

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145563	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/25/2025
NAME OF PROVIDER OR SUPPLIER The Citadel at Saint Anne Place		STREET ADDRESS, CITY, STATE, ZIP CODE 4405 Highcrest Road Rockford, IL 61107	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview and record review the facility failed to ensure residents were treated with dignity by answering call lights in a timely manner. This applies to 4 of 4 residents (R15, R16, R17, R18) reviewed for dignity in the sample of 18. The findings include: On 11/25/25 at 11:30 AM R15 stated, It takes a long time, but I do not know how long because I do not have a clock. It feels like at least 20 - 30 minutes most of the time. It is worse during shift change or when they are on their breaks. I lay in wet diapers quite a while- all the time. They often come in and turn the light off and say they will be back and sometimes they come back and sometimes they don't. It is not good. Some are very nice and others are not. Some do not want to listen to what I want them to do. One girl yesterday threatened to leave the room and not come back. On 11/25/25 at 11:40AM R16 stated, Sometimes an hour- usually a little less. Sometimes I wet my pants because I have to wait so long. Makes me feel helpless. Nighttime I think is the worst. Some of the staff are nice, some are very rude. They are really good at turning off the call lights. I tell them as many times as they turn them off; I will turn it back on. On 11/25/25 at 11:45AM R17 stated, I have waited anywhere from 15 minutes to 2 hours to have my call light answered. This IV has been beeping for 30 minutes now. The nurse said she was going to set a timer on her watch so she could come and turn it off. (continued to beep until Surveyor reported to nurse at 12:15PM). I have a catheter and a stoma, so I have that going for me but when I put my call light on, I usually need a pain pill, or I need to be repositioned in the bed. When they don't come it makes me feel like I have no value, like my concerns and my needs are immaterial. They said that whenever a CNA (Certified Nurse Assistant) walks past the room and my call light is on, they should be checking to see what I need. That never happens. My doctor is currently looking for another place for me to live. On 11/25/25 at 12:00PM R18 stated, Sometimes the call light doesn't get answered at all and I try to make it to the bathroom on my own. It is either that or wet the bed. Plenty of time I have dribbled in my Depends because I can't get there in time. What does that sign say? (Sign on the bathroom door reads- Wait for the nurse, don't get up alone. Well sometimes that is not possible. I always tell them they are going to have a bigger mess to clean up if they don't come in time. I have fallen a couple of times, and I am afraid it will happen again. But I have to go to the bathroom. If they just take me in there then I will find my way back. Sometimes that light in there (bathroom) is still going off 15-20 minutes after I have gotten myself back in the bed. The facility Residents' Rights for People in Long-term Care Facilities Pamphlet given to residents on admission to the facility stated, Your facility must provide services to keep your physical and mental health, and sense of satisfaction.		

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 0684 Level of Harm - 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 ensure a thorough assessment was performed for a resident sustaining a fall and failed to identify an acute fracture prior to sustaining a second fall. This failure resulted in R3 sustaining a fall with x-ray results showing a right hip impacted subcapital fracture of right femoral neck without staff identifying and reporting her injury and sustaining a 2nd fall approximately two days later delaying emergency care and services. This applies to 1 of 3 residents (R3) reviewed for quality of care in the sample size 18. The findings include: R3's face sheet shows diagnoses including Alzheimer's, unspecified intracapsular fracture of right femur, subsequent encounter for closed fracture with routine healing, unspecified fracture of left pubis, palliative care, anxiety, muscle weakness, unsteadiness on feet, repeated falls and hypertension. R3's Fall Risk assessment dated [DATE] shows she is high risk for falls. R3's Final Incident Report dated 10/10/25 shows on 10/5/25 approximately 12:45 PM, (R3) was observed laying on right side in the dining room. Assessment revealed limited range of motion (ROM) to her right lower extremity.(R3) sent out to the local hospital x-rays shows a right femur fracture. (R3's report does not include her first fall on 10/3/25 and the x-ray results on 10/4/25 showing a right hip fracture). R3's hospital records dated 10/5/25 shows (R3) had multiple ER visits for recurrent falls who presented after a fall unwitnessed fall from her wheelchair. Nurse that assessed her noticed she was crying when moving her lower extremities.reported another fall on 10/2 or 10/3.decreased ROM to right hip about 10 degrees flexion limited by pain.right lower extremity appears shorter and externally rotated.right x-ray shows subcapital femoral neck fracture with varus angulation. R3's X-Ray report dated 10/4/25 shows right hip impacted subcapital fracture of right femoral neck with varus deformity. On 11/24/25 at 10:05 AM, V14 (Registered Nurse/RN) said on 10/3/25, she was R3's nurse when she fell from her bed. After the fall R3 was rubbing her right hip and wincing in pain and could not verbally communicate. R3 said she was working with V21 (Agency RN) who did the fall follow up documentation. V21 had a lighter assignment and has lots of nursing home experience and we were working together as a team. V14 said V21 has a lot more nursing home experience than her and V21 was helping her assess R3. V14 said she was R3's primary nurse and did not document the fall in the medical record at that time because V21 said she would document R3's fall. V14 said she was asked to put in a nursing note by the facility because there was no documentation regarding her fall on 10/3/25. V14 said she put in note on 10/13/25 (ten days later) because she was told to by management. She could recall R3 having pain to her right hip but does not recall any changes to her right lower extremity. On 11/24/25 at 9:09 AM, V21 (Agency RN) said on 10/3/25, she offered to help V14 (RN) because she was behind and really struggling. V21 said she put in some orders and notified the provider of the fall. V21 said she did not assess R3 following her fall and was not R3's nurse. When a resident falls, nursing should assess the resident including vitals, pain, check range of motion, notify the family, and physician. On 11/25/25 at 7:00 AM, V13 (RN) said she was R3's nurse on third shift after she fell on the previous shift. V13 said when she arrived, R3 was sitting at the nurse's station, she was having obvious pain to her right hip. R3 was guarding her right hip. When x-ray arrived R3 was transferred to her bed. V13 said she assisted R3 into bed, I don't remember how R3 was transferred back to bed but said she had a change in her transfer status but could not recall the details. V13 said she does not remember assessing R3's right leg and she received the x-ray results by fax and remembers there was no evidence of a fracture. My memory of the night is not good. V13 said after a resident sustains a fall, post fall monitoring includes checking rom (range of motion), pain, and monitoring for any changes. V13 said she should have done an assessment on R3 and documented her findings in the medical record. V14's nurses note late entry date 10/13/25 (10 days later) documents on 10/3/25 .(R3) at foot of bed right hip in contact with floor. Assisted back to bed with CNA.(R3) indicating via gesture that hip is painful.V21's nurses note dated 10/3/25 at 8:14 PM, (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	documents order received for x-ray of right hip and leg related to fall in resident bedroom.V13's nurses note dated 10/4/25 at 6:33 AM, documents (R3) continue to have guarding leg and hip. STAT (urgently) X-ray performed, and report shows no recent fracture or dislocation. X-ray results placed in V19's (Nurse Practitioner) folder for review. The next nurses note dated 10/5/25 at 1:39 PM, shows (R3) had an unwitnessed fall in the dining room.(R3) observed laying on her right side.has limited ROM (range of motion) bilateral lower extremities, crying out when bilateral lower extremities are moved.sent to the local hospital. R3's electronic medical record shows from 10/3/25 to 10/5/25 there was no assessment of her right lower extremity until her 2nd fall on 10/5/25. R3's Pain Assessment Record dated 10/3/25 to 10/5/25 shows pain score of 4 to 8 recorded. R3's hospital records dated 10/5/25 shows (R3) had multiple ER visits for recurrent falls who presented after a fall unwitnessed fall from her wheelchair. Nurse that assessed her noticed she was crying when moving her lower extremities.reported another fall on 10/2 or 10/3.decreased ROM to right hip about 10 degrees flexion limited by pain.right lower extremity appears shorter and externally rotated.right x-ray shows subcapital femoral neck fracture with varus angulation. On 11/24/25 at 2:25 PM, V19 (NP) said she was not aware of R3's hip fracture on 10/4/25. She would expect staff to notify her of the x-rays results and assess residents after a fall to monitor for injuries. On 11/24/25 at 11:13 AM, V16 (Nurse Manager) said she is the fall coordinator, when a resident falls nursing should assess the resident and document in the progress notes. Post fall monitoring should occur every shift for 72 hours to monitor for changes and document their assessment. R3 was a high risk for falls with frequent falls. R3 had a fall on 10/3/25 in her room, she is not sure what happened with her fall because the nurse did not document the fall at the time. V2 (DON/Director of Nurses) spoke to the nurse about her assessment and her lack of documentation and follows up on the falls with injury. V16 said R3 had a 2nd fall two days later 10/5/25 with an injury. Staff should send out a resident to the ER right away if the x-ray results show a fracture and report it the physician. Imaging usually calls the facility to report fractures. She is not sure why R3 was not sent after her x-ray results showed a right femur fracture on 10/4/25. On 11/24/25 at 12:47 PM, V2 (DON) said she was not aware of R3's right femur fracture on 10/4/25 until she started printing out the documents today. V2 confirmed R3's x-ray dated 10/4/25 shows a right femur fracture and V13 documented there was no fracture. When she pulled the hospital report she assumed the fracture was from the 2nd fall. V2 said she was aware of R3's fall on 10/3/25 and was made aware V14 did not document R3's fall assessment. V2 said staff should document and assess a resident after falling, with post fall monitoring for 72 hours, monitor for changes and notify the x-ray reports. We have a problem with nursing not assessing, monitoring or reporting x-results. The facility's Fall Clinical Protocol Policy dated 2008 states, Assessment and Recognition as part of the initial assessment, the physician will help identify individuals with a history of falls and risk factors for subsequent falling.in addition, the nurse shall assess and document/report the following: vitals, recent injury especially fracture or head injury, musculoskeletal function, observing for changes in normal range of motion, weight bearing., etc., pain.monitoring and follow up.the staff with the physicians guidance, will follow up any fall with associated injury until the resident is stable and delayed complications such as late fracture or subdural hematoma have been ruled out or resolved. The facilities Notification of Change Guidance Policy dated 2024 states, It is the practice of this facility that changes in a resident condition or treatment are immediately shared with the resident and/or the resident representative.and are reported to and consulted with the attending physician.an accident involving the resident, which results in injury and has the potential for requiring physician intervention.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to initially identify a pressure ulcer and put interventions in place to prevent the area from worsening for a resident at high risk for developing pressure ulcers. This applies to 1 of 3 residents (R5) reviewed for pressure ulcers in the sample of 18. The findings include: R5's EMR (Electronic Medical Record) shows that R5 was admitted to the facility on [DATE] with diagnoses including right femur fracture, second lumbar vertebrae fracture, right acetabular fracture, complicated by acute hypoxia, respiratory failure and hypokalemia following a motor vehicle accident. R5 was discharged back to the hospital on [DATE] due to hypokalemia and elevated white blood cell count. R5's Wound Assessment Details Report dated 11/11/25 shows that R5 has a left buttocks wound measuring 9.0 x 11.0 x 0.10cm (centimeters) with a scant amount of serosanguineous exudate. The wound is described as facility acquired MASD (moisture associated skin damage). The Wound Physician Assessment also dated 11/11/25 states, Patient presents for initial evaluation of left gluteal wound. Onset/Duration: ?1week, Initial etiology: pressure, Drainage: minimal, Odor: present. The affected area demonstrates moisture associated skin damage (MASD) with superficial epidermal erosion consistent with prolonged exposure to moisture and irritants. Appearance: Irregular partial-thickness skin breakdown with erythema, maceration and superficial denudement. No full thickness tissue loss is present. On 11/24/25 at 10:00AM V16 (RN/Registered Nurse- Nurse Manager) stated, (R5) was here after a bad Motor vehicle accident- here for wound care and therapy. He was moved after the first day because with his bariatric bed and the mechanical lift the room he was in was just too small. He had a bariatric bed with an air mattress from (DME company). The bed had some issues, and you had to hold the cord in a certain way to get it to go up and down and about 2-3 days before he left for the hospital the air mattress had kept inflating and deflating. So, on a Friday (11/7/25) night I know they moved him to a regular mattress so he would be comfortable to sleep. I don't know how long he was on the regular mattress, but I know the wound care nurse wanted him on the air mattress. He came in with a surgical wound to his right hip, a DTI (Deep tissue injury) to his right heel and then he acquired MASD to his left buttocks. He required turning and repositioning. He was alert and oriented and was getting therapy but was not too keen about getting out of bed. On 11/24/25 at 11:00AM V20 (Medical Records) stated, The bed was not going up and down, so I contacted (company). I don't have control over when they come - all the nurses know that. I put in the requests, but they come out when they can. I requested the bed to be repaired on 11/6/25 and they came on 11/6/25. I requested the mattress to be fixed on 11/11/25 and they came out but they brought the wrong size mattress, so they came the next day (11/12/25) with the right one. On 11/24/25 at 11:30AM V17 (LPN/Licensed Practical Nurse - Wound Care) stated, (V18) did the initial assessment for everyone. I did a skin assessment the day after (R5) got here - on 11/6/25. Then (V18) did the assessment and said it was MASD when (V18) said his butt was hurting so we looked at it. He wasn't moving much on his own- he was complete assist with movement- his wife would often say he was in too much pain and just leave him, but he also didn't make much effort. He was not eating much- I remember talking to him about his wounds and trying to get them to heal- he had been in the hospital a while and we wanted him to eat so he could get better. I would often see his breakfast tray, and he would say he wasn't hungry. On 11/24/25 at 12:40PM V2 (Director of Nursing) stated, (R5) was here following a motor vehicle accident. He was here for therapy. He was non weight bearing so the main focus was bed mobility. They notified me that the mattress was broken- it was over a weekend, and they put him on a regular mattress- they had a hard time getting him a new one and I called (DME company) and got him one within 45 minutes. The wound doctor (V18) was here, and (R5) had MASD on his buttocks and he debrided it. (V17) said he scraped it off. R5's Braden Scale for Predicting Pressure Sore Risk dated 11/5/25 shows that R5 was High Risk. The facility policy entitled Prevention of Pressure Wounds dated January 2017 states, Pressure (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	injuries are usually formed when a resident remains in the same position for an extended period of time causing increased pressure or a decrease of circulation (blood flow) to that area and subsequent destruction of tissue.		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on observation, interview and record review the facility failed to ensure sterile catheter dressing changes were performed for a resident with a PICC (Peripherally Inserted Central Catheter) this applies to 1 of 3 residents (R2) reviewed for central lines in the sample of 18. The findings include: On 11/21/25 at 8:28 AM, R2 was in her room lying in bed. R2 said she had a PICC in her left upper arm placed on 9/16/25, because she had infection in her knee, and she was getting IV antibiotics. The staff were not changing the dressing weekly. She told the staff it needed to be changed weekly, and they said they did not know how to do change the dressing because they were not RN's (Registered Nurse's). R2 said her PICC line was removed because it got clogged. On 11/21/25 at 9:40 AM, V11 (RN) said PICC line dressings should be changed once a week. Only RN's can change the dressing on PICC lines and there should be an order when to change the dressing. On 11/21/25 at 3:05 PM, V2 (Director of Nursing-DON) said R2 had a PICC line for IV antibiotics. V2 said residents with PICC lines should have weekly dressing changes. V2 said nursing should put in the order to change the PICC lines to ensure the dressing is done. V2 confirmed R2 did not have orders entered to change her PICC line dressing weekly and R2's dressings were not done. R2's Vascular Access Order/Consent is dated 9/16/25 for insertion of her PICC line. R2's Physician Order Sheets dated October 2025 shows there is no order to change her PICC line dressing. R2's Medication Administration Record (M.A.R.) shows on 10/21/25 orders to discontinue PICC line and IV antibiotics for treatment of a wound infection. The facility's Central Venous Catheter Dressing Changes Policy revised 2016 states, Central venous catheter dressings will be changed at specific intervals, or when needed, to prevent catheter-related infections. dressings must stay clean, dry and intact. change transparent semi-permeable membrane dressings at least every 5-7 days and PRN (as needed when wet, soiled or not intact). equipment and supplies to replace sterile dressing. sterile central venous catheter dressing kit. The following information should be recorded in the residents medical record: date and time the dressing was changed, location and objective of insertion site .signature and title of the person recording the data.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review the facility failed to administer medications as ordered by the resident's physician. This applies to 1 of 3 residents (R1) reviewed for medication administration in the sample of 13. The findings include: On 11/21/25 at 9:45 AM R1 stated, It took 11 hours for me to finally get my Depakote. It was on September 20th. I talked to the night shift and then the day shift and then the swing shift and no one had time to give me my medication. Finally, it was given to me after Bingo (after 2PM). I should get it twice a day at 8AM and 8PM. On 11/21/25 at 3:15 PM V8 (Ombudsman) stated, I know she was really upset when she went the whole day without getting her medications. On 11/21/25 R1's Medication Administration Record for September was reviewed and shows no initials for the administration of Depakote (Anticonvulsant) 125 milligram (mg) at 8:00 AM or 8:00 PM on September 20, 2025. This same form also shows no initials for the administration of R1's Bupropion XL (Antidepressant) 300mg at 8:00 AM or her Abilify (Antipsychotic) 2mg at 8:00 PM. On 11/21/25 V2 (Director of Nursing) confirmed that V7 (Agency Nurse) was the nurse assigned to administer R1's medications on September 20, 2025. On 11/21/25 Surveyor called V7 and left a message with a request to return the call. No return call was received prior to survey exit on 11/25/25.		