STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145457	A. Building B. Wing	06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quincy Healthcare & Sr Living	1440 North 10th Street Quincy, IL 62301

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Interview and Record Review, the facility failed to ensure a physician was notified of a residents change in skin conditions when new concerns were identified for one of three residents (R1) reviewed for Change of Condition in the sample of three.Findings include:The facility's Change in Resident Condition or Status policy, dated 2/2021, documents Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. The nurse will notify the resident's attending physician or physician on call when there has been a (an): accident or incident involving the resident; discovery of injuries of an unknown source; significant change in the resident's physical/ emotional/ mental condition. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.The facility's Skin Tears- Abrasions and Minor Breaks policy, dated 9/2013, documents When an abrasion/skin tear/bruise is discovered, complete a Report of Incident/ Accident. Notify the responsible family member. Physician notification may be routine (that is, non-immediate) if the abrasion is uncomplicated or not associated with significant trauma. Notify the physician of any abnormalities (i.e., excessive bleeding, localized swelling, redness, drainage, tenderness, pain etc.). Report other information in accordance with facility policy/guideline and professional standards of practice.R1's Care Plan, dated 5/19/26, documents R1 was admitted to the facility on [DATE] and has left and right lower extremity venous stasis ulcers due to disease processes. This care plan does not document R1 has any other wounds.R1's Nursing Progress Notes, dated 5/18/26 at 1:19 AM and completed by V6 (Registered Nurse), documents (R1) taken to the restroom CNA (Certified Nursing Assistant, unknown) reports blood in the toilet. (V6) assessed (R1) noting dark discoloration to back of her legs and a small open area 0.5 centimeters by 0.5 centimeters on right labia.R1's Skin Check, dated 5/18/26 at 3:32 AM and completed by V6, documents Skin impairment site groin, description: small area to right labia. This same form documents the skin area is new, a treatment was not obtained and R1's care plan was not reviewed or updated.R1's electronic medical record does not document that a physician or the Director of Nursing (V2) were ever notified of R1's newly discovered labial tear.On 6/23/26 at 1:50 PM, V6 (Registered Nurse) confirmed she was the nurse working on 5/18 when it was noted that R1 had blood in the toilet. V6 denied notifying anyone of the new finding after filling out a skin observation for the right labial tear. V6 stated It was a small laceration to her labia. I might've said something to the nurse in report. I did not call the doctor or notify anyone at one in the morning.On 6/23/26 at 2:40 PM, V2 (Director of Nursing) stated she was not made aware of R1 having a labia tear and stated it should have been reported immediately to her and a physician.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Interview and Record Review, the facility failed to report a new injury of unknown source to the abuse coordinator for one of three residents (R1) reviewed for Abuse in the sample of three.Findings include:The facility's Abuse, Neglect, Exploitation and Misappropriation Prevention policy, dated 4/2021, documents Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. Investigate and report any allegations within timeframes required by federal requirements. Protect residents from any further harm during investigations.The facility's Investigating Resident Injuries policy, dated 4/2021, documents All resident injuries are investigated. The director of nursing services or a designee assesses all resident injuries and documents findings in the medical record. The medical director or attending physician shall review and verify conclusions about the possibility of a medical or other similar cause of the findings. If nursing and medical assessment determines an injury of unknown source the investigation will follow the protocols set forth in our facility's established abuse investigation guidelines. Injury of unknown source is defined as an injury that meets both of the following conditions: The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time; or the incidence of injuries over time.R1's Nursing Progress Notes, dated 5/18/26 at 1:19 AM and completed by V6 (Registered Nurse), documents (R1) taken to the restroom CNA (Certified Nursing Assistant, unknown) reports blood in the toilet. (V6) assessed (R1) noting dark discoloration to back of her legs and a small open area 0.5 centimeters by 0.5 centimeters on right labia.R1's Skin Check, dated 5/18/26 at 3:32 AM and completed by V6, documents Skin impairment site groin, description: small area to right labia. R1's electronic medical record dated 5/18/26-5/20/26 does not document any further notes or assessment of R1's open area to her labia. This record does document R1 was admitted to the hospital on [DATE].On 6/23/26 at 11:30 AM, V1 (Administrator in Training) stated she does not have any injury of unknown source investigations for the past three months and that none of those have been reported to her.On 6/23/26 at 1:50 PM, V6 (Registered Nurse) confirmed she was the nurse working on 5/18 when it was noted that R1 had blood in the toilet. V6 denied notifying anyone of the new finding after filling out a skin observation for the right labial tear. V6 stated It was a small laceration to her labia. I might've said something to the nurse in report. I did not call the doctor or notify anyone at one in the morning.On 6/23/26 at 2:40 PM, V1 and V2 (Director of Nursing) both denied knowing that R1 had a labia tear discovered prior to her hospitalization. V1 stated I thought that was after she went to the hospital. V1 confirmed she is the facility's abuse coordinator, and she should have been notified so she could complete an investigation. V2 confirmed that the open area is in a location that would require some investigation. V2 stated she was not made aware of R1 having a labia tear and stated it should have been reported immediately.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Interview and Record Review, the facility failed to ensure residents were provided adequate bathing/showers to maintain proper hygiene and skin care for two of three residents (R1, R2) reviewed for showers in the sample of three.Findings include:The facility's Bath, Shower/Tub policy, dated 2/2018, documents The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin.The facility's Resident Council minutes for April, May and June 2026 all document that resident showers are not being given twice a week and the issue remains on-going.1. R1's Physician Order Sheet, dated 5/15/26, documents R1 was admitted to the facility on [DATE] and has diagnoses including Morbid Obesity, Heart Failure, Peripheral Vascular Disease, Methicillin Resistant Staphylococcus Aureus infection and Cellulitis of the left lower limb.On 6/23/26 at 11:05 AM, V5 (local hospital Registered Nurse) confirmed caring for R1 when she transferred to the hospital on 5/20/26. V5 stated (R1's) labia and groin were my biggest concerns. (V12, R1's Power of Attorney) told us she felt like R1 was not getting cleaned adequately or showered very often. (R1) kept saying she was sore down there. We (emergency room staff) cleaned bloody yeast from her groin, and it took about 45 minutes. Her wounds weren't cared for and her hygiene was not adequate to prevent infection.R1's Shower/Bath Skin Assessment sheets for April and May 2026 document R1 went from 4/2 to 4/12 (10 days) between showers and went from 4/19-5/3 (14 days) between showers.2. R2's Physician Order Sheet, dated 6/23/26, documents R2 was admitted [DATE] and has diagnoses including Vascular Dementia, Osteoporosis and Chronic Pain. This same order sheet documents R2 has an order for (mechanical lift) for all functional transfers.R2's Skin Monitoring shower sheets for May and June 2026 document R2 was given a shower 5/23, 5/26 and 5/30/26. R2's medical record does not contain any other shower sheets for those months.On 6/23/26 at 2:30 PM, V2 (Director of Nursing) confirmed staff are supposed to document bathing and skin conditions on the facility's shower and skin sheets. V2 confirmed they only have three shower sheets for R2 and agreed there are large gaps in time for R1's showers. V2 stated This is all of the documentation I could find.

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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 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 Interview and Record Review, the facility failed to properly assess a resident's new skin condition and ensure identified wounds were evaluated and obtain treatment orders for one of three residents (R1) reviewed for wounds in the sample of three.Findings include:The facility's Skin Tears- Abrasions and Minor Breaks policy, dated 9/2013, documents The purpose of this procedure is to guide the prevention and treatment of abrasions, skin tears, and minor breaks in the skin. Obtain a physician's order as needed. Document physician notification in medical record. An abrasion is an area on the skin that has been damaged by friction, scraping, rubbing or trauma. A skin tear is the disruption of epidermis resulting in a lifting or friction of the skin. If the wound is bleeding, gently apply a compress with pressure over the wound and reinforce the compress as needed to control any bleeding. If the bleeding persists after efforts to stop it, or an object is embedded into the abrasion, or other medical attention is needed, notify the physician. This policy also documents Record the following information in the resident's medical record: Complete in-house investigation of causation. Generate Non-Pressure form. Document physician and family notification, and resident education (if completed) in medical record. How the resident tolerated the procedure. Any problems or resident complaints related to the procedure. Any complications related to the abrasion (e.g., pain, redness, drainage, swelling, bleeding, decreased movement). If the resident refused the treatment, the reason for refusal and the resident's response to the explanation of the risks of refusing the procedure, the benefits of accepting and available alternatives. Interventions implemented or modified to prevent additional abrasions (e.g., clothes that cover arms and legs). When an abrasion/skin tear/bruise is discovered, complete a Report of Incident/ Accident. Notify the responsible family member. Physician notification may be routine (that is, non-immediate) if the abrasion is uncomplicated or not associated with significant trauma. Notify the physician of any abnormalities (i.e., excessive bleeding, localized swelling, redness, drainage, tenderness, pain etc.). Report other information in accordance with facility policy/guideline and professional standards of practice.R1's Care Plan, dated 5/19/26, documents R1 was admitted to the facility on [DATE] and has left and right lower extremity venous stasis ulcers due to disease processes. This care plan does not document R1 has any other wounds.On 6/23/26 at 2:00 PM, V7 (Registered Nurse) confirmed taking care of R1 the day she suffered a fall from the toilet. V7 stated R1 did not have any lacerations to her private area, labia or groin at that time and stated she has had redness in the past on her backside but on 5/15, she did not have bruising or discoloration to her back or the backs of her legs.R1's Bath Skin Assessment sheet, dated 5/17/26 and signed off by V9 (Registered Nurse) documents that new skin areas were identified during R1's shower on 5/17/26. This sheet documents R1 has slight redness in the front vaginal and perinium area and inside red and skin peeling open areas to R1's buttock area. R1's Skin Check, dated 5/18/26 at 3:32 AM and completed by V6 (Registered Nurse), documents Skin impairment site groin, description: small area to right labia. This same form documents the skin area is new, a treatment was not obtained and R1's care plan was not reviewed or updated. R1's electronic medical record, dated 5/15/26-5/20/26, does not document any new wound assessments, treatment orders or any updates to R1's Care Plan upon discovery of R1's new skin conditions. This medical record does document R1 was transferred to the local hospital for lower extremity weakness and admitted to the hospital.On 6/23/26 at 1:50 PM, V6 (Registered Nurse) confirmed she was the nurse working on 5/18 when it was noted that R1 had blood in the toilet. V6 denied notifying anyone of the new finding after filling out a skin observation for the right labial tear. V6 It was a small laceration to her labia. (R1's) back of her legs were discolored. V6 also stated I did not call the doctor or notify anyone at one in the morning. I am not aware if it was told to V1 (Administrator in Training) or V2 (Director of Nursing), or if an order for treatment was ever obtained.R1's Hospital emergency room Progress note, dated 5/20/26 at 11:42 AM, documents Skin: Scattered abrasions on the back laterally both sides, likely (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from gait belt. Open areas from excoriation and lower abdominal fold and up on labia, minor bleeding noted.On 6/23/26 at 11:05 AM V5 (local hospital Registered Nurse) stated I took care of (R1) in the hospital. (R1's) labia and groin were my biggest concerns. (R1) kept saying she was sore down there. (R1's) had a slit in her groin and another on her labia that were both untreated. Her groin wound was deep, and she had blood in her underwear. These wounds weren't cared for, and her hygiene was not adequate to prevent infection. I did talk to someone from the facility, but I am not sure who. I told them about (R1's) wounds and they acted surprised to hear about them.On 6/23/26 at 2:40 PM, V2 (Director of Nursing) stated she was not made aware of R1 having new skin concerns in the days before she was transferred to the hospital and was not aware of a labial tear. V2 confirmed that if new skin conditions are discovered they should be reported to her, and the physician should be notified to get treatment orders.

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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. Based on Interview and Record Review, the facility failed to ensure a resident was monitored and assessed for skin injuries after falling and ensure a post fall risk assessment was completed for one of three residents (R1) reviewed for Falls in the sample of three.Findings include:The facility's Assessing Falls and Their Causes policy, dated 3/2018, documents After a Fall: Document any observed signs or symptoms of pain, swelling, bruising, deformity, and/or decreased mobility; and any changes in level of responsiveness/ consciousness and overall function. Note the presence or absence of significant findings. Complete an incident report for resident falls no later than 24 hours after the fall occurs. The incident report should be completed by the nursing supervisor on duty at the time and submitted to the director of nursing services. After an observed or probable fall, clarify the details of the fall, such as when the fall occurred and what the individual was trying to do at the time the fall occurred. When a resident falls, the following information should be recorded in the resident's medical record: Assessment data, including vital signs and any obvious injuries. Completion of a fall risk assessment.R1's Progress Notes, dated 5/15/26 at 11:00 AM and completed by V7 (Registered Nurse) documents (R1) was assisted to the bathroom, then when she was ready to get off the toilet, she slid down to the floor. This note also documents No injury noted. Got (R1) off the floor via (mechanical lift) to wheelchair.R1's electronic medical record does not document any skin assessment, post fall assessment, or updated fall risk assessment.On 6/23/26 at 2:00 PM, V7 (Registered Nurse) confirmed taking care of R1 the day she suffered a fall from the toilet. V7 stated I was the one who lowered (R1) to the floor on 5/15/26 after the incident. V7 then stated he did not document a fall note, fall assessment, skin assessment or update her record to reflect a fall because he lowered her to the ground and it wasn't a fall in his opinion. On 6/23/26 at 2:40 PM, V2 (Director of Nursing) confirmed that being lowered to the floor on 5/15/26 was a fall for R1 and stated a fall assessment, skin assessment, post fall monitoring and fall risk updates should have been conducted at that time.