

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145813	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
NAME OF PROVIDER OR SUPPLIER Metropolis Rehab & Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE 2299 Metropolis Street Metropolis, IL 62960	
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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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** A. Based on observation, interview, and record review the facility failed to ensure residents were free from neglect for 1 (R1) of 5 residents reviewed for abuse in a sample of 15. This failure resulted in a protracted period of time with unmanaged pain with R1 calling 911 a total of 5 times requesting an ambulance due to new onset severe pain to R1's right hip that had a nondisplaced right femur fracture found 6 days prior. The calls took place over a period of 2 hours and 3 minutes, during this time the nurse caring for R1 was called by the police dispatcher and said R1 was confused, had an affinity for pain medication, and there was no reason for R1 to be transferred to the hospital. The facility then failed to immediately administer Cardio-Pulmonary Resuscitation (CPR) and administer Narcan when R1 was found unresponsive after R1 returned from the hospital where R1 received injectable Dilaudid potentially contributing to R1 expiring. The Immediate Jeopardy began on [DATE] at approximately 8:41 AM when R1 called 911 requesting an ambulance to transport him to the hospital due to severe new onset hip pain. V45 (Administrator), V42 (Regional Director of Operations), V18 (Regional Clinical Director), and V46 (Regional [NAME] President of Operations) were notified of the Immediate Jeopardy on [DATE] at 2:53 PM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on [DATE], 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 observation, interview, and record review the facility failed to ensure residents were free from abuse for 1 (R4) of 5 residents reviewed for abuse in a sample of 15. Findings include: A. R1's admission Record documented an admission date of [DATE] with diagnoses including fracture of unspecified part of neck to right femur, periprosthetic fracture around internal prosthetic right hip joint, pain in right hip, chronic pain syndrome, and reduced mobility. According to R1's [DATE] ambulance report R1 expired in the Emergency Department of the local hospital on [DATE] (3 days after admission). R1's Minimum Data Set, dated [DATE] documents a Brief Interview on Mental Status (BIMS) assessment score of 0, indicating severe cognitive impairment. R1's Care Plan Report documented a [DATE] focus of the resident has pain with [DATE] interventions of monitor/record/report to Nurse resident complaints of pain or requests for pain treatment. R1 Physician Order Summary Report documents R1 had an order for Acetaminophen Tablet 325 MG (milligrams) give 650 mg by mouth every six hours as needed for pain or elevated temperature not to exceed 40000 mg per day. Start date [DATE]. This report also includes an order for Hydrocodone-Acetaminophen tablet 7.5-325MG give 1 tablet by mouth every 4 ours as needed for pain for 3 days. Do not exceed 3 GM (grams) acetaminophen from all sources in 24 hours. Start date [DATE] and end date [DATE]. R1's hospital record documented an admission date of [DATE] with a discharge date of [DATE] documented in part . Patient's Chief Complaint: Transferred to our hospital (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 - Few	entering the medication. V2 said if the Narcan was also selected an order would be sent to V3 (Medical Director) to be signed and sent to the pharmacy. V2 said V5 had access to the emergency stock medication system and had personally shown V5 how to pull medications for residents. On [DATE] at 2:39 PM, the facility's crash cart kept between 200 and 300 hall did not have an AMBU bag present. V51 was asked if a resident needed CPR to be started where an AMBU bag could be found and V51 said honestly I would have no idea. Maybe the oxygen room. V51 went to the oxygen room and no AMBU bag could be found. V51 said she would have to ask where AMBU bags were stored in the facility. V51 said she was told AMBU bags could be found in a supply closet on 300 hall. V51 said the crash carts were supposed to be checked daily on night shift. At this time the crash cart had a check list titled Split Hall Emergency Cart that documented on [DATE] an AMBU-bag with mask was present. The facility's 11/2025 Abuse, Prevention and Prohibition Policy documented in part . Each Resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. This facility prohibits mistreatment, neglect, or abuse of residents. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. This presumes that all instances of abuse, even to those residents in a coma, can cause physical harm, pain, or mental anguish. Definitions: Deprivation of Goods and Services by Staff. Abuse also includes the deprivation by staff of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. In these cases, staff have the knowledge and ability to provide care and services, but choose not to do it, or acknowledge the request for assistance from a resident(s), which result in care deficits to a resident(s). Neglect. means failure to provide goods and services necessary to avoid physical harm, pain, mental anguish, or emotional distress. The facility's 3/2025 Cardiopulmonary Resuscitation Policy documented in part . Cardiac arrest is defined as inadequate cardiac contractions resulting in insufficient blood flow throughout the body (pulselessness). The goal of early delivery of CPR is to try to maintain life until emergency response team arrives to deliver Advanced Life Support (ALS). 1. If a resident is found unresponsive and not breathing normally, a clinical staff member will verify code status using the medical record. 2. If the resident is a full code, per the medical record, a staff member that is certified in CPR will initiate CPR until emergency response team arrives. The facility's 12/2024 Advanced Directive Policy documented in part . 2. Information about whether or not the resident has executed an advanced directive shall be placed in the medical record. 4. The plan of care for each resident will be consistent with his or her documented treatment preferences and/ or advance directive. 9. The Interdisciplinary Team will review at regular intervals with the resident his or her advance [sic] directives to ensure that such directives are still the wishes of the resident. Staff will assist the resident or representative to make changes to advanced directives in accordance with state law. Changes and/or revocations will be added to the clinical record. The Care plan will be updated to reflect the change. The facility's 2/2025 Pain Management policy documented in part . If is the policy of this facility to respect and support the resident's tight to optimal pain assessment and management. Each and every resident has a right to the assessment and management of pain. Effective pain management can remove the adverse psychological and physiological effects of unrelieved pain. Optimal management of the resident experiencing pain enhances the healing and promotes both physical and psychological wellness. It is the responsibility of all clinical staff to assess and periodically reassess the resident pain and relief from pain. strategies for pain management include but are not limited to: Assessing potential for pain, recognizing onset, present sand duration of pain and assessing characteristics of pain. Addressing/ treating underlying causes of pain to extent possible. The facility's 12/2024 Significant Condition Change and Notification policy (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Metropolis Rehab & Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE 2299 Metropolis Street Metropolis, IL 62960	
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	documented in part . Purpose: To ensure that the resident's family and/or representative and medical practitioner are notified of resident changes such as those listed below: A significant change in the resident's physical, mental or psychosocial status. (See below for examples). Abnormal, unusual or new complaints of pain. When the above situations exists, the licensed nurse will contact the resident's representations and their medical provider. The medical practitioner will be contacted immediately for any emergencies regardless of the time of day. If the medical practitioner cannot immediately be reached in an emergency, the facility medical director will be called. If that medical practitioner cannot be reached, the director of nursing or the charge nurse can make arrangements for transportation to the emergency department. All significant changes will be recorded. in the resident record.The facility's Opioid Overdose policy documented in part . Opioid overdose occurs when a person takes a larger dosage of opioids than their body can handle, and breathing slows or stops as a result eventually leading to brain damage or death. Signs of Opioid Overdose: Unresponsiveness to voice or touch. Loss of consciousness. Slow, shallow, irregular or stopped breathing. Limp, lifeless body or movement. Vomiting. It is out policy for licensed staff to monitor for signs of opioid overdose and to administer naloxone to individuals experiencing an opioid overdose at the earlier opportunity to minimize chance of death. 3. Identify and confirm signs of potential opioid overdose. 4. Attempt to wake or rouse the resident. Perform sternal rub if no response to voice or shaking. 5. Assess the resident's breathing. 6. If unresponsive and not breathing, then call 9-1-1. 7. Obtain Naloxone from the E-kit, crash cart or designated accessible location. Ensure that it is not expired, is unused and is free from tampering or defects. 8. Maintain universal precautions and administer naloxone as follows. 9. Initiate CPR after administration of Naloxone. 10. If there is no response to the first dose of Naloxone after 2-3 minutes, then staff shall administer a second dose of Naloxone and continue with CPR while awaiting EMS.The Immediate Jeopardy that began on [DATE] was removed on [DATE] when the facility took the following actions to remove the immediacy:The incident occurred on [DATE] and the investigation was completed on [DATE].On [DATE], V54 (LPN Infection Control Nurse/ ICN) completed re-education for nurse involved (V5 LPN) regarding emer		

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to initiate Cardio-Pulmonary Resuscitation (CPR) timely for 1 (R1) of 4 residents reviewed for death in a sample of 15. This failure resulted in a delay in providing immediate emergency basic life support including CPR after finding R1 in his wheelchair with no pulse and no respirations. After CPR was initiated, R1 was transferred via ambulance to the local hospital and pronounced dead. The Immediate Jeopardy began on [DATE] at approximately 5:30 PM when R1 was found unresponsive in his room. V45 (Administrator), V42 (Regional Director of Operations), V18 (Regional Clinical Director), and V46 (Regional [NAME] President of Operations) were notified of the Immediate Jeopardy on [DATE] at 2:53 PM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on [DATE], but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. Findings include: R1's admission Record documented an admission date of [DATE] with diagnoses including fracture of unspecified part of neck to right femur, periprosthetic fracture around internal prosthetic right hip joint, pain in right hip, chronic pain syndrome, and reduced mobility. R1's Minimum Data Set, dated [DATE] documented a Brief Interview on Mental Status (BIMS) assessment score of 0, indicating severe cognitive impairment. On [DATE] at 1:28 PM, V8 (Certified Nursing Assistant/ CNA) said on [DATE] around 1:45 PM R1 returned to the facility from the hospital where R1 had received pain medication (Dilaudid/ hydromorphone). V8 stated around 5:15PM R1 rang his call light and when V8 entered R1's room R1 was vomiting into the trash can. V8 said R1 asked V8 to assist R1 to his wheelchair to go to the bathroom to get cleaned up because R1 had a bowel movement in his incontinence brief. V8 said she asked if R1 needed any further assistance and R1 said no. V8 said she left R1's room and informed V5 (Licensed Practical Nurse/ LPN) that R1 was vomiting then started passing evening meal trays. V8 said she checked on R1 approximately 10 to 15 minutes later and found R1 sitting in his wheelchair in his room by the bathroom door. V8 said when she spoke to R1 he did not respond. V8 said that is when she noticed R1 was not breathing. V8 said R1 did not have any discoloration at that time and was warm to the touch. V8 said she immediately went to inform V5 that R1 was unresponsive and asked what R1's code status was. V8 said V5 checked R1's code status and said R1 was a full code, then V5 walked down to R1's room, looked at R1, then walked back up the hall to the nurse's station. V8 said V5 did not appear to be in a hurry. V8 said V5 then got the attention of V4 (LPN), the oncoming nurse that was standing outside of the facility by glass doors next to the nurse's station and sent V4 down to R1's room to start CPR. V8 said she and V4 placed R1 on the floor and V8 went to get the crash cart. V8 said V10 (CNA) and V6 (CNA) were coming down the hall with the crash cart to R1's room to assist with CPR. V8 stated CPR was not started for a while and I would estimate maybe 5 to 10 minutes before CPR was started after I found (R1) unresponsive. On [DATE] at 2:32 PM, V5 (LPN) said V8 came out of R1's room and asked if R1 was a full code and said she did not think R1 was breathing. V5 said she went to R1's room and found R1 to be unresponsive. V5 said R1 looked normal, (R1) was sitting in his wheelchair slack [NAME] with his head back. V5 said she went back to the nurse's station and knocked on the glass doors to get V4 from outside and told V4 to go start CPR on R1 so she could call EMS (Emergency Medical Services). V5 said she then called 911 and she believes EMS arrived 5 or 6 minutes later. On [DATE] at 2:45 PM, V5 said she was not sure if the facility had an AED (Automated External Defibrillator) and was not sure where the facility kept the (continued on next page)		

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	crash cart or where an AMBU (Artificial Manual Breathing Unit) bag could be found. On [DATE] at 2:55 PM, V4 (LPN) said she was an agency nurse and [DATE] was the first time she came to the facility. V4 said she arrived at the facility at 5:30 PM and went to the hall she was assigned to. V4 said she had walked outside of the facility to make a phone call when V5 banged on the glass doors motioning for her to come inside. V4 said she was told to go to R1's room and V4 walked to R1's room. V4 said when she entered R1's room R1 was sitting in his wheelchair facing the wall unresponsive. V4 said V8 told her R1 was a full code and they needed to start CPR. V4 said she and V8 placed R1 in the floor and V4 started doing chest compressions. V4 said after she entered R1's room it was maybe 5 minutes after starting CPR when EMS arrived. On [DATE] at 2:45 PM, V10 (CNA) said on [DATE] she went to V5 to ask for pain medication for another resident and heard V5 say there was a resident that needed CPR to be started so V10 ran down the hall to get V6 (CNA) and the crash cart. V10 said after retrieving the crash cart she entered the hallway R1's room was located on and saw V8 and V4 standing outside R1's room's doorway. V10 said V6 went into R1's room and started compressions while V10 found the AMBU bag. V10 said she handed the AMBU bag to V4 to start giving breaths to R1. V10 said the AMBU bag was not hooked up to oxygen and V10 was not sure if the crash cart had an oxygen tank on it. On [DATE] at 2:24 PM, V6 (CNA) said on [DATE] she was passing the evening meal trays when V10 came running down the hall and told her a resident (R1) needed CPR and V6 and V10 went to get the crash cart. V6 said when V6 and V10 arrived in the hallway of R1's room she saw V4 and V8 standing outside the door to R1's room. V6 said R1 was lying on a sheet on the floor in his room and CPR had not been started. V6 said she went into R1's room and started doing chest compressions. V6 said while V6 was doing chest compressions V4 was using the AMBU bag to give R1 breaths. V6 said V7 (LPN) came into R1's room and took over chest compressions while V4 continued using the AMBU bag. V6 said she was upset V5 had not called a code on the facility intercom and was also upset no one had started CPR until she arrived to R1's room. On [DATE] at 12:34 PM, V3 (Medical Director) said he expected CPR to be started if someone was found to be unresponsive, not breathing, and having no pulse within a minute. V3 said if R1 was found unresponsive and was warm it was possible R1's life could have been saved if CPR had been started immediately. R1's Electronic Medical Record (EMR) documented a IDPH (Illinois Department of Public Health) Practitioner Order for Life-Sustaining Treatment (POLST) Form signed by R1 on [DATE] with an X denoting Attempt Resuscitation/ CPR and an X denoting Full Treatment: Primary goal of sustaining life by medically indicated means. This document was scanned into R1's EMR on [DATE]. R1's EMR also documented a POLST form signed by R1 on [DATE] with an X denoting No CPR: Do Not Attempt Resuscitation and an X denoting Comfort-Focused Treatment: Primary goal is maximizing comfort through symptoms management. Allow natural death. This document was signed by the medical director on [DATE] and was scanned into R1's EMR on [DATE]. On [DATE] at 10:07 AM, V2 (Director of Nursing/ DON) said R1's POLST form was signed by V3 on [DATE] and was emailed to the facility on [DATE]. V2 said due to [DATE] being a Saturday the staff with access to that email account were not in the facility to upload the new POLST form into R1's EMR. V2 said when R1 was found unresponsive on [DATE] staff would have seen R1 was a full code and should have started CPR immediately. R1's [DATE] progress note documented in part . At approximately 1715 (5:15 PM) CNA (V8) assisted resident to the bathroom. CNA left room to provide privacy. Approximately 10 minutes later CNA returned to room and found resident in wheelchair unresponsive to stimuli. Nursing staff (V5) came to observe resident finding him unresponsive. Staff nurse called 911 and instructed additional nurse staff to begin CPR. EMS (Emergency Medical Services) arrived at approximately 1740 (5:40 PM) and took over CPR administration. Narcan was administered by EMS (continued on next page)		

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	with no response. Resident was taken to (Local Hospital) at 1757 (5:57 PM). (V25, R1's Power of Attorney/ POA) was notified of what had occurred and where resident had been taken. On call nurse notified. Attempted to call (V3 Physician) no answer.R1's [DATE] ambulance report documented EMS (Emergency Medical Services) was called at 5:48 PM, arrived at patient at 5:54 PM, and left the facility with R1 at 6:05 PM and documented in part .Upon EMS arrival, we found a patient lying supine on the floor of his room. CPR in progress by fire department and nursing home staff. CPR was halted and pulse check was recorded. No pulse at this time. CPR was continued. CPR continued until arrival at ED.The facility's 3/2025 Cardiopulmonary Resuscitation Policy documented in part . Cardiac arrest is defined as inadequate cardiac contractions resulting in insufficient blood flow throughout the body (pulselessness). The goal of early delivery of CPR is to try to maintain life until emergency response team arrives to deliver Advanced Life Support (ALS). 1. If a resident is found unresponsive and not breathing normally, a clinical staff member will verify code status using the medical record. 2. If the resident is a full code, per the medical record, a staff member that is certified in CPR will initiate CPR until emergency response team arrives.The Immediate Jeopardy that began on [DATE] was removed on [DATE] when the facility took the following actions to remove the immediacy:The incident occurred on [DATE] and the investigation was completed on [DATE].On [DATE], V54 (LPN Infection Control Nurse/ICN) completed re-education for nurse involved (V5 LPN) regarding emergency response procedures and the requirement to initiate CPR without delay for residents who are full code. On [DATE], V18 (Regional Clinical Director) completed counseling with nurse V5 (LPN) regarding the incident. All licensed nurses and applicable staff were re-educated on the facility's CPR policy, emergency response procedures, and resident code status verification on [DATE] by V42 (Regional Director of Operations), V54 (LPN ICN), V55 (Registered Nurse/RN, Assistant Director of Nursing).Mock code drills will be conducted on all shifts to reinforce expectations for immediate CPR initiation. On [DATE] V54 (LPN ICN), and V55 (RN Assistant Director of Nursing) completed an audit of all resident code status. The audit revealed that two residents that did not have their code status listed in the banner. The first resident's banner was updated to reflect code status. An order was in place; the care plan indicates the current code status. The second resident's banner was updated to reflect code status. An order is in place; the care plan indicates the current code status. Updated on [DATE]. The DON or designee will conduct and document mock code drills monthly or as needed for 3 months.The DON or designee will conduct random audits of staff understanding of the CPR policy, emergency response procedure and resident code status verification 5 times a week for 60 days. The audits will include direct staff interviews, review of the resident code status identification process, and validation of staff knowledge regarding immediate response expectations when a resident is found unresponsive. Any staff member identified as having knowledge deficits will receive immediate re-education and follow-up validation of competency. The DON or designee will review new admission code status and/or changes in code status during QA clinical meeting and ensure resident's clinical records have order and polst scanned into resident's clinical record.Findings will be reported through the QAPI process with additional education provided as indicated.Staff will initiate CPR immediately when indicated and according to resident wishes and facility policy, ensuring timely emergency response and resident safety. Immediacy removal date [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. Based on interview and record review the facility failed to seek timely medical treatment and complete physician ordered laboratory testing for 1 (R13) of 5 residents reviewed for quality of care in a sample of 15. This failure resulted in R13 experiencing respiratory distress with Acute Hypoxic Respiratory Failure with oxygen saturations at 60-70%. Findings include: R13's admission Record documented an admission date of 4/10/26 with diagnoses including anemia, hypertension, and atrial fibrillation. R13 5/15/26 Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 6, indicating R13 was severely cognitively impaired. R13's 5/27/26 at 3:02 AM Progress Note documented in part . Primary Chief Complaint: Altered Mental Status. Overnight the patient has become more agitated, argumentative and not behaving like himself. His oxygen saturation are dropping down to the low 90s and 89% this morning. Otherwise vitals are stable. He does have a bit of a cough and there's reports some wheezing and rhonchi type lung sounds. Orders: . Stat (at once/immediately) cbc (complete blood count), bmp (basic metabolic panel), procal (procalcitonin), bnp (b-type natriuretic peptide) due to AMS (Altered Mental Status). R13's Order Summary Report documented a 5/27/26 order for CBC, BMP, Procal, and BNP stat. R13's 5/1/26-5/31/26 Medication Administration Record documented a 5/27/26 order for CBC, BMP, Procal, and BNP stat but the box denoting the labs were completed was blank. On 6/12/26 at 11:24 AM, V2 (Director of Nursing/ DON) said the nurse had been aware of R13's lab orders and put them into R13's Electronic Medical Record (EMR). V2 said when the nursing staff tried to draw R13's blood they could not find a vein. V2 said this task had been passed on to the next shift but was not sure if any staff had followed up on it. V2 said she would call the lab and see if the labs had been completed. During the course of this investigation, the facility was not able to produce evidence that R13's 5/27/26 ordered CBC, BMP, Procal, and BNP were completed. R13's 6/5/26 at 12:28 PM Progress Note documented in part . MD (Medical Doctor) notified by DON (Director of Nursing) of decline in respiratory status and transport to ER (Emergency Room). R13's 6/5/26 at 12:45 PM Progress Note documented in part . Resident has had congestion throughout the day that has progressively become worse. O2 (Oxygen) has been on continuously 4L/M/NC (4 liters per minute per nasal cannula). Respiratory RN (Registered Nurse) assessed resident and O2 sats are now 74% and respiratory status continues to decline. DON ad [sic] Respiratory RN notified this nurse to send resident to ER. R13's 6/5/26 at 12:55 PM Progress Note documented in part . Spouse/ POA (Power of Attorney) notified of decline in respiratory condition and need to send to ER for eval (evaluation). R13's 6/5/26 at 1:00 PM Progress Note documented in part . EMS (Emergency Medical Services) notified of need for transport to ER. (32 minutes after the order to send R13 to the hospital for further treatment was obtained.) R13's 6/5/26 ambulance report documented EMS were notified at 1:06 PM that R13 needed transferred to the hospital, arrived at facility at 1:15 PM, and left the facility with R13 at 1:25 PM. (57 minutes after the order to send R13 to the hospital had been obtained.) On 6/24/26 at 10:52 AM, V68 (Licensed Practical Nurse/ LPN) said she was the nurse caring for R13 on 6/5/26 from 6:00 AM -6:00 PM. V68 said she was sitting at the nurses' station when V2 (Director of Nursing/ DON) and V69 (Registered Nurse) told her R13 needed sent to the hospital. V68 said V2 and V69 were taking care of R13 at this time and V68 did not see R13 until R13 was leaving. V68 said she was just documenting and doing what V2 and V69 told her to do. V68 said she was not familiar with how to contact a doctor because the facility had changed to telehealth healthcare provider system and was not familiar with it. V68 said it was about an hour between the onset and when R13 was transferred to the hospital. On 6/11/26 at 12:34 PM, V3 (Medical Director) said he expected staff to follow physician orders and labs should be completed as (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	ordered. V3 said he expected staff would call for an ambulance immediately after obtaining the order and getting approval from the resident's family. R13's 6/5/26 Emergency Department Encounter documented in part . presents to the emergency department with CC (Chief Complaint) of respiratory distress. Noted to be saturating in the 60s to 70s upon arrival, low 80s on nonrebreather. Did not tolerate CPAP (Continuous Positive Air Pressure) in the truck. He has no history of COPD (Chronic Obstructive Pulmonary Disease), heart failure, CAD (Coronary Artery Disease), etc. He reports that he has been ill for the last 3 to 4 weeks but it got worse over the last couple days. He has audible rales. Reassessment. Transition from nonrebreather to BiPAP (Bilevel Positive Airway Pressure) with significant improvement in respiratory status. Chest x-ray shows bilateral pneumonia versus pulmonary edema. He has an elevated BNP as well as an elevated white count so treatment with antibiotics and Lasix. Also given DuoNeb and steroids. unable to give additional fluids due to existing volume overload. Discussed findings with family and patient, admitted to ICU. Final Impression. 1. Acute hypoxic respiratory failure. 2. Pneumonia of both lower lobes due to infection organism. 3. Acute pulmonary edema. R13's hospital record documented a 6/9/26 note documenting in part .Hospital Course: (R13) was admitted 6/5 with respiratory distress. He had an infiltrate and elevated BNP. He was started on BIPAP and monitored in ICU (Intensive Care Unit). He was able to transition to nasal cannula and then moved to PCU (Progressive Care Unit). He had fairly rapid improvement in his respiratory status. On the morning of 6/8 he was back to baseline and stable for transfer back to SNF (Skilled Nursing Facility). R13 was discharged from the hospital back to the facility on 6/9/26.		

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide adequate pain control for 1 (R1) of 3 residents reviewed for pain control out of a sample of 15. This failure resulted in R1 being in excruciating pain for 2 hours and 3 minutes and calling 911 a total of 5 times requesting an ambulance. Findings include: R1's admission Record documented an admission date of 5/20/26 with diagnoses including fracture of unspecified part of neck to right femur, periprosthetic fracture around internal prosthetic right hip joint, pain in right hip, chronic pain syndrome, and reduced mobility. R1's Minimum Data Set, dated [DATE] documents a Brief Interview on Mental Status (BIMS) assessment score of 0, indicating severe cognitive impairment. R1's Care Plan Report documented a 5/20/26 focus of the resident has pain with 5/20/26 interventions of monitor/record/report to Nurse resident complaints of pain or requests for pain treatment. R1 Physician Order Summary Report documents R1 had an order for Acetaminophen Tablet 325 MG (milligrams) give 650 mg by mouth every six hours as needed for pain or elevated temperature not to exceed 40000 mg per day. Start date 5/20/26. This report also includes an order for Hydrocodone-Acetaminophen tablet 7.5-325MG give 1 tablet by mouth every 4 ours as needed for pain for 3 days. Do not exceed 3 GM (grams) acetaminophen from all sources in 24 hours. Start date 5/20/26 and end date 5/23/26. R1's hospital record documented an admission date of 5/17/23 with a discharge date of 5/19/26 documented in part . Patient's Chief Complaint: Transferred to our hospital for right femoral fracture. being admitted to our hospital for the management of right femoral fracture. As reported, patient was moving a plant and then he lost his balance and fell landing on his right side. Patient initially presented to (another hospital), with initial workup done in the ED showing a right femoral periprosthetic fracture. R1's Progress Notes dated 5/20/26 documented in part, at 00:10 (12:10AM) resident arrived to facility via stretcher with Regional Ambulance service from an out of state hospital. He is admitted to facility for rehab therapy for a right femoral fracture after a fall at home. He is alert and oriented x 4. Pleasant and cooperative with staff. On 6/23/26 at 8:33 PM, V44 (Licensed Practical Nurse/ LPN) said she was the nurse caring for R1 on the night of 5/22/26. V44 said R1 was alert and oriented to person, place, and time. V44 said R1 was very upset and aggressive when asking for pain medication due to hip pain. V44 said after she administered R1's pain medication R1 went back to his room and went to sleep. V44 said R1 had not displayed any aggressive behaviors relating to pain prior to this incident to her knowledge. V44 said she did not think R1 was exhibiting narcotic pain medication seeking behaviors. V44 said R1 had not requested to be sent to the hospital during her shift. On 6/23/26 at 10:03 AM, V53 (Certified Nursing Assistant/ CNA) said she was the CNA caring for R1 on the night shift on 5/22/26. V53 said R1 did not seem confused. V53 said that was the first time V53 had met R1 and was not sure how cognitive R1 was at baseline but during her shift R1 appeared to be alert and oriented. On 6/23/26 at 1:28 PM, V8 (CNA) said she was the CNA caring for R1 on 5/23/26 during dayshift . V8 said she was not sure of R1's cognitive status at baseline because that was the first time she met R1 but R1 did not seem confused. V8 said R1 told her he was in excruciating pain because the night before he had hit his leg on something and had an increase in pain. V8 said R1 requested pain medication several times and was requesting to be sent to the hospital. V8 said she reported to V5 (Licensed Practical Nurse/ LPN) was requesting pain medication due to an increase in pain and requesting to be sent to the hospital. A recording from a 911 call from R1 on 5/23/26 at 8:41 AM was reviewed. In the call R1 requested an ambulance to transport him to the hospital due to tremendous pain to his right hip and that R1 was in great pain. A recording from a 911 call from R1 on 5/23/26 at 9:06 AM was reviewed. (continued on next page)		

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F 0697 Level of Harm - Actual harm Residents Affected - Few	In the call R1 requested an ambulance to transport him to the hospital because he was in tremendous pain and that R1 just needed some help. A recording from V65 (Police Dispatcher) to V5 (Licensed Practical Nurse/ LPN), the nurse caring for R1, on 5/23/26 at 9:08 AM was reviewed. In the call the dispatcher told V5 R1 had called 911 twice requesting an ambulance due to pain. V5 told the dispatcher, (R1) is just going to keep calling you. I don't know what to do. And We have an affinity for pain medication. V5 explained to the dispatcher R1's pain medication was as needed not scheduled and (R1) doesn't get it a quickly as (R1) would like to. V5 then stated, In my professional opinion, (R1) does not need to be seen by an ER (Emergency Room) like he doesn't need emergency care. The dispatcher then asked, (R1) just wants more pain medication? and V5 responded, Yes. V5 then said (R1's) not all the way there, indicating R1 was confused. V5 then went on to say, I don't want to say disregard this but this is kind of normal for (R1). A recording from a 911 call from R1 on 5/23/26 at 9:32AM was reviewed. In the call R1 requested an ambulance to transport him to the hospital. In the call R1 stated, over the night I have damaged my hip again. The dispatcher said she had spoken with V5 about R1's pain medication and it was not time for R1 to receive pain medication. The dispatcher then said the nurse has to call them before an ambulance could be sent. A recording from a 911 call from R1 on 5/23/26 at 10:41AM was reviewed. In the call R1 requested an ambulance to transport him to the hospital. R1 said he needed to be transferred to the emergency room to get an X-Ray. The dispatcher then said yes, but your nurse has to order that. We can't just send something over there without the nurse telling us. So, you have to talk to the nurse first. R1 then asked the dispatcher if he called the hospital R1 had been admitted to the facility from and asked them to send an ambulance would they send one up here? and the dispatcher said they would not. Not without your nurse ordering it. R1 responded, what if I just tell them anything. I just need an ambulance. The dispatcher responded Well, you're going to have to tell them you are in a nursing home and what room you're in and they're going to call your nurse like I did. R1 then asks the dispatcher if she had found out what room R1 was in and the dispatcher said she did not. R1 then tells the dispatcher, the pain pills are having a little effect and I have been panting for 2 hours. A recording from a 911 call from R1 on 5/23/26 at 10:44AM was reviewed. In the call R1 asked the dispatcher what they are going to do. R1 said someone said to just keep calling 911 and the dispatcher responds Well, if you keep calling 911 you are going to get a fine for it. R1 then says No, I don't want to do that. The dispatcher said Well, this is like abuse of 911 because you have to talk to your nurse. This is probably your sixth or seventh time calling. R1 then says, I know. I know. I know. And I hate this but I'm going to do what I need to do to not get in trouble. The dispatcher then says, Right, yeah, you have to talk to your nurse and tell the nurse to call us if they want to send an ambulance. I can't send one without them saying so. A recording from a 911 call from V5 on 5/23/26 at 10:59 AM was reviewed. In the call V5 stated, I have a resident that is adamant about being sent to the ER. He swears his hip is broken. He has called several times and now he has called the police. The dispatcher (V65) said I think I know who you are talking about. I think he has called here like 7 times. V5 then says, I just got off the phone with the police and they said well can't you just take his phone and I was like no. The dispatcher (V65) then tells V5 an ambulance will be sent to the facility to transport R1 to the hospital. R1's 5/23/26 at 11:30 AM Progress Note documented in part . C/O (Complains Of) severe pain in right hip. Pain medicine administered at 5am and 9am. Stated pain medicine did not help. Pt (patient) behavior demanding, belligerent. Insisting to go to (Name of Out of State Hospital) ED regarding hip pain. Resident would not comply with alternative treatment options. Multiple calls made to police department and 911. Called police department 9 times. Spoke with (V61 R1's Significant Other) about what was happening. Explained that resident had received pain medication, and that patient was being belligerent, calling the (continued on next page)		

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F 0697 Level of Harm - Actual harm Residents Affected - Few	authorities multiple times, demanding to go (Name of Local Hospital) swing bed or (Name of Out of State Hospital) ED. (V61) communicated understanding of the issue and stated she would contact residents next of kin. Spoke with (V62 Police Officer) regarding the multiple calls made to the police dept. (Local Police Department) (V62) stated that understanding of abuse of emergency line needs to be communicated to resident. (V62) said that he would contact (V61) to also update her on what was going on. Telephone number provided by nurse. Abuse Coordinator (V1 Former Administrator) contacted by nurse to explain what was happening. Explained that resident was being sent to the ED due to being belligerent toward staff, and demanding to be taken to (Name of Out of State Hospital) ER or (Name of Local Hospital) swing bed. Resident was taken to (Name of Hospital) ER by EMS (Emergency Medical Services) staff at 11:25 AM. R1's 5/23/26 Emergency Department Encounter documented in part . presents to the emergency department for persistent right hip pain related to a known right hip fracture sustained after a fall. Initial hip fx (fracture) fixed at (Name of Hospital) in July 2025. Treatment non op (non-operational) when admitted [DATE]. Last night he was in a wheelchair and bumped into a door and a few other walls, worsening his hip pain. Pain remains localized to the lateral aspect of the right hip. Home pain control has consisted of acetaminophen. He requests additional pain medication today. Mental status: he is alert and oriented to person, place, and time.12:36 PM hydromorphone (Dilaudid) injection 1 mg intramuscular.R1's 5/1/26-5/31/26 Medication Administration Record (MAR) documented an order for Hydrocodone-Acetaminophen Tablet 7.5-325 MG Give 1 tablet by mouth every 4 hours as needed for pain for 3 Days, Do not exceed 3 GM acetaminophen from all sources in 24 hours with a start date of 5/20/26. The following doses were given with the correlating pain scale assessments: 5/20/26 at 10:25 PM pain scale 5, 5/21/26 at 5:19 AM pain scale 5, 9:21 AM pain scale 6, 8:25 PM pain scale 3, 5/22/26 at 11:59 PM pain scale 7, 5/23/26 at 4:51 AM pain scale 6. R1's MAR documents an order for Acetaminophen Tablet 325 MG (milligrams) give 650 mg by mouth every six hours as needed for pain or elevated temperature not to exceed 40000 mg per day. Start date 5/20/26. R1 received 1 dose on 5/20/26 at 8:20 AM pain scale 8. According the pain scale chart listed on R1's Physician Order Summary: 0-1 No Pain; 2-3 Mild Pain; 4-5 Moderate Pain; 6-7 Severe Pain; 8-9 Very Severe Pain; 10 Worst Possible Pain.R1's 5/20/26 Hydrocodone-Acetaminophen 7.5-325 mg Controlled Substances Proof of Use form documented the medication was given but was not documented on the MAR with no accompanying pain scale assessment on the following dates: 5/21/26 at 2:54 PM, 5/22/26 at 8:00 AM, 3:00 PM, and 9:00 PM, 5/23/26 at 9:45 AM. R1's 5/23/26 at 5:31 PM Progress Note documented in part . Returned from ED (Emergency Department) at 1345 (1:45 PM). Received Dilaudid pain medication at 12:36 (PM). No current c/o (complaint of) pain. In bed resting with eyes closed. On 6/23/26 at 2:32 PM, V5 (LPN) said she was the nurse caring for R1 on 5/23/26. V5 stated everything was normal, R1 had received pain medication around 5:00 AM then V5 administered pain medication to R1 around 9:00 AM. V5 said R1 requested to be sent to a local hospital for swing bed services and V5 told R1 that a referral would have to be sent to the local hospital prior to R1 being sent. V5 said R1 then requested to be sent to the hospital R1 had been at prior to being admitted . V5 said she told R1 there wasn't much they could do for him at the ER. V5 said, R1 kept calling 911 so I finally sent him out to the hospital R1 was at prior to his admission to the facility. V5 said, R1 was just a crotchety old man who would scream and yell for his pain meds. V5 said R1 told V5 his hip was hurting and V5 said she told R1, I knew it was hurting but it wasn't broken it was just fractured, and I finally just said OK I'll send you out. When V5 was asked why she did not contact a physician, V5 stated she called the on call nurse (V63/LPN/Wound Nurse) and the administrator to let them know what was going on and did not call a physician. V5 said when R1 returned to the facility from the hospital, where R1 had received a dose of (continued on next page)		

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Dilaudid (Hydromorphone), R1 was still screaming and disturbing other residents. On 6/11/26 at 12:34 PM, V3 (Medical Director) said if a resident had a change in their pain level he would expect a medical provider to be notified for pain control. The facility's 2/2025 Pain Management policy documented in part . If is the policy of this facility to respect and support the resident's right to optimal pain assessment and management. Each and every resident has a right to the assessment and management of pain. Effective pain management can remove the adverse psychological and physiological effects of unrelieved pain. Optimal management of the resident experiencing pain enhances the healing and promotes both physical and psychological wellness. It is the responsibility of all clinical staff to assess and periodically reassess the resident pain and relief from pain. strategies for pain management include but are not limited to: Assessing potential for pain, recognizing onset, present sand duration of pain and assessing characteristics of pain. Addressing/ treating underlying causes of pain to extent possible.		

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Medical Director attended the scheduled Quality Assurance meetings. This failure has the potential to affect all 64 residents living in the facility. Findings include: The facility's QAPI (Quality Assurance and Performance Improvement) Meeting Sign In Sheets dated 5/29/26, March 2026, 2/18/26, 1/21/26, 11/19/25 and 8/21/26 did not document a signature from the facility's medical director affirming the medical director's attendance. The QAPI Meeting Sign In Sheet dated 12/31/25 documents in the signature [NAME] for the medical director Verbal. On 6/29/26 at 1:20 PM, V42 (Regional Director of Operations) stated she doesn't know why the medical director was not present for the scheduled QAPI meetings, but the medical director should be attending the QAPI meetings. V42 stated she doesn't know what Verbal means where the medical director's signature should be on the QAPI Meeting Sign In Sheet for 12/31/25. The facility's policy titled QAPI Policy dated August 2025 documents The QAPI Program takes a systematic, comprehensive, and data-driven approach to maintaining and improving safety and quality while involving all caregivers in practical and creative problem solving. A Resident Matrix dated 6/4/26 documents there are 64 residents living in the facility.		

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on interview and record review, the facility failed to ensure staff were trained on the required annual trainings. This has the potential to affect all 64 residents currently residing at the facility. Findings include: On 6/29/26 at 3:00 PM, staff trainings for V6 (Certified Nursing Aide/CNA), V40 (CNA), V47 (CNA), V12 (Licensed Practice Nurse/LPN), V23 (LPN), and V5 (LPN) were provided to this surveyor by V42 (Regional Director of Operations) and V18 (Regional Clinical Director) and were reviewed. It was noted at that time that training subjects missing for V6 included effective communication, QAPI (Quality Assurance and Performance Improvement), infection control, behavioral health, and the required in-service training for nurse aides. Training subjects missing for V40 included effective communication, resident rights and responsibilities, QAPI, infection control, compliance and ethics, behavioral health, and the required annual in-service training for nurse aides. Training subjects missing for V47 included effective communication, QAPI, infection control, compliance and ethics, behavioral health, and the required annual in-service training for nurse aides. Training subjects missing for V12 include effective communication, QAPI, infection control, and behavioral health. Training subject missing for V23 includes infection control. Training subjects missing for V5 included effective communication, QAPI, and compliance and ethics. On 7/1/26 at 11:01 AM, V18 stated they do not have a policy related to staff training requirements and all of the training documents they had for V6, V40, V47, V12, V23, and V5 had been provided. A Resident Matrix dated 6/4/26 documents there are 64 residents living in the facility.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review that facility failed to ensure Uniform Practitioner Orders For Life-Sustaining Treatment (POLST) status reflected resident wishes as desired throughout the Electronic Health Record and available for staff to access for 1 (R1) of 6 residents reviewed for advanced directives in the sample of 15. Findings include: R1's admission Record documented an admission date of [DATE] with diagnoses including fracture of unspecified part of neck to right femur, periprosthetic fracture around internal prosthetic right hip joint, pain in right hip, chronic pain syndrome, and reduced mobility. R1's Minimum Data Set, dated [DATE] documents a Brief Interview on Mental Status (BIMS) assessment documented a score of 0, indicating severe cognitive impairment. R1's Electronic Medical Record (EMR) documented a IDPH (Illinois Department of Public Health) Practitioner Order for Life-Sustaining Treatment (POLST) Form signed by R1 on [DATE] with an X denoting Attempt Resuscitation/ CPR and an X denoting Full Treatment: Primary goal of sustaining life by medically indicated means. This document was scanned into R1's EMR on [DATE]. R1's EMR documented a POLST form signed by R1 on [DATE] with an X denoting No CPR: Do Not Attempt Resuscitation and an X denoting Comfort-Focused Treatment: Primary goal is maximizing comfort through symptoms management. Allow natural death. This document was signed by the medical director on [DATE] and was scanned into R1's EMR on [DATE]. On [DATE] at 10:07 AM, V2 (Director of Nursing/ DON) said R1's POLST form was signed by V3 (Medical Director) on [DATE] and was emailed to the facility on [DATE]. V2 said due to [DATE] being a Saturday the staff with access to that email account were not in the facility to upload the new POLST form into R1's EMR. V2 said when R1 was found unresponsive on [DATE] staff would have seen R1 was a full code and should have started CPR immediately. The facility's 12/2024 Advanced Directive Policy documented in part .2. Information about whether or not the resident has executed an advanced directive shall be placed in the medical record. 4. The plan of care for each resident will be consistent with his or her documented treatment preferences and/ or advance directive. 9. The Interdisciplinary Team will review at regular intervals with the resident his or her advance [sic] directives to ensure that such directives are still the wishes of the resident. Staff will assist the resident or representative to make changes to advanced directives in accordance with state law. Changes and/or revocations will be added to the clinical record. The Care plan will be updated to reflect the change.		

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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 notify the physician with a change of condition for 2 of 4 (R1 and R12) residents reviewed for change of condition in the sample of 15. Findings Include: 1. R1's admission Record documented an admission date of 5/20/26 with diagnoses including fracture of unspecified part of neck to right femur, periprosthetic fracture around internal prosthetic right hip joint, pain in right hip, chronic pain syndrome, and reduced mobility. R1's Minimum Data Set, dated [DATE] documents a Brief Interview on Mental Status (BIMS) assessment documented a score of 0, indicating severe cognitive impairment. On 6/23/26 at 8:33 PM, V44 (Licensed Practical Nurse/ LPN) said she was the nurse caring for R1 on the night of 5/22/26. V44 said R1 was alert and oriented to person, place, and time. V44 said R1 was very upset and aggressive when asking for pain medication due to hip pain. V44 said after she administered R1's pain medication R1 went back to his room and went to sleep. V44 said R1 had not displayed any aggressive behaviors relating to pain prior to this incident to her knowledge. V44 said she did not think R1 was exhibiting narcotic pain medication seeking behaviors. V44 said R1 had not requested to be sent to the hospital during her shift. On 6/23/26 at 10:03 AM, V53 (Certified Nursing Assistant/ CNA) said she was the CNA caring for R1 on the night shift on 5/22/26. V53 said R1 did not seem confused. V53 said that was the first time V53 had met R1 and was not sure how cognitive R1 was at baseline but during her shift R1 appeared to be alert and oriented. On 6/23/26 at 1:28 PM, V8 (CNA) said she was the CNA caring for R1 on 5/23/26. V8 said she was not sure of R1's cognitive status at baseline because that was the first time she met R1 but R1 did not seem confused. V8 said R1 told her he was in excruciating pain because the night before he had hit his leg on something and had an increase in pain. V8 said R1 requested pain medication several times and was requesting to be sent to the hospital. On 5/23/26 at 8:41 AM, 9:06 AM, 9:32 AM, 10:41 AM, and 10:44 AM R1 called 911 asking for an ambulance to take him to the hospital due to tremendous pain in his right hip that was previously diagnosed with a femur fracture and the pain pills are having little effect. On 5/23/26 at 9:08 AM, a call from the police dispatcher (V65) to V5 (Licensed Practical Nurse/ LPN), the nurse caring for R1, was reviewed with the dispatcher telling V5 that R1 had called 911 twice requesting an ambulance due to pain and V5 told the dispatcher (R1) is just going to keep calling you. I don't know what to do. And we have an affinity for pain medication. V5 explained to the dispatcher R1's pain medication was as needed not scheduled and (R1) doesn't get it a quickly as (R1) would like to. V5 then said in my professional opinion, (R1) does not need to be seen by an ER (Emergency Room) like he doesn't need emergency care and the dispatcher said (R1) just wants more pain medication? V5 responded Yes. V5 then said (R1's) not all the way there indicating R1 was confused. V5 then went on to say I don't want to say disregard this but this is kind of normal for (R1). (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's 5/23/26 at 11:30 AM Progress Note documented in part . C/O (Complains Of) severe pain in right hip. Pain medicine administered at 5am and 9am. Stated pain medicine did not help. Pt (patient) behavior demanding, belligerent. Insisting to go to (Name of Out of State Hospital) ED regarding hip pain. Resident would not comply with alternative treatment options. Multiple calls made to police department and 911. Called police department 9 times. Spoke with (V61 R1's Significant Other) about what was happening. Explained that resident had received pain medication, and that patient was being belligerent, calling the authorities multiple times, demanding to go (Name of Local Hospital) swing bed or (Name of Out of State Hospital) ED. (R1's Significant Other) communicated understanding of the issue and stated she would contact residents next of kin. Spoke with (V62 Police Officer) regarding the multiple calls made to the police dept. (Local Police Department) (V62) stated that understanding of abuse of emergency line needs to be communicated to resident. (V62) said that he would contact (V61) to also update her on what was going on. Telephone number provided by nurse. Abuse Coordinator (V1 Former Administrator) contacted by nurse to explain what was happening. Explained that resident was being sent to the ED due to being belligerent toward staff, ad demanding to be taken to (Name of Out of State Hospital) ER or (Name of Local Hospital) swing bed. Resident was taken to (Name of Hospital) ER by EMS (Emergency Medical Services) staff at 11:25 AM. On 6/23/26 at 2:32 PM, V5 (LPN) said she was the nurse caring for R1 on 5/23/26. V5 stated everything was normal, R1 had received pain medication around 5:00 AM then V5 stated she administered pain medication to R1 around 9:00 AM. V5 said R1 requested to be sent to a local hospital for swing bed services and V5 told R1 that a referral would have to be sent to the local hospital prior to R1 being sent. V5 said R1 then requested to be sent to the hospital R1 had been at prior to being admitted . V5 said she told R1 there wasn't much they could do for him at the ER. V5 said R1 kept calling 911 so I finally sent him out to the hospital R1 was at prior to his admission to the facility. V5 said R1 was just a crotchety old man who would scream and yell for his pain meds. V5 said R1 told V5 his hip was hurting and V5 said she told R1 I knew it was hurting but it wasn't broken it was just fractured, and I finally just said OK I'll send you out. When V5 was asked why she did not contact a physician, V5 stated she called the on call nurse (V63/LPN/Wound Nurse) and the administrator to let them know what was going on and did not call a physician. R1's Electronic Medical Record (EMR) 5/23/26 Progress Notes documented no medical provider was notified of R1's increase in pain. On 6/11/26 at 12:34 PM, V3 (Medical Director) said he would expect staff to notify a medical provider if a resident had an increase in pain. The facility's 12/2024 Significant Condition Change and Notification policy documented in part . Purpose: To ensure that the resident's family and/or representative and medical practitioner are notified of resident changes such as those listed below:. A significant change in the resident's physical, mental or psychosocial status. (See below for examples). Abnormal, unusual or new complaints of pain. When the above situations exists, the licensed nurse will contact the resident's representations and their medical provider. The medical practitioner will be contacted immediately for any emergencies regardless of the time of day. If the medical practitioner cannot immediately be reached in an emergency, the facility medical director will be called. If that medical practitioner (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cannot be reached, the director of nursing or the charge nurse can make arrangements for transportation to the emergency department. All significant changes will be recorded. in the resident record. 2. R12's admission Record with a print date of 6/24/26 documents R12 was admitted to the facility on [DATE] with diagnoses that include cerebral infarct, myasthenia gravis, muscle weakness, cognitive communication deficit, dysphagia, anemia, heart disease, cardiac pacemaker, and history of falls. R12's current Care Plan documents a Focus area of, (R12) has anemia. Date Initiated: 06/09/2026. This Focus area includes the intervention of .Monitor/document/report to MD (physician) PRN (as needed) following s/sx (signs/symptoms) of anemia: pallor, Fatigue, Dizziness, Syncope, Headache, Palpitations, Weakness, Feeling of cold, Low Hgb/hct (hemoglobin/hematocrit), SOB (shortness of breath) on exertion, Sore tongue, Chest pain, Tinnitus, Headache, Changes in cognition. Date Initiated: 03/23/2026. R12's Minimum Data Set, dated [DATE] documents a Brief Interview for Mental Status score of 06, indicating a severe cognitive deficit. R12's Progress Notes document the following. 6/6/26 3:42 AM, Resident continues on new medication Mirtazapine QHS (every night) for decreased appetite and Scopolamine Patch for nausea/increased secretions. Resident was alert and took HS medications whole with mashed watermelon which had been thickened. Resident tolerated well with no c/o (complaints of) nausea or difficulty swallowing. She is resting in bed quietly with eyes closed. Alert but drowsy at this time. Easy to wake to verbal stimuli. She denies complaints at this time. Skin to coccyx is red with a small round dark purple area in the center (less than 1 cm (centimeter) in circumference). Treatment order updated to apply zinc paste and cover with foam dressing for protection. Also noted multiple small hard red bumps to bilateral labia majora and around anus that appear to be ingrown hairs with no s/s (no signs or symptoms) of infection. She has had scant amount of urine output this shift. Urine is dark amber in color and malodorous. VSS (vital signs) BP (blood pressure) 122/80 (manual), HR (heart rate) 78, RR (respirations) 20, SPO2 94% on room air. Respirations even and unlabored. No s/s (signs/symptoms) of distress or discomfort noted. Bed in lowest position with wheels locked for safety. Call light within resident's reach. 6/6/26 11:07 AM, Res (resident) slept well last night. Awoken this am (morning) and res (resident) to eat breakfast. Res left alone then came back and was able to get res to eat half her yogurt and a small cup of water. Mouth care given due to dry lips. Continues on Scopolamine 1.5/72 hr (hour) patch noted to left ear for excess mucous/nausea x 10 days and Mirtazapine 7.5 mg (milligrams) at hs (nighttime). Skin warm and dry. Color wnl (within normal limits). Res. Speech very soft. Call light within reach. To continues (sic) current poc (plan of care). 6/6/26 3:27 PM, Resident awake and kicking legs off the side of her bed. Res said she was getting up in chair. Res very week (sic). Res drinking her cold water really well today. Res only ate 2 bites of meat and gravy and 2 bites of mashed potatoes at lunch and said she did not want anymore and began belching. Res afraid she was getting sick. Res assisted with check and change and has been wet x (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(times) 2 today. No family here today so far noted. Call light within reach and bed remote. TV turned on for res as well. To continue current poc. R12's progress notes do not document physician notification of the change in condition, including the dark amber malodorous urine. On 6/18/26 at 3:08 PM, V29 (CNA/Certified Nursing Assistant) stated she called V2 (Director of Nurses/DON) and reported a decline in R12's condition. V29 stated she reported R12 had a green discharge and mucus bumps on her labia. V29 stated she reported the change to V44 (Licensed Practical Nurse/LPN) who told her she thought they had already done blood work. V29 stated she felt like R12 needed to be sent to the hospital for evaluation but V2 told her she would check on it the next morning. V29 stated she didn't follow up with V2 to see if anything was done. On 6/24/26 at 5:00 PM, V44 (LPN) stated R12 had a decline in her condition, and she remembered her urine being dark and a vaginal discharge. V44 stated she didn't remember if she contacted the physician or if she passed it on to day shift to contact them. V44 stated if she had contacted the physician she would have documented it in the progress note unless it was a crazy day and she forgot to. On 6/22/26 at 3:10 PM, V2 (DON/Director of Nurses) stated V29 (CNA) called her and reported the symptoms of dark urine and discharge, and she called the facility and spoke with an unknown agency nurse. V2 stated she told them to call telehealth. V2 stated the next time she was at the facility she looked at R12's progress notes but didn't read them. V2 stated there was a note in there so she was sure they had contacted the physician. V2 stated she didn't assess R12 or follow up. V2 stated she would expect the nurse to notify the physician. On 6/22/26 at 3:16 PM, V1 (Former Administrator) stated she was unaware of the decline in R12's condition and/or that the physician wasn't notified. On 6/24/26 at 9:10 AM, V39 (Power of Attorney) stated R12 had stopped eating and she didn't want a bunch of tests done. V39 denied concerns with the care R12 received at the facility. On 7/6/26 at 10:21 AM, V18 (Regional Clinical Director) stated she had reached out to the physician office and they were unable to find any communication from the facility regarding R12's change in condition. V18 stated the physician should have been notified. The facility Significant Condition Change and Notification policy dated 12/2024 documents, Purpose: To ensure that the resident's family and/or representative and medical practitioner are notified of resident changes such as those listed below.Symptoms of infectious process.other abnormal assessment findings.Procedure: When any of the above situations exists, the licensed nurse will contact the resident's representative and their medical practitioner. Prior to calling the medical practitioner the nurse will complete the SBAR assessment.The medical practitioner will be contacted immediately for any emergencies regardless of the time of day. Non-emergency notifications may be made the next morning if the situation occurs on the late evening or night shift. This applies to any day of the week including holidays. If the medical practitioner cannot immediately be reached in any (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	emergency, the medical director will be called. If that medical practitioner cannot be reached the director of nursing or the charge nurse can make arrangements for transportation to the emergency department. Each attempt will be charged as to the time the call was made, who was spoken to, and what information was given to the medical practitioner. In a non-emergency situation, the primary medical practitioner will be called unless he/she has left an alternate name to call. If after two attempts, there is no response to calls, the medical director will be contacted. Change of condition is reviewed by DON (Director of Nurses) or designee for the continued need for additional documentation.		

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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. Based on interview and record review the facility failed to report an allegation of staff to resident abuse immediately to the administrator and to the state agency (Illinois Department of Public Health) for 1 of 6 residents (R4) reviewed for abuse and neglect in the sample of 15. Findings include: R4's admission Record documented an admission date of 3/9/26 with diagnoses including dependence on renal dialysis, muscle weakness, and need for assistance with personal care. R4's 6/8/26 Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 14, indicating R4 was cognitively intact. R4's 4/8/26 at 10:24 PM Progress Note authored by V23 (Licensed Practical Nurse/ LPN) documented in part .Resident up in wheelchair propelling towards front door of facility. Facility phone rang and this nurse answered, finding that resident was on the phone with the police due to him calling 911. Nurse explained that resident was fine and in wheelchair at nurse's station. Resident had refused to go to bed earlier and now was telling police on phone to come and pick him up. This nurse called resident's significant other and explained what was going on with resident. Significant other said she was the POA (Power of Attorney) and wanted for nurse to take resident's phone until tomorrow when she gets here. Nurse asked significant other to speak with resident and maybe he would calm down. Phone given to resident for him to talk to family, but resident began cursing and yelling in phone and threw phone that nurse. Resident then grabbed items on nurse's station and started throwing items on floor and at staff. Resident assisted to his room by several staff due to resident kicking and punching. Resident face kicked CNA (Certified Nursing Assistant) but only caught CNA glasses. Resident grabbed nurse's arm and started cursing nurse, stating, you are a f***** b***h and I will kill you. Other staff present at the time and removed resident's hand from nurse's arm. R4's 4/9/26 at 1:30 PM Progress Note documented in part .Resident has been up in w/c most of today. No behaviors or aggression noted this shift. Resident's spouse came in and brought paperwork for POA gave to Social Services to review and upload into chart. Resident's cell phone was given to spouse. The facility's investigation folder of R4's 5/15/26 incident contained an undated statement from V24 (Certified Nursing Assistant/ CNA) documenting in part . (V24) stated that she was aware of the phone being taken from (R4) the first time around the time (R4) was moved from the 400 hall (that was around 4/8/26). (V24) stated that (R4) called the police and (V23 Licensed Practical Nurse/ LPN) snatch [sic] the phone out of his hand and told him to get the hell down there. (V17) was in the building at the time. (V24) stated (V24) told (V17) and (V17) stated I know we need to have a meeting. (V24) stated that (R4) was combative with staff and had hit (V23) and (V23) forced (R4's) arms down on his lap. (V24) stated that (R4) told (V23) to stop, and (V23) told (V24) to get on my d**n hall. The last time I (V24) worked (R4) followed me around and asked for his phone. I (V24) asked (V17) about it and (V17) said absolutely not sir and then said I am not dealing with (R4). (V24) was asked if she reported this to anyone and she stated (V17). The abuse policy was discussed with (V24) and who and when alleged abuse must be reported. (V24) stated that the staff are all like family and you don't want to cause a problem. The facility's investigation folder of R4's 5/15/26 incident contained an undated statement from V23 documenting in part . 7. Have you witnessed a staff member taking (R4's) cell phone? Couple of months ago but this incident May. Comments: A couple months ago (R4) was calling 911 and he was being physically abusive c (with) staff so I called (V64 R4's Significant Other) (to come sit with (R4)). (V64) said to that (R4's) phone and (V64) would be in and get it. That is all I know personally. Denied ripping from hands. Told (R4) that (V64) was going to come and get. (Education provided- res. (resident) rights). On 6/23/26 at 3:27 PM, V24 (CNA) stated R4 is loud and (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	curses a lot. V24 stated during the incident involving V23 (LPN) R4 had just been moved from the 400 hall to the 200 hall and was confused. V24 stated R4 came to the nurse's station and was confused about where he was and asking to go home. V24 stated R4 was trying to talk to V23 and she said I'm not listening to this, go back to your room. R4 responded with listen b***h I'm going to call the police. V23 said hell no, spun R4's wheelchair around and R4 threw his feet on the ground. R4 grabbed the caboodle sitting on the nurse's station and smacked V23 (LPN) with it. V24 stated night shift was coming in and V23 said to the night shift CNA's to help her. V24 stated V23 was trying to get R4 down the hall and the night shift CNA's went to help her. V24 stated she stopped them and told them she could get him in bed. V24 stated they transferred R4 to bed. V24 stated V27 (CNA) was standing at the foot of the bed, V23 and V26 were standing between the bathroom and closet door. V24 stated R4, kicked V27 and hit V23 in the face. V24 stated V23 grabbed R4's wrist and she V24 called V17 (Assistant Director of Nursing/ ADON) and told her what happened and she was afraid to leave the facility and leave R4 alone. V24 stated V17 told her she was on her way into the facility and would check on him. V24 stated she wrote a statement about it and gave it to V1 (Former Administrator). On 6/23/26 at 2:54 PM, V23 stated R4 was calling 911 and the police were calling the facility so she called V64 (R4's Significant Other) and she said R4 wouldn't listen to her if she tried to talk to him. V23 stated she went to R4's room and he was calling 911 and screaming at the top of his lungs. V23 stated she entered his room, and two midnight shift CNA's V27 (CNA) and V26 (CNA) came in to assist her when they heard R4 screaming obscenities at V23. V23 stated R4 was swinging, hitting, kicking and V27 and V26 showed up so he wouldn't knock the crap out of V23. V23 stated she took R4's phone and gave it to the day shift nurse and told her V64 was coming to get it. When asked how V23 got the phone if R4 was being combative and V23 stated R4 finally gave it to her. On 6/23/26 at 12:58 PM, V17 said no one reported the 4/8/26 incident to her. On 6/18/26 at 4:23 PM, V18 (Regional Clinical Nurse) and V42 (Regional Director of Operations) were asked if there was an investigation of R4's 4/8/26 incident and V42 responded the 4/8/26 incident was investigated with a 5/15/26 incident. V42 was asked why the 4/8/26 incident was not listed in the 5/27/26 final report and V42 responded she was not sure and would have to review the 5/27/26 final report. V42 was asked if a Facility Reported Incident had been completed for R4's 4/8/26 incident and V42 responded no it had not. R4's Facility Reported Incident of 5/15/26 final report on 5/27/26 documented sent to the Illinois Department of Public Health did not document an incident that occurred on 4/8/26. During the course of this investigation, the facility was unable to provide reproducible evidence of an investigation or a Facility Reported Incident of R4's 4/8/26 incident was reported to the Illinois Department of Public Health. The facility's 11/2025 Abuse, Prevention and Prohibition Policy documented in part .The facility Administrator, employee, or agent who is made aware of any allegation of abuse or neglect shall report of cause a report to be made to the mandated state agency per reporting criteria. Such reports may also be made to the local law enforcement agency in the same manner. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property will be reported immediately to the Administrator. The person made aware of allegations of abuse or neglect or the Administrator will report the allegations of abuse and neglect to the mandated state agency and law enforcement. The allegation will be reported no later than 2 hours, or per state regulations, after the allegation is made.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to thoroughly investigate allegations of abuse for 2 of 6 (R4 and R11) residents reviewed for abuse in the sample of 15. Findings Include: 1. R4's admission Record documented an admission date of 3/9/26 with diagnoses including dependence on renal dialysis, muscle weakness, and need for assistance with personal care. R4's 6/8/26 Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 14, indicating R4 was cognitively intact. R4's Care Plan Report documented a revised 6/8/26 Focus area . has a behavior problem yells out frequently for staff and at times cursing at staff. Resident curses staff & residents. Makes accusations about staff and missing items. (R4) has a cell phone & has been provided with the person to contact if he has a concern. Resident can become physically aggressive with staff. With a 5/28/26 intervention if resident is upset provide support revised 6/8/26 intervention of Behavior #1: Yelling out for staff. 1. Engage in conversation with resident. 2. Provide resident with reassurance. 3. Provide positive attention. (ask resident if he wants his back scratched) and a revised 6/8/26 intervention of Behavior #2: Physical aggression (Grabbing hair). 1. Providing resident with opportunity to voice concerns and engage in conversation. 2. Provide reassurance. 3. Take resident out to courtyard to talk. R4's Facility Reported Incident of 5/15/26 final report on 5/27/26 documented in part .IDPH (Illinois Department of Public Health) surveyor informed (V42) Regional Director and (V18) Regional Nurse Consultant that resident (R4) alleged that a staff member had ripped his phone out of his hands and took his phone from him. A staff member stated that (V17 Assistant Director of Nursing/ ADON) had gone to the resident's room and took the resident's phone. (V17) was suspended pending investigation. (V2 Director of Nursing/ DON) stated that during their morning clinical meeting it was discussed that (R4) had called 911 multiple times and family was going to pick up his phone. It was mentioned at this time that the phone was in the resident's room. (V60 Director of Therapy) stated that she had just been with the resident and his phone was in his room. (V60) stated that she could go get the phone. (V60) stated that she went to (R4's) room and without incident was able to get his phone and gave it to (V17). (V17) was interviewed. (V17) stated that she did not go to the resident's room and take his cell phone. (V17) stated that she was in morning clinical meeting when they discussed (R4) calling 911. (V60) stated that she would go get the phone. (V60) returned with the phone and handed it to her (V17). (V17) stated that she took the phone to the nurse (V22 Licensed Practical Nurse/ LPN). (V17) was told that the family was going to come to the facility and pick up the phone. (V60) was interviewed. (V60) stated that she was in the morning clinical meeting when the team was discussing (R4) calling 911. (V60) stated that she was just with the resident and the phone was still in the room and offered to get the phone. (V60) stated that she went to the room to get the phone, and without incident obtained the phone and gave it to (V17). Other staff who were interviewed had no direct knowledge of the incident reported. (R4) was interviewed. (R4) stated that he had not had any issues with his phone being taken away and denied having words with anyone regarding his phone. (R4) stated that he called 911 because he felt threatened. When asked to describe the staff member he said it was a woman, do not know her name, she is black, she is heavy and had a wig on. (R4) stated that this person came into his room and went over to his roommate, pulled the curtain and (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	gave a finger gesture. (R4) stated that he gave it right back and called her a fat b***h. (R4) stated that it wasn't anything she said that made him feel threatened, but it was because she didn't help him and went to the roommate. (R4) stated that another staff member came in and went to the other side of the room and went behind the curtain. (R4) stated that when she left, she was carrying a bag. (R4) stated that he knows his phone was in the bag. (R4) stated that is why he called the police. (V22) was interviewed. (V22) stated that (R4's) family was notified that he had called 911 multiple times. (V22) stated that family was coming to the facility to get the phone. (V22) stated that she was not sure who took the phone, but (V17) brought it to her, and she locked it up in the cart until family arrived. (V22) stated that she did go into the room to provide care for (R4's) roommate. (V22) stated that (R4) was throwing things across his room and was cursing. (V22) said that she pulled the privacy curtain but make no physical contact with (R4). (V64 R4's Significant Other) was interviewed. (V64) stated that she was aware (R4) called 911. (V64) gave the staff directions to get the phone, and someone would come to pick it up. Then IDT (Interdisciplinary Team) reviewed the allegation. Based on statement/ discrepancy provided by (R4), and staff and family interviews, the facility is unable to substantiate the allegation of abuse. The investigation determined that (V17) was not the staff member involved. (R4) was unable to identify the staff member during the investigation. R4's 4/8/26 at 10:24 PM Progress Note authored by V23 (Licensed Practical Nurse/ LPN) documented in part .Resident up in wheelchair propelling towards front door of facility. Facility phone rang and this nurse answered, finding that resident was on the phone with the police due to him calling 911. Nurse explained that resident was fine and in wheelchair at nurse's station. Resident had refused to go to bed earlier and now was telling police on phone to come and pick him up. This nurse called resident's significant other and explained what was going on with resident. Significant other said she was the POA and wanted for nurse to take resident's phone until tomorrow when she gets here. Nurse asked significant other to speak with resident and maybe he would calm down. Phone given to resident for him to talk to family, but resident began cursing and yelling in phone and threw phone at nurse. Resident then grabbed items on nurse's station and started throwing items on floor and at staff. Resident assisted to his room by several staff due to resident kicking and punching. Resident face kicked CNA but only caught CNA glasses. Resident grabbed nurse's arm and started cursing nurse, stating, you are a f*****g b***h and I will kill you. Other staff present at the time and removed resident's hand from nurse's arm. R4's 4/9/26 at 1:30 PM Progress Note documented in part .Resident has been up in w/c most of today. No behaviors or aggression noted this shift. Resident's spouse came in and brought paperwork for POA (Power of Attorney), gave to Social Services to review and upload into chart. Resident's cell phone was given to spouse. The facility's investigation folder of R4's 5/15/26 incident contained an undated statement from V24 (Certified Nursing Assistant/ CNA) documenting in part . (V24) stated that she was aware of the phone being taken from (R4) the first time around the time (R4) was moved from the 400 hall (that was around 4/8/26). (V24) stated that (R4) called the police and (V23 Licensed Practical Nurse/ LPN) snatch [sic] the phone out of his hand and told him to get the hell down there. (V17) was in the building at the time. (V24) stated (V24) told (V17) and (V17) stated I know we need to have a meeting. (V24) stated that (R4) was combative with staff and had hit (V23) and (V23) forced (R4's) arms down on his lap. (V24) stated that (R4) told (V23) to stop, and (V23) told (V24) to get on my d**n hall. The (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Metropolis Rehab & Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE 2299 Metropolis Street Metropolis, IL 62960	
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	last time I (V24) worked (R4) followed me around and asked for his phone. I (V24) asked (V17) about it and (V17) said absolutely not sir and then said I am not dealing with (R4). (V24) was asked if she reported this to anyone and she stated (V17). The abuse policy was discussed with (V24) and who and when alleged abuse must be reported. (V24) stated that the staff are all like family and you don't want to cause a problem. On 6/23/26 at 3:27 PM, V24 (CNA) stated R4 is loud and curses a lot. V24 stated during the incident involving V23 (LPN) R4 had just been moved from the 400 hall to the 200 hall and was confused. V24 stated R4 came to the nurse's station and was confused about where he was and asking to go home. V24 stated R4 was trying to talk to V23 and she said I'm not listening to this, go back to your room. R4 responded with listen b***h I'm going to call the police. V23 said hell no, spun R4's wheelchair around and R4 threw his feet on the ground. R4 grabbed the caboodle sitting on the nurse's station and smacked V23 (LPN) with it. V24 stated night shift was coming in and V23 said to the night shift CNA's to help her. V24 stated V23 was trying to get R4 down the hall and the night shift CNA's went to help her. V24 stated she stopped them and told them she could get him in bed. V24 stated they transferred R4 to bed. V24 stated V27 (CNA) was standing at the foot of the bed, V23 and V26 were standing between the bathroom and closet door. V24 stated R4, kicked V27 and hit V23 in the face. V24 stated V23 grabbed R4's wrist and she V24 called V17 (Assistant Director of Nursing/ ADON) and told her what happened and she was afraid to leave the facility and leave R4 alone. V24 stated V17 told her she was on her way into the facility and would check on him. V24 stated she wrote a statement about it and gave it to V1 (Former Administrator). The facility's investigation folder of R4's 5/15/26 incident contained an undated statement from V23 documenting in part . 7. Have you witnessed a staff member taking (R4's) cell phone? Couple of months ago but this incident May. Comments: A couple months ago (R4) was calling 911 and he was being physically abusive c (with) staff so I called (V64 R4's Significant Other) (to come sit with (R4)). (V64) said to that (R4's) phone and (V64) would be in and get it. That is all I know personally. Denied ripping from hands. Told (R4) that (V64) was going to come and get. (Education provided- res. (resident) rights). On 6/23/26 at 2:54 PM, V23 stated R4 was calling 911 and the police were calling the facility so she called V64 (R4's Significant Other) and she said R4 wouldn't listen to her if she tried to talk to him. V23 stated she went to R4's room and he was calling 911 and screaming at the top of his lungs. V23 stated she entered his room, and two midnight shift CNA's V27 (CNA) and V26 (CNA) came in to assist her when they heard R4 screaming obscenities at V23. V23 stated R4 was swinging, hitting, kicking and V27 and V26 showed up so he wouldn't knock the crap out of V23. V23 stated she took R4's phone and gave it to the day shift nurse and told her V64 was coming to get it. When asked how V23 got the phone if R4 was being combative and V23 stated R4 finally gave it to her. On 6/23/26 at 12:58 PM, V17 said no one reported the 4/8/26 incident to her. On 6/18/26 at 4:23 PM, V18 (Regional Clinical Nurse) and V42 (Regional Director of Operations) were asked if there was an investigation of R4's 4/8/26 incident and V42 responded the 4/8/26 incident was investigated with the 5/15/26 incident. V42 was asked why the 4/8/26 incident was not listed in the 5/27/26 final report and V42 responded she was not sure and would have to review the 5/27/26 (continued on next page)		

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