility's Abuse Prevention and Reporting policy, revised March 2026, documents all abuse allegations will be documented and investigated, and at a minimum will include attempts to interview the person who reported the incident, anyone likely to have knowledge of the incident and the resident, and residents who the accused employee has regularly provided care for and staff who has regularly worked with the accused. 1.) On 6/29/26 at 11:10 AM and on 6/30/26 at 8:05 AM, V4, Licensed Practical Nurse, was working on the dementia unit/hallway of the facility. This unit contained a video surveillance camera located at the entrance of the hallway facing the exit door at the opposite end of the hall. The facility's Final Abuse Investigative Report, dated 6/16/26, documents on 6/11/26 a staff to resident (R1) abuse allegation was reported. An unidentified Certified Nursing Assistant (CNA) was interviewed and reported being asked to watch R1 because R1 kept trying to get up from R1's chair, R1 was agitated and weak, and R1 could not stand up but kept trying. This CNA noticed a sheet tucked around R1 and the wheelchair, and two CNAs took R1 to be laid down in bed. The facility concluded based on staff interviews R1 experienced episodes of agitation and staff responded appropriately by providing one to one supervision until R1 could be laid down. The alleged abuse incident report, dated 6/11/26 for R1's abuse allegation, documents staff notified V3, Regional Administrator, that R1 had a sheet secured around R1's waist and wheelchair. This report documents a nurse (unidentified) statement dated 6/11/26 as having two admissions who weren't doing well, R1 was weak and kept trying to get up, the nurse was next to R1 the entire time and asked a CNA to watch R1 so the nurse could take a break. The nurse securely tucked a sheet around R1's waist and chair. The nurse also had R1 double gowned restricting R1 from using R1's hands as R1 normally does. This report documents unidentified CNA statements, dated 6/11/26 and 6/15/26, as being called by the nurse to sit with R1 and CNAs walked into the room and found R1 tied to a chair referred to as an illegal restraint. The nurse responded it was going to be undone when the nurse was done with her work, and the nurse wasn't going to keep R1 tied there. The above abuse investigation and report do not identify the names of the staff involved or the staff interviewed. There is no documentation the facility reviewed video surveillance or interviewed any residents regarding the alleged perpetrator (V4 Licensed Practical Nurse). The Corrective Action Form, dated 6/15/26, documents a verbal warning was given to V4, LPN, for misconduct regarding an incident on 6/11/26 at 4:20 PM that occurred on the facility's dementia unit/hall. R1's Minimum Data Set, dated [DATE], documents R1 has severe cognitive impairment, R1 did not use any physical restraints, and R1 required dependence on staff for transfers. R1's electronic medical record (EMR) does not document a physician's order for restraints prior to 6/29/26, an assessment for physical restraint use, medical symptoms justifying restraint use or alternative less restrictive measures implemented prior to restraint use. R1's Interdisciplinary Team Note, dated 6/16/2026 at 2:11 PM, documents following the investigation of the allegation on 6/11/26, the facility determined R1 experienced agitation and staff responded appropriately with one-to-one care and supervision until R1 could be laid down. R1's skin and pain assessment found no new skin alterations and R1's care plan was reviewed and updated as appropriate to ensure R1's psychosocial needs are met. The facility's June 2026 Nursing Daily Schedules document V4 worked in the facility on the 300 and 400 hallways. These schedules (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	document V4 worked on R1's hallway (the Dementia unit) 6:00AM-6:00 PM shift on 6/11/26 and resumed working this unit as of 6/16/26. On 6/29/26 at 11:29 AM, V5, CNA, stated on 6/11/26 at approximately 5:30 PM, V4 came out of the dementia unit nurses' station asking V5 and V8 CNA to watch R1 so V4 could take a break. V5 stated R1 was found sitting in a wheelchair with a sheet rolled linear across R1's torso and tied behind R1's wheelchair, out of R1's reach preventing R1 from getting out of the wheelchair. V5 stated R1 also had two hospital gowns on, one frontward and one backward, which were tied keeping R1's arms down and restricting movement as R1's arms were not through the sleeves. V5 was unsure how long R1 had been like that as V4 had been in the nurse's station with R1 with the door closed for about 30 minutes prior. On 6/29/26 at 11:44 AM, V8 confirmed V8 witnessed R1 restrained by V4 with the same descriptions as V5 stated. V8 stated prior to this V4 was sitting with her foot on R1's lap preventing R1 from standing and V4 has done this a few times before. On 6/29/26 at 2:08 PM, V3 stated R1 returned from the hospital during mealtime, R1 was not doing well, he was a mover and wanderer, and staff were trying to keep R1 busy so the staff could pass meal trays. V3 stated V3 was told V4 had a sheet draped across R1's lap, V8 reported the sheet was tied but V4 reported it wasn't. V3 stated V3 completed the initial report and handed the allegation over for V1 to complete the investigation. V1 stated V1 spoke to V4 who asked the CNAs to watch R1 so V4 could take a break, and V4 tucked a sheet around R1's waist and wheelchair. V1 stated V4 denied having the sheet tied or R1 double gowned. V1 stated V1 spoke to V8 and V5 who reported finding R1 tied to R1's wheelchair and double gowned by V4 restricting R1's hand movement. V1 stated additional CNA's were interviewed and no residents were interviewed since the incident occurred on the facility's Dementia unit. V1 confirmed the facility's investigation does not identify or include the staff involved, the staff interviewed, review of video surveillance or resident interviews. V1 and V3 stated a physical restraint was in place as ordered so abuse was not substantiated, V4 was given a verbal warning and allowed to return to work. V3 confirmed the facility's surveillance cameras are functioning. V3 stated these cameras are not reviewed for abuse investigations as that is not facility policy. On 7/1/26 at 5:15 PM, the facility's active video surveillance screens were viewed with V3 on the computer in the front office. The dementia hall video was clear and able to see residents and staff moving about. The entire hallway was visible besides a small portion that was partially obstructed by a decorative banner that was hanging in front of the camera on the hallway. R1's room doorway located across from the nurse's station and hallway were visible. This was confirmed with V3. On 7/2/26 at 10:13 AM, V3 stated the facility's video surveillance maintains footage for a 72 hour period. 2.) The facility's Final Abuse Investigation Report, dated 6/24/26, documents the following: V1 was notified of an allegation of sexual abuse of R5 by R4 (who reside on the Dementia unit) on 6/17/26 at approximately 7:10AM. The Certified Nursing Assistant (CNA V7) stated that V7 briefly stepped away from the dining room and upon returning V7 observed R4 seated in a wheelchair with R4's hand inside the front waistband of R5's pants who was standing. The facility's investigative file for this allegation does not document the names of staff interviewed and only contains interviews with two staff, a nurse and CNA. The investigation does not include any other staff or resident interviews or that video surveillance was reviewed. The following additional resident to resident sexual abuse allegations were identified through staff (V8 CNA, V16 CNA, V17 CNA, and V19 Licensed Practical Nurse) and resident (R10) interviews conducted on 6/29/26 and 6/30/26 between 8:00 AM and 3:33 PM: R9 has predatory behaviors including going into female resident rooms R10 and R11, watching them undress and go to the bathroom, and R10 and R11 have expressed fear of R9. R11 have expressed fear of R9. R9 rubbed R15's back and near R15's breasts, R9 attempted to get R15 out of bed and undressed which was reported to the former Administrator, V66. Around 4-5:00 PM on 6/11/26 V8 found R5 and (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R9 in R9's room with the door shut, R9 had his hand up underneath R5's shirt and R5 was not wearing a bra. R10 stated R10 has had problems with another resident coming into R10's room and R10 identified R9 by R9's name. R10 stated R10 tells R9 to get out of R10's room and R9 will just stand there, and R9 also goes into R10's friend's room (R11) located across the hall. R10 stated (R9) scares me (R10). At this time R10 approached R9's doorway. R10 pointed and identified R9 by name and R9 was the man R10 was referring to. R10's MDS, dated [DATE], documents R10 has moderate cognitive impairment. The facility's abuse log dated January-June 2026 do not include any allegations involving R9. On 7/1/26 at 5:15 PM, the facility's active video surveillance screens were viewed with V3 on the computer in the front office, including a full view of the Dementia unit's dining room. On 6/29/26 at 2:08 PM, V1 confirmed V1 completed the investigation for this allegation and the investigation did not identify staff names who were interviewed. V1 stated V1 interviewed V7, CNA, and V28, Registered Nurse. V1 confirmed no other staff or residents were interviewed and video surveillance was not reviewed for this abuse investigation. V1 and V3 both stated nothing had been reported to them about R9's behaviors of watching female resident undress and toilet or touching female residents inappropriately. V1 and V3 stated the allegation of R9 having his hand up R5's shirt was reported today by V24. On 7/1/26 at 8:56 AM, V3 stated V66 (Former Administrator) was the facility's administrator a year ago. V3 was not aware of any prior abuse allegations involving R9 and V3 will check the abuse allegation files. At 9:04 AM, V3 confirmed there were no abuse investigations involving R9, besides an allegation of staff to resident verbal abuse regarding food.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to provide assistance with eating for one of three residents (R16) reviewed for Activities of Daily Living on the sample list of 20. Findings Include: R16's Care Plan, dated 3/24/26, documents R16 is diagnosed with Activity Intolerance, Alzheimer's Disease, Dementia, Fatigue and has an Activity of Daily Living self-care performance deficit that requires one staff to assist with eating. R16 has a risk for weight loss and is under Hospice Care. R16 requires meal intake monitoring and has a goal to eat 50 percent or more of R16's meals. On 7/6/26 at 4:55 PM, R16 was sitting in R16's wheelchair in the television room by R16's self. R16 had a sandwich on R16's lap which R16 was tearing up into pieces but not eating. The sandwich had been torn apart but R16 was not eating it. On 7/7/26 at 9:00 AM, R16's breakfast tray was on R16's overbed table, untouched. R16 denied eating breakfast. At 10:00 AM, facility staff had still not come in to assist R16 with eating. On 7/6/26 at 2:35 PM, V50, Hospice Registered Nurse, stated R16 requires staff assistance with eating. R16 will eat if staff take the time to feed R16 and continue to offer foods R16 likes. R16 enjoys soda pop and pudding. V50 stated facility staff need to take the time to feed R16. On 7/7/26 at 2:00 PM, V2, Director of Nurses, confirmed R16 is on Hospice services, does not have a great appetite, has weight loss, has wounds, is nutritionally at risk, and requires staff assistance with eating. Staff are to attempt to assist R16 with every meal. Staff should not be leaving R16 with food in R16's lap and should be providing queuing, encouragement, and assistance.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure post-fall monitoring was completed timely and reflected ongoing assessment for one (R,6) of three residents reviewed for falls on a sample list of 20 residents. Findings include: On 6/29/26 at 10:55 AM, R6 was sitting in a wheelchair and eating chips in their room. R6 recalled the fall that occurred on 5/8/26. While describing the incident, R6 leaned forward in the wheelchair and pointed to the left foot, then to the space between the front and back wheelchair wheels. When asked for clarification, R6 nodded yes to indicate the left foot became caught between the wheelchair wheels, causing a forward fall. R6 lifted sweatpants to show bruising on both knees and pointed to the right hand, which was in a brace. R6 confirmed with a nod that these were the areas injured during the fall and again nodded yes when asked if healing was occurring and if R6 was feeling better. An Incidents by Incident Type Report, dated 6/29/26, documents a witnessed fall on 5/8/26. R6's Minimum Data Set, dated [DATE], documents R6 is moderately cognitively impaired. R6's 72-hour Occurrence Follow-up Charting (R6's post fall monitoring and assessments) for 5/8/26 at 10:56 PM, 5/9/26 at 9:56 AM, 5/9/26 at 4:56 PM, 5/10/26 at 11:57 AM, and 5/10/26 at 7:57 PM documents identical, verbatim documentation in each assessment entry and all entries were signed on 5/13/26. On 6/29/26 at 3:45 PM, V2, Director of Nursing, stated that 72-hour follow-up charting is expected to be completed by each shift after a fall. V2 confirmed R6 did not have all required 72-hour follow-up documentation completed correctly and noted that most entries were opened and completed on 5/13/26, which V2 stated is not the facility expectation. On 7/7/26 at 11:49 AM, V65, Regional Nurse Consultant, stated the facility does not have a policy addressing neurological checks or post-fall assessments.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to consistently implement wound prevention interventions and complete weekly skin/wound assessments for one of three residents (R16) reviewed for pressure ulcers on the sample list of 20 residents. Findings Include: The facility's Pressure Ulcer Prevention policy, dated December 2025, documents the policy's purpose is to prevent and treat pressure injuries. Staff are to use positioning devices, pads, pillows, etc. to reduce pressure from heels and toes as indicated. The facility's Pressure Injury and Skin Condition Assessment policy, dated December 2025, documents each pressure ulcer will be assessed and measured at least every seven days by a licensed nurse and documented in the resident's clinical record. A wound assessment for each identified open area will be completed and will include site location, size, stage of wound, odor, drainage, description, and date and initials of individual performing the assessment. R16's Care Plan, dated 6/23/26, documents R16 is diagnosed with Impaired Mobility, Heart Failure, Failure to Thrive, and Incontinence which place R16 at risk for skin impairment. R16 has actual pressure wounds. Staff are to minimize pressure over bony prominences. On 7/2/26 at 2:00 PM, R16's bilateral pressure relieving booties were in R16's wheelchair under blankets. R16 was in R16's bed lying down. On 7/2/26 at 2:35 PM, V50, Hospice Registered Nurse, confirmed R16 requires the use of bilateral pressure relieving booties to assist with wound prevention and healing. V50 confirmed when staff arrived, R16's booties were in R16's wheelchair covered with blankets and not on R16's feet as R16 lay in bed. V50 confirmed this is an important wound intervention because of R16's contractures and inability to move R16's feet and legs much on her own. V50 confirmed R16 has pressure wounds on both of R16's feet/ankles. On 7/6/26 at 4:30 PM, V49, Wound Nurse/Assistant Director of Nurses, confirmed R16 has wounds on both of R16's feet and ankles and due to R16's bilateral leg contractures. R16's feet and ankles often rub together and R16 cannot move them well on R16's own to relieve pressure. V49 confirmed R16 requires the use of pressure relieving booties on both feet to help relieve pressure or wound formation or deterioration. V49 confirmed the booties are not always kept on R16 as they should be. V49 confirmed weekly skin/wound assessments are not always completed for R16 and multiple assessments in the last couple months were left incomplete. On 7/7/26 at 2:00 PM, V2, Director of Nurses, confirmed R16 is on Hospice services, does not have a great appetite, has had recent weight loss, has wounds, is nutritionally at risk, and requires consistent interventions to prevent further skin breakdown and wound deterioration. V2 also confirmed R16's skin/wounds should be assessed thoroughly by the facility at least weekly and that documentation should be available in R16's medical record.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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 complete thorough fall investigations following falls for two (R7, R1) residents and did not implement fall interventions for two (R7, R13) out of three residents reviewed for falls on a sample list of 20 residents. The Facility's Fall Prevention Program policy, revised May of 2022, documents safety interventions will be implemented for each resident identified as being at risk for falls. It further documents, all assigned nursing personnel are responsible for ensuring ongoing precautions are put into place and consistently maintained. 1. An Incidents by Incident Type Report, dated 6/29/26, documents R7 had unwitnessed falls on 4/10/26, 4/20/26, 4/25/26, 4/26/26, 5/17/26, and a witnessed fall on 4/26/26. R7's Minimum Data Set (MDS), dated [DATE], documents R7 is moderately cognitively impaired. R7's Care Plan documents R7 is at risk for falls and has an intervention, dated 4/26/26, for the Medical Director to review medications related to increase falls. R7's Fall Follow Up Note, dated 4/27/26, documents the Interdisciplinary Team met and discussed R7's fall on 4/26/26. It also documents as an intervention to prevent further falls that the Medical Director will be notified of R7's increased fall risk and a medication review will be requested. R7's Unwitnessed Fall Risk Management, dated 4/26/26 at 2:45 a.m. does not document any statements from staff documenting when R7 was last seen prior to the fall. On 6/29/26 at 10:12 AM, R7 was observed seated in a wheelchair in the resident room watching television. The room was tidy and the bed was made. R7 appeared well groomed and was wearing hat. Anti-rollback devices were present on the wheelchair, and the call light was within reach. R7 stated R7 can recall falling a couple of times within the past month or two but was unable to recall the details of the falls or any injuries associated with them. On 6/30/26 at 9:20 AM, V14, Licensed Practical Nurse, could not recall R7's fall on 4/26/26. On 7/2/26 at 10:57 AM, V39, Certified Nurse's Aide, was contacted in regard to R7's fall on 4/26/26 at 2:47AM. V39 stated V39 no longer works at the facility and directed surveyor to call someone else and ended the call. On 6/30/26 at 10:19 AM, V2, Director for Nursing (DON), stated the investigations for R7's falls were still being put together as V2 was unaware that falls that were not reportable to the State Agency should be investigated. V2 stated staff should be collecting witness statements at the time of a resident's fall and entering them into the Risk Management. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/7/26 at 11:50 AM, V2, DON, stated the Medical Director would have been faxed to review R7's medications. V2 stated V2 reached out to the Medical Directors office but confirmed V2 does not have any documentation that R7's medications were reviewed after R7's falls on 4/26/26. On 6/30/26 at 10:35 AM, V2, DON, stated every fall investigation should have witness statements from any staff present at the time of the fall. V2 stated the witness statements would indicate when a resident was last seen by staff. V2 confirmed there are no witness statements for R7's fall on 4/26/26 at 2:45a.m. 2. An Incidents by Incident Type Report, dated 6/29/26, documents R1 had unwitnessed falls on 4/9/26, 4/11/26, and 6/5/26. R1's Unwitnessed Fall Risk Management, dated 4/9/26 at 6:13 AM, does not document statements from staff regarding the last time R1 was seen or checked on prior to the fall. R1's Unwitnessed Fall Risk Management, dated 4/11/26 at 12:15 PM, does not document statements from staff regarding the last time R1 was seen or checked on prior to the fall. On 6/30/26 at 10:35 AM, V2, DON, stated every fall investigation should have witness statements from any staff present at the time of the fall. V2 stated the witness statements would indicate when a resident was last seen by staff. On 7/2/26 at 9:51 AM, V2, DON, stated there are no statements for R1's falls on 4/9/26 and 4/11/26. 3. R13's Incident Note, dated 5/30/26, documents R13 sustained a fall at 4:50 PM. R13 was found on the floor next to R13's bed. R13 was unable to say how it happened. R13 was not injured. R13's Fall Follow-up Note, dated 6/1/26, documents R13's fall was reviewed, and it was determined R13 slid out of bed. A raised edge mattress was implemented as a new fall-related intervention. On 7/2/26 at 2:00 PM, R13's bed had an air mattress but no raised edge mattress in place. On 7/7/26 at 2:00 PM, V2, Director of Nurses, confirmed R13's raised edge mattress was never ordered or put into place after R13's fall on 5/30/26.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on interview and record review, the facility failed to provide and document urinary catheter care for one of three residents (R13) reviewed for catheter care on the sample list of 20. Findings Include: The facility's Urinary Catheter Care policy, dated December 2025, documents in order to reduce the risk of or prevent infections in residents with indwelling catheters, urinary catheter care should be performed and documented on the Treatment Administration Record (TAR) at least daily. R13's Care Plan, dated 6/18/26, documents R16 has an indwelling urinary catheter related to Obstructive and Reflex Uropathy. R13's Treatment Administration Record for June 2026 does not document any urinary catheter care completed. On 7/6/26 at 4:30 PM, V49, Assistant Director of Nurses (ADON), confirmed R13 has a urinary catheter has had some recent urinary tract infections. Staff should be providing catheter care every shift. Catheter care should be documented on the TAR daily. On 7/7/26 at 2:30 PM, V2, Director of Nurses, confirmed R13 has a urinary catheter and catheter care should be completed at least daily and charted on the TAR in R13's medical record.		