STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145858	A. Building B. Wing	03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Au Well Care Home, Inc	152 Wilma Drive Maryville, IL 62062

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35156 Based on observation, interview, and record review the Facility failed to ensure call lights were being answered in a timely manner for 5 of 7 residents (R11, R14, R23, R31, and R51) reviewed for call lights in the sample of 82. Findings include: On 3/4/2025 at 3:42 PM, V21, Ombudsman stated there have been a lot of complaints related to call lights not being answered and residents waiting for hours to be changed. 1-R31's Minimum Data Set (MDS) dated [DATE] document he was cognitively intact for decision making of activities of daily living. On 3/10/2025 at 1:32 PM, R31 stated call lights were not being answered in a timely manner. I can usually get my needs met but not everybody in here can. Especially at nights the staff are not answering the call lights. I have heard lots of residents complaining about the long wait call lights. Ever since (V3, Medical Doctor) took over, nobody is in charge and staff do whatever they want to do. 2-R11's MDS dated [DATE] document he was cognitively intact for decision making of activities of daily living. R11 has no impairment on the upper or lower extremity, he uses a wheelchair and requires substantial/maximal assistance- Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort for most of his activities of daily living. On 3/10/2025 at 1:42 PM, R11 stated he is in a wheelchair, and he needs help with a lot of stuff. Whenever he puts the call light on it's not answered timely and it's not uncommon that he has to sit for hours waiting for help. It should not be like this. 3-R51's MDS dated [DATE] document R51 was cognitively intact for decision making of activities of daily living. On 3/10/2025 at 1:49 PM, R51 stated he can walk independently and take care of himself, but there are a lot of residents in here that need help. Staffing is horrible and they are never in a hurry to answer the call lights. They make the residents wait a lot. I have heard people complaining about it. I know they talked about at the Resident Council Meetings. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4-R23's MDS dated [DATE] document he was moderately impaired for cognition. On 3/10/2025 at 2:02 PM, R51 stated call lights are rarely answered in less than 10 minutes, and most of the time its over an hour before someone comes and helps you. 5-R14's MDS dated [DATE] document R14 was cognitively intact for decision making of activities of daily living. On 3/10/2025 at 2:12 PM, R14 stated he was the President of Resident Council and residents have been complaining about call lights taking too long and not being answered. Resident Council Meeting Minutes dated 2/5/2025 document, Call lights not being answered. The Resident Right Policy with a revision date of 11/18 documents, Nursing home residents have the right to: Dignity, respect and a comfortable living environment. On 3/10/2025 at 3:02 PM, V11, Regional MDS Coordinator stated there was no policy on call lights.

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F 0558 Level of Harm - Actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35156 Based on interview, observation, and record review the Facility failed to ensure water temperatures were comfortable for residents living in the Facility. This failure resulted in R31 and R38 expressing feelings of aggravation, R50 describing water temperatures as being uncomfortable, and R54 stating concerns as he has to leave the facility to bathe at a friends house. This has the potential to affect all 73 residents residing in the facility. Findings include: On 3/6/2025 at 3:14 PM, Water temperatures were taken with a metal calibrated thermometer. On 3/6/2025 at 3:20 PM, There are two shower rooms on the 200 hall. The first shower room has no sink and or toilet only a shower and the water temperature after running the water for one minute registered 74.8 Fahrenheit. (F). On 3/6/2025 at 3:21 PM, V24, Certified Nursing Assistant stated, Residents use both showers on both halls it does not matter what halls they are on they use both sides. On 3/6/2024 at 3:32 PM, On the 200 halls on the opposite area next to the nurse's station was the second shower. In the shower room the sink has a sign that documents, Do No use sign there was a working toilet and the shower temperature running for two minutes was 74.2 F and the sink temperature running for two minutes was 72.4 F. On 3/6/2025 at 3:39 PM, R67, and R68 share a bathroom with R69. The sink water temperature after running for one minute was 89.7, (F) Fahrenheit. On 3/6/2025 at 3:48 PM, R60, and R61 share a Room with R63 and R64, the water temperature at the sink after running for one minute was 83.5 F. On 3/6/2025 at 3:54 PM, R58 and R59's water temperature at the sink after running for one minute was 89.9 F. On 3/6/2025 at 4:02 PM, R38, and R39 share a room with R40, and R41 the water temperature at the sink after running for one minute was 64.0 F. On 3/6/2025 at 4:04 PM, R38 stated, The water temperature is very aggravating, and this has been going on for so long. The water is cold, then it is warm, then it is hot now it is cold. I don't want to take a shower when the water is cold, would you want to take a cold shower. The water is cold today. On 3/6/2025 at 4:14 PM, R44 and R6's bathroom sink water temperature after running the water for one minute was 64.7 F. On 3/6/2025 at 4:19 PM, R49, R50, R53 and R54's bathroom water sink temperature after running for one minute was 70.4 F. (continued on next page)

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F 0558 Level of Harm - Actual harm Residents Affected - Some	On 3/6/2025 at 4:22 PM, R54 stated, The water really needs to be hotter. I personally, don't like to take cold showers. This has been going on for months and I mean months. I try and go to a friend's house at least once a week just to take a shower. I am lucky I have a friend who will let me go and take a shower at their home. Not everyone can do that. The water is too cold especially today. I am not sure anybody would want to take a shower with the water being so cold. On 3/6/2025 at 4:33 PM, R47, R48, R51 and R52's water temperature in the bathroom running for one minute sink temperature was 68.4 F. On 3/6/2025 at 4:37 PM, R47 stated, the water is cold again, the water does not stay hot. I don't want a shower in this cold water. This has been going on since December. Nobody wants a cold shower. On 3/6/2025 at 4:43 PM, R42's Water temperature in her bathroom sink running for one minute was 62.4F. On 3/6/2025 at 4:49 PM, R50 stated, the water is terrible today. Now it is cold again. When staff clean me up the water is so cold and its very uncomfortable to me. I don't like taking cold showers. On 3/6/2025 at 4:52 PM, R70 and R71, R73's water temperature at the bathroom sink running for one minute was 62.8 F. On 3/6/2025 at 4:59 PM, R73, R74, R75 and R76's Room at the bathroom sink running for one minute was 67.5 F. On 3/6/2025 at 5:00 PM, R74 stated the water was cold again this morning. It was nice on Saturday but it's cold again today. We have been having issues with cold water for too long. On 3/6/202 at 5:02 PM, R78's room at the bathroom sink running for one minute was 62.4F. On 3/6/2025 at 5:03 PM, 100 Hall Shower room running for one minute at the sink was 85.1 F, at the Shower running for one minute the water temperature was 75.4 F. On 3/6/2025 at 5:04 PM, R19, R20 and R37's water temperature at the bathroom sink running for one minute was 86.7 F. On 3/6/2025 at 5:09 AM, R15, R16, R17, and R18's water temperature a the bathroom sink running for one minute was 84.7 F. On 3/6/2025 at 5: 12 PM, R31 's water temperature at the sink running for one minute was 88.9 F. On 3/6/2025 at 5:14 PM, R31 stated, We have not had hot water here since December. They are getting money for us to stay here and it's not right that they do not have to make sure we have hot water. Nobody wants to take a shower or wash their face in cold water. They have excuse after excuse, but bottom line is they need to fix it the right way and replace the things that are breaking. This has been going on too long. I don't want to take a cold shower. On 3/6/2025 at 5:18 PM, R21's water in the bathroom sink was running for one minute was 87.5. (continued on next page)

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F 0558 Level of Harm - Actual harm Residents Affected - Some	On 3/6/2025 at 5:19 PM, V12, Certified Nursing Assistant (CNA) stated the water is running really cold today I was hoping the water would be heating up it has been running for over five minutes now, but it is still cold. I don't like to use cold water, but it is cold today and it is not getting warmer. On 3/6/2025 at 5:20 PM, R27 and R28's bathroom sink water running for one minute water temperature was 79.7 F. On 3/6/2025 at 5:25 PM, R33, R34, 's bathroom sink water temperature running for one minute was 63.9 F. On 3/6/2025 at 5:30 PM, R34 stated they have been having cold water, cold showers, everything is cold today. I am not planning on taking any showers today with that cold water. On 3/6/2025 at 5:30 PM, R42, R43, and R45's bathroom sink running for one minute was 80.3F. On 3/6/2025 at 5:33 PM, R29, R30 and R32's bathroom sink running water for one minute was 86/9 F. On 3/6/2025 at 5: 39 PM, R22, R23, R25 and R26's bathroom sink running water for one minute was 86.2 F. On 3/7/2025 at 1:45 PM, V17, Activity Director stated, I noticed back in December we started getting complaints from residents about the water being cold. I know last week they were so happy because they said the hot water was finally working again. Resident Council Meeting Minutes dated 3/4/20245 documents, Hot water working. Resident Council Meeting Minutes dated 2/5/2025 documents, Showers not being given in a timely manner. On 3/7/2025 at 2:22 PM, tour of the basement was conducted and the red recirculatory part attached to a large pipe which takes the hot water and moves it through the pipes was making a loud clicking sounds/noises. There were two large boilers in the basement but only one boiler was working. The temperature Gadge on the working boiler was registering 78.0 F. On 3/7/2025 at 2:36 PM, V29, Maintenance Man stated, I started working here on 1/23/2025 and from day one I have been having issues with the water temperatures here in this building. I think that sound that you are hearing is telling us the recirculatory part which takes the hot water and moves it around the whole building is not functioning. Only one of the two boilers is working. I want that Gadge that says 78 degrees to be at 150 and with the mixing valve it will take the temperatures to what we want to see in the water which is ideally a temperature of 110.0 F. On 3/7/2025 at 3:53 PM, V1, Administrator stated, The plumbers were out here on 2/28/2025 and they were replacing a mixing valve because we did not have hot water. I do not have an invoice yet. We thought that fixed the issues with not having hot water. I know we have been having issues with the hot water off and on again since January 2025. (continued on next page)

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F 0558 Level of Harm - Actual harm Residents Affected - Some	The Facility Plumbing Invoice date of service 1/29/2025 documents, 1-29, called out for broken hot waterline water was coming out of tunnel, found line leaking in a room at the end of hall fixed line and restored water to building. 1-30, recalled out still no hot water, went thru all tunnels could not find break , isolated different areas with valves ,finally found a 1 in hot waterline under kitchen floor leaking ,installed valve to isolate no more leaking lines. 2-3, install new hot water line to kitchen area for 3 pan sink and prep sink. The Facility Plumbing invoice date of service 1/30/2025, requested quotes to get boilers operational and back up and running as there is not proper hot water in the building. Both boilers are in desperate need of service and repair. Unit 1 needs a new inducer motor, igniter and control board as well as a complete tear down of the condensation line and clean out for proper operation of the boiler. (please note that parts are listed from the manufacturer. Also there will be a complete flushing of the heat exchanger. Unit 2 needs a new igniter and inducer motor as it is struggling to maintain what it is doing now. And would also need a cleaning if the condensate trap and heat exchanger as well. Parts are days out on these items as well. Please call technician if you wish to proceed. The Illinois Department on Aging Residents' Rights for People in Long-Term Care Facilities revised 11/18 documents, Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Your facility must be safe, clean, comfortable and homelike. Maintenance Water Temperature Log dated 3/7/2025 documents East Shower room [ROOM NUMBER] degrees Fahrenheit, and west shower room [ROOM NUMBER].0 degrees Fahrenheit. The undated Water Temperature Log documents, Plumbing fixtures used by resident should provide tempered water between 105 and 120 degrees Fahrenheit. The Facility's Long-Term Care Facility Application for Medicare and Medicaid (CMS 671) dated 3/7/25 documents there are 73 residents living in the Facility.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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** 49494 Based on observation, interview, and record review the facility failed to ensure residents (R3, R30, R45) were free from neglect, physical abuse, and verbal abuse including a threat of death. This failure has the potential to affect all 73 residents residing in the facility. The Immediate Jeopardy began on 3/2/25 when a physical altercation occurred between V20 CNA (Certified Nurse Assistant) and R45. R45 required emergency medical treatment and antibiotics due to the injuries caused by V20 including a bite to R45 resulting in a laceration of her finger. R45 also sustained facial lacerations and a black eye during this altercation. V1, Administrator, was aware of this allegation/encounter and failed to initiate an abuse investigation and remove V20 from the facility. V20 remained onsite, caring for residents the remainder of her shift. On 3/5/25 V1, Administrator, and V11, Regional MDS Consultant witnessed V22 LPN (Licensed Practical Nurse) raise his voice and stated to R45 he wasn't going to allow her to attack another female staff member and if she did, he was going to beat her to death. R45 then made an allegation of sexual abuse by V22 in the presence of V1 and V11. V1 did not immediately suspend V22 and allowed V22 to work the night shift on 3/5/25. V1, Administrator/Abuse Coordinator failed to do the following: immediately remove staff from the building who abused R45, notify authorities of a death threat made by a facility nurse to R45 in the presence of V1, implement interventions to protect residents from abuse, failed to implement an abuse prevention program and interventions which resulted in R30 being physically abused 3 times by (R58, R24, R55). This failure resulted in R30 being flipped from his wheelchair by R55 with unknown injuries due to a lack of assessment, bruising to R30's face after being hit in the face by R58, and an initial report that R24 had grabbed R30's arm with unknown injuries due to a lack of assessment. No protection program was implemented to safeguard R30's impaired cognitive status with wandering tendencies. V25, Regional Chief Executive Officer, was notified of the Immediate Jeopardy on 3/14/25 at 11:18 AM. Based on observation, interview, and record review the immediate jeopardy remains at the time of the exit. Findings Include: 1. R45's face sheet, print date of 3/11/24, documented R45 has diagnoses including osteoarthritis, type 2 diabetes mellitus with diabetic neuropathy, bipolar disorder, major depressive disorder severe with psychotic symptoms, generalized anxiety disorder, hypertension, chronic embolism, and thrombosis of deep veins of lower extremity, adult failure to thrive, and personal history of suicidal behavior. R45's MDS (Minimum Data Set), dated 1/16/25, documented R45 is cognitively intact and requires supervision or touch assistance with all ADLS (activities of daily living). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R45's Preadmission Screening and Resident Review document, dated 1/9/25, documented R45 has been diagnosed with bipolar disorder with difficulty concentrating, easily angered, feelings of worthlessness, moods go from one extreme to another, tearful, trouble sleeping, anxious thoughts, and seeing or hearing things that others do not see or hear. It continues, R45 falls into the category of having a diagnosis that the PASRR (Preadmission Screening and Resident Review) was designed to assess. Your condition is likely to require expert treatment in the future. That diagnosis is: a serious mental health condition. Your care needs are appropriate to be serviced in any nursing facility setting. You are in need of a nursing home because: you need help with bathing, grooming, dressing, transfers, using the restroom, medication management and other tasks. You are diagnosed with bipolar disorder which significantly impacts your daily life. You may benefit from medication management and psychiatric support. R45's care plan, print date of 3/11/25, documented R45 is at risk for abuse and neglect related to diagnosis of bipolar depression, and suicidal ideations. Interventions include immediately report any episodes of unknown injury, abuse or change in resident's behaviors to Administrator for immediate intervention and review. R45's care plan does not address her history of aggression towards other residents nor staff. R45's care plan does not address her history of mood swings, anxiety, nor her history of hearing and seeing things that others do not see or hear related to her diagnosis of bipolar disorder. On 3/3/25 at 1:12 PM V1, Administrator, stated she had a resident R45 attack a CNA, (Certified Nurse Assistant), V20 last night and the CNA V20 bit R45 in self-defense. V1 stated she just found out about the incident a short time ago when she arrived at work. V1 asked the surveyor if she should report the incident since the employee was defending herself. On 3/3/25 at approximately 3:15 PM V1, Administrator came to the room where the surveyors were located and asked if she could talk with us for a minute. V1 sat down in the chair and said she just found out that on Sunday an altercation happened between staff and a resident. She said the CNA was just defending herself. V1 said she knows for a fact the CNA was just defending herself because she watched the video. She said R45 came up the hallway with a pillowcase that had something in it and there was a CNA standing there and she tried to hit the CNA with the pillowcase, so the CNA was just defending herself. V1 stated the CNA bit R45's finger and there was a laceration from this. V1 said R45 ended up going out to the hospital to be evaluated. V1 asked since it was self-defense did, she still need to do an investigation, and do I still need to suspend the CNA? Surveyor reminded V1 she was not a consultant for the facility. The facility's Long-Term Care Facility Serious Injury Incident Report, dated 3/3/25, documented on 3/3/25 it was reported to the administrator that there was an incident between resident R45 and employee V20. R45 made verbal threats and then physically assaulted employee V20. R45 was sent to the hospital and the police were also notified. There is an ongoing investigation and the resident R45 was moved to the other hall when she returned from the hospital. On 3/4/25 at 1:50 PM V5 LPN (Licensed Practical Nurse) stated she did not work last weekend but when she returned to work on Monday, 3/3/25, R45 was already moved to a room on the other side of the building. V5 stated she was told R45 was moved because something happened over the weekend between R45 and a CNA. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 3/4/25 at 2:03 PM V4 LPN stated R45 was moved to the west side of the building because she hit an employee. On 3/4/25 at 2:12 PM Surveyor interviewed and observed R45. R45 stated she had a fall on Saturday night, 3/1/25, because her marijuana gummy interacted with her medication. R45 stated the night nurse V22 and the CNA V20 picked up her up off the floor with a harness and she did not like the way they got her up off the floor. R45 stated she was upset about the way they picked her up, so she went to talk to them when they came to work on Sunday evening, 3/2/25, and the CNA V20 scratched her face, hit her in the eye, and bit her finger. R45 was observed with the following injuries: multiple scabbed scratches to her left outer eye with the following measurements #1) 1-inch scabbed scratch left outer eye, #2) 1-inch scabbed scratch below left eye, #3) 1/2-inch scabbed scratch above left eyebrow, and #4) 1.5-inch scabbed scratch left side of face/cheek bone. R45 was also observed with a 2 cm scabbed scratch on the middle of her nose, a 2 cm scabbed scratch to the tip of her nose, a 2-inch scabbed scratch below her right eye, R45's right eye was observed to be black/bruised with edema and a moderate amount of yellow drainage. R45's right pinky finger was observed with 1/2 inch laceration. R45 stated again all these injuries were caused by V20 CNA. On 3/4/25 at 2:18 PM V8 CNA stated she worked day shift on Sunday, 3/2/25 from 6 AM to 6 PM. V8 stated R45 was sent to the hospital on 3/1/25 because R45 was allegedly high from taking a gummy, fell , and had to go to the hospital. V8 stated R45 returned from the hospital on her shift on 3/2/25 and that R45 stated she was looking for V20 CNA because R45 was angry at V20 for the way she and the night nurse picked her up off the floor when she fell . V8 stated she warned V20 that R45 was looking for her. V8 stated she clocked out on Sunday a few minutes after 6 PM and as she was walking out of the facility the police and ambulance pulled into the facility, so she went back in to assist with resident care. V8 stated she did not witness the altercation between V20 and R45. V8 stated when she returned to work her next shift R45 was moved to the other side of the facility because V20 always works the side of the building that R45 lived on prior to the altercation. V8 stated she was told the injuries to R45's face and finger was from the CNA V20 defending herself from R45. On 3/4/2025 at 3:13 PM, V1, Administration stated, I can't believe I might get another IJ because a staff member was defending herself. This is ridiculous! On 3/4/25 at 3:23 PM, V2, ADON (Assistant Director of Nursing) stated I was coming into work that day and when I walked into the door somebody was calling my name. There had been an altercation between V20 LPN, (Licensed Practical Nurse), and R45. I called the police and V19 came out. He took statements. I did not take any statements. I am not really sure what happened. I did not witness anything. I was told V20 was defending herself against R45. I did call the police. Staff gave him statements. I did not do any investigation. I did call V1, Administrator, and left a message. The police came out and V19 was the investigator from the local police department. He took statements from everyone that day. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R45's local hospital records, dated 3/2/25, documented R45 presents to the emergency department with chief complaint of altercation with staff member. EMS (Emergency Medical Services) reports the patient was hitting staff members with pillowcase filled with soda cans. The patient also attempted to punch staff member and got her right pinky finger caught in the staff members mouth the patient also got scraped on her left cheek. It continues, the patient was given a dose of Augmentin as the laceration to her finger was secondary to a human bite due to it being secondary to human bite the wound will be allowed to close by secondary intent as the risk of infection. Patient will also be started on Augmentin. Patient was seen by crisis and evaluated the patient was safety planned for discharge back to the facility. Discharge Plan: clinical impression: aggressive behavior, abrasion of face, human bite of finger. Instructions: Antibiotic form, human bite, abrasion, acute wounds. Please keep the wound on your finger clean, it should be allowed to heal by secondary intent and keep a clean dressing on it changing it twice a day. Physician order for Amoxicillin 125 mg tablet Q12H (every 12 hours) for 10 days. R45's hospital discharge instructions, dated 3/2/24, documented human bites are often more serious than animal bites. Wounds are more likely to become infected because of the germs in a person's mouth. On 3/6/25 at 8:33 AM V23 LPN stated I was working the night V20 CNA and R45 got into it. I was getting ready to leave and go home. I was coming down the hallways and I heard a loud commotion of people screaming at each other. I was the first one on the scene. R45 was holding onto V20's hair and V20 was holding on with hand to her hair and the other hand she was pushing on R45. R45 has scratches on her face that were open and bleeding. The scratches were on her whole face. I do not recall V20 yelling for help. I am not sure I would have heard them because the alarm was going off too. I did not see R45 holding any pillowcase. I don't know anything about a pillowcase. On 3/6/25 at 8:25 AM R45 stated her finger hurts more than it did two days ago from the bite by V20 CNA. R45 stated I was mad at V20 CNA and V22 LPN about the way they picked me up off the floor the night before, so I did swing at V20 and then she scratched my face all up and bit my finger. This made me anxious and more depressed. On 3/6/25 at 10:37 AM V25, Regional Director, stated she was told V1 had a copy of the video with the altercation between V20 CNA and R45 but V1 said she doesn't have the video. V20 stated she was informed about the staff/resident incident on Monday morning by V2, ADON and that V2 informed her she did notify V1 on Sunday right after the altercation. V20 stated staff should not put their hands on another resident resulting in injuries like occurred with R45. On 03/06/25 at 11:01 AM, V24, CNA, said on the day of the incident with R45 and V20, CNA she was in the building. V24 said R45 had been making statements all day she was going to get V20 when she got here. V24 said when V20 got here all the staff went and told her what R45 was saying and not to go by her. V24 said she did not see any type of pillowcase in R45 hands during this altercation. On 3/10/25 at 11:08 AM V11, Regional MDS Consultant, stated V1, Administrator, was a no call no show, we can't get her to answer her phone, and we cannot find any of the abuse investigations you requested. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 3/10/25 at 11:52 AM Surveyor requested the final investigation with witness statements for the altercation between V20 CNA and R45 from V11 and V25. V11 stated I am not going to lie we have nothing. V25 stated V20 was fired last week by V1. V25 stated I guess V1 fired V20 because of what happened between her and R45. Surveyor requested V20's employee file and V25 replied there is nothing documented in V20's employee file regarding her termination. V25 stated V1 did not complete an investigation on the altercation between V20 and R45. The local police department report, dated 3/7/25 and authored by V19, documented I spoke with R45, and she stated the following: R45 believed V20 twisted her ankle as she was attempting to place her in bed due to her level of intoxication on 3/2/25. She told nursing staff that if she saw V20 CNA she was going go get her. V20 was pushing a medical cart past her when she grabbed V20 by her face and pulled her forwards herself and that's when they started fighting. I observed R45 to have two lacerations to her face and one to her finger. R45 advised she would like to be checked out by EMS for her injuries. It continues, I did not observe any marks on V20, but she stated that she believed that her tooth was knocked loose and that her mouth was bleeding prior to our arrival on the scene. It continues, staff stated they would move R45 to the other side of the facility for the evening and would keep V20 working on the other side of the facility. On 3/10/25 at 2:09 PM V2, ADON, stated the night V20 CNA and R45 had the altercation, she came into work because she was assigned to the floor on night shift, and she did not witness the incident, but she observed R45 with a cut under her left eye and it was bleeding. V2 stated I was told R45 attacked V20. V20 should have backed away from the resident when R45 came at her. 2. On 3/10/25 at 11:52 AM V11, Regional MDS Consultant, stated last Wednesday (3/5/25) he heard V22 LPN raise his voice and state to R45 if she hurts another staff member again, he will beat her to death. V11 stated V22 was terminated a few days later but he did work the night shift that night (3/5/25) after V22 threatened R45. V25, Regional, was present and stated this was not reported to (State Agency), there is no investigation for this, nor is there any documentation in V22's employee file. On 3/12/25 at approximately 11:00 AM V11 provided a written statement authored by him that documented on 3/5/25 at approx. 11:30 AM I witnessed V22 LPN walk into the Administrator's office and V22 told V1 that he wanted to talk to R45 in her office, V1 said ok, that's fine. V1 then closed her door. I heard V22 raise his voice and state that he wasn't going to allow her to attack another female staff member and if she did, he was going to beat her to death. I got up and immediately knocked on the door to pull V22 out of that room, but I heard V1 tell V22 don't answer it, it's just V11. V22 continued to yell at R45 for approx. two minutes telling her that he won't allow her to attack anyone else and he said to her try it again and see what happens. V22 then said, I heard you are saying that I sexually assault you, are you crazy. I heard R45 say you put your balls on my head. V22 yelled loudly no I didn't, you're crazy, I would never do that. R45 said I'm leaving then V22 opened the door and left. I immediately went into V1's office and told her he needs either immediately suspended or terminated. She told me Well he is off duty, I told her it didn't matter because he will have to come to work and R45 will have to be around him. She said to me that she was the administrator and that she has been doing this many years and she knows what she is doing besides he was just standing up for a staff member that got seriously hurt and told me again to keep my mouth shut about thing I don't know what I'm talking about. V1 then told me she was going to call V25 and picked up her phone and told me to get out of her office and close the door. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 3/12/25 at 11:19 AM V25, Regional Chief Executive Officer, stated she was aware of the abuse allegations by R45 against V22 LPN including the abuse witnessed by V1 and V11. V1 stated this and all of the abuse allegations should have been reported and investigated. V25 stated she told V1 to immediately fire V22 after he threatened R45, and she did not. V25 stated when they originally took over this facility they were going to try and make it more of a mom-and-pop facility but then they realized with the current star ratings they would continue to specialize in psychiatric care. Surveyor requested staff education documentation on how to care for residents with mental illness and V25 stated she would have to look and see if there has been any education provided. V25 again confirmed that the facility does not have any of the abuse investigations for the ones requested by the survey team including the abuse by V22 against R45 that was witnessed by V1 and V11. V25 stated the facility does not have any termination records for V20 nor V22 and that V1 actually let V22 resign. On 3/12/25 at 12:05 PM V3, Medical Director/Owner, stated he was aware of the sexual abuse allegation made by R45 against V22 LPN and if he was aware of the verbal threat V22 made to R45 when he stated he was going to beat her to death in the presence of V1 and V11. V3 stated he was aware and that he investigated it by talking to V22 on the phone that night (3/5/25) and that V22 stated it was not true. Surveyor asked V3 if he had documentation of his investigation for survey team to review and V3 replied he did not document it. V3 stated V22 was on duty working as a nurse the night he interviewed V22 via phone on 3/5/25. V3 stated V22 was terminated. Surveyor then asked V3 if the statement made by V25, Regional Chief Executive Officer, about V22 being allowed to resign rather than be terminated was true and V3 replied yes that is true. 3. R45's progress note, dated 2/22/25 at 11:19 AM, documented this nurse was summoned to front lobby by staff. Observed resident and peer arguing and yelling obscenities at one another. Resident was sitting on buttocks on floor, legs outstretched, wheeled walker nearby, peer was standing in front of wheeled walker. When asked what happened, resident stated she approached peer and asked, So I heard you were supposed to be slapping me today? Resident then states that peer pushed her to the floor. This nurse assisted resident back to her feet. Resident and peer redirected to different areas. It continues, Administration, ADON (Assistant Director of Nursing), and MD made aware. R38's face sheet, print date of 3/11/25, documented R38 has diagnoses including demyelinating disease of central nervous system, cerebrovascular disease, multiple sclerosis, major depressive disorder, and hypertension. R38's MDS, dated [DATE], documented R38 is cognitively intact, ambulates with a walker, and requires supervision with ADLS. R38's progress note, dated 2/22/25 at 11:16 AM, documented this nurse was summoned to front lobby by staff. Observed resident and peer arguing and yelling obscenities at one another. Resident was standing in front of her wheeled walker and peer was sitting on buttocks on floor, legs outstretched, wheeled walker nearby. When asked what happened resident stated peer approached resident with aggression and attempted to grab her neck. She, in turn pushed peer to the floor. This nurse assisted peer back to feet. Resident and peer redirected to different areas. Resident denies any pain or discomfort related to event at this time. Administration, ADON, and MD made aware. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R38's progress note, dated 2/22/25 at 11:20 AM, documented resident assessed by this nurse and no injuries noted r/t incident involving a peer. Resident denies pain r/t incident when asked what happened resident stated peer came up to her and attacked me by grabbing my neck. Resident states she wants to press charges, local police called, and officer came out to speak with resident. The facility's event report for R38, dated 2/22/25 at 11:27 AM, documented type of event that occurred was an allegation of abuse from peer, peer grabbed/scratched her neck. On 3/10/25 at 12:07 PM R38 stated the day she got attacked by R45 that R45 kept walking by her near the dining room, then R45 said something, I am not sure what she said, then she grabbed me by my neck. She scratched my neck when she grabbed it. I shoved her away and she fell down onto the floor. I about fell in the process. The police came but I ended up not pressing charges against R45. I just wanted her out of here and now she is at another facility. The facility's Long-Term Care Facility Serious Injury Incident Report (Initial), dated 2/22/25, documented R38 alleges that she was struck by fell ow resident R45 in the dining room. The two but at this time the writer does not know the outcome or the name of the responding officer. On 3/10/25 at 11:08 AM V11, Regional MDS Consultant, stated V1, Administrator, was a no call no show today and that they cannot find any of the abuse investigations including the resident-to-resident abuse investigation dated 2/22/25 for R38 and R45. On 3/10/25 at 11:52 AM V25, Chief Executive Officer, confirmed the facility does not have an abuse investigation for the altercation between R38 and R45 that was documented on 2/22/25. On 3/11/25 at 12:13 PM V33 CNA stated she was in the dining room the day R38 and R45 got into a fight. V33 stated she heard yelling and when she looked up, she saw R45 lying on the floor and R38 standing near R45. V33 stated she heard R38 say R45 came at her and scratched her neck. 4. R30's face sheet, print date of 3/3/25, documented R30 has diagnoses including schizophrenia, dementia, depression, generalized anxiety disorder, unspecified mood disorder, and weakness. R30's MDS (Minimum Data Set), dated 1/29/25, documented R30 is severely cognitively impaired and requires partial/moderate assistance with mobility. 5. The facility's Serious Injury Incident and Communicable Disease Report dated 2/25/25 at 12:45 PM, documented R58 allegedly hit R30 in the face in the dining room. They were separated and reside on different halls. The police were notified and R30's POA (Power of Attorney) notified as well as MD (Medical Doctor). Full report to follow. R30's EMR (electronic medical records) progress notes do not document the incident, nor any incident follow up assessments nor monitoring of R30's condition. The facility was unable to provide an incident report of the resident-to-resident incident that was reported on 2/25/25. R58's face sheet, print date of 3/3/25, documented R58 has diagnoses including hemiplegia and hemiparesis following cerebral infarction affect left non-dominant side, major depressive disorder, generalized anxiety disorder, cerebrovascular disease, hypertension, and a history of alcohol abuse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R58's MDS, dated [DATE], documented R58 is cognitively intact and is independent with mobility. R58's behavior tracking, dated 1/20/25, I am an IOP (Identified Offender Program) with a history of criminal trespassing, unlawful use of a weapon and I have a history of inappropriate contact with my peers and staff. On 3/3/25 at 1:12 PM V1, Administrator, stated she did complete the initial report to (State Agency) on the resident-to-resident altercation between R58 and R30. V1 stated she watched the surveillance footage and R30 was propelling himself in his wheelchair in the dining room, R30 knocked a cup over on a table, and R58 punched R30 in the face. V1 stated she does not have any witness statements yet and she does not have the final investigation completed. V1 stated her final investigation will substantiate abuse because the video proved R58 punched R30. V1 stated the police were called, responded to the facility, and they too watched the video of R58 punching R30 in the face. V1 stated R58 told the police he will hit R30 again if needed. V1 stated the incident was willful by R58. On 3/3/25 at 2:17 PM R30 was observed sitting in his wheelchair in the dining room approximately 5 feet from R58 without any staff present. R30 was observed with an approximate half dollar bruise to his right upper cheek. On 3/3/25 at 2:47 PM R58 stated he did hit R30 because R58 placed his cane on the ledge in the dining room and R30 grabbed his cane. R58 stated he grabbed his cane, then R30 came at him so he punched him in the face. R58 stated R30 then started crying. On 3/3/25 at 3:18 PM V8 CNA stated she stayed with R30 for a while after he got hit by R58. V8 stated R30 seemed quiet and withdrawn after the incident. On 3/4/25 at 9:10 AM V1 stated the bruise on R30's face was caused by R58 punching R30 last week. The facility's Long-Term Care Facility Serious Injury Incident Report, dated 2/25/25, documented on 2/25/25 at approximately 12:27 PM R58 hit R30 in the face. This incident was immediately reported to the administrator, who reported the incident allegation and started an investigation. The police were notified and came to start a report. The officer interviewed both R30 and R58. R30 was able to answer yes when asked if he was in pain, but did not answer any other questions, as his baseline. R30 was assessed for pain and injury with none noted, voiced, or presented with any injury. He did develop a bruise post injury. R58 admitted in the interview that he did hit R30 in the face with his fist when he came near him. When asked why he stated that R30 was coming for his cane, and no one can touch his things and he would do it again if he had to and that he did intentionally hit R30. The administrator was able to watch the video footage immediately after the incident and did confirm that the incident did occur and could see that R30 was wheeling through the dining room and ended up next to R58. R58 was in the corner behind a half wall in his wheelchair with his cane on the ledge of the half wall. R30 appeared to get his wheelchair wheels briefly stuck on the corner of the half wall/ledge. While next to R58, R30 picked up a cup and tossed it towards R58 and made motions towards the cane and R58 swung his fist, hitting R30 in his right cheek. R30 reacted but never struck R58. R30 then wheeled away. The video footage is available upon request and the police report will be as soon as is available to this writer. It has not yet been determined if charges will be filed against R58. Both residents will be referred to counseling service and the incident reported to the psych consultant. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	6. R24's face sheet, print date of 3/10/25, documented R24 has diagnoses including cerebral infarction due to thrombosis of bilateral vertebral arteries, type 2 diabetes mellitus, history of cardiac arrest, hyperlipidemia, essential dysfunction of bladder, history of malignant neoplasm of thyroid, and complete traumatic amputation of left foot. R24's MDS, dated [DATE], documented R24 is cognitively intact and requires partial to moderate assistance with mobility and ADLS. R24's care plan, print date of 3/10/25, documented R24 has a history of verbal and physical aggression. The facility's Long-Term Care Facility Serious Injury Incident Report, initial report dated 3/4/25, documented a resident-to-resident incident was reported between two residents, R24 and R30, R24 allegedly grabbed the arm of R30. There were no injuries and the two were separated. On 3/10/25 at 11:08 AM surveyor asked V11, Regional MDS Consultant, if the facility Administrator was coming into work today. V11 stated V1 was a no call, no show today, and we cannot get her to answer her phone. V11 stated we cannot find any of the abuse investigations that you have requested including the one for R24 and R30. On 3/10/25 at 11:52 AM Surveyor asked V25, Regional Chief Executive Officer, for the preliminary investigation and/or final investigation for the resident-to-resident altercation between R24 and R30 that was documented on the initial report, dated 3/4/25. V25 stated there is no investigation for the altercation between R24 and R30. V11 was present during this conversation and stated, I am not going to lie we have nothing. R24's and R30's EMRS were reviewed and neither document the altercation between them that was reported by the facility on 3/4/25. On 3/10/25 at 2:20 PM R24 stated I did have a fight with R30 last week because I asked him to move out of the way so I could get through the hallway. R30 started growling at me and then punched me several times on my arm so I grabbed his arm tightly to stop him from punching me anymore. R24 then stated that a CNA broke up the fight between him and R30, but he does not remember the name of the CNA. R24 stated it hurt when R30 punched his arm. 7. R3's face sheet, print date of 3/10/25, documented R3 has diagnoses including Parkinson's disease, encephalopathy, type 2 diabetes, morbid obesity, dysphagia following cerebral infarction, atherosclerotic heart disease, paranoid schizophrenia, developmental disorder, and altered mental status. R3's care plan, print date 3/10/25, documented R3 is at risk for abuse and neglect related to schizophrenia diagnosis. R3's care plan also documented R3 has a history of making sexually inappropriate comments toward staff. On 3/6/25 at 10:05 AM surveyor was sitting at the [NAME] unit nurse's station and observed R30 propel self in his wheelchair up to R3 who was sitting in his wheelchair on the west unit short hall. R3 started yelling at R30, then surveyor heard R30 yell f--- off to R3. Surveyor then observed a facility housekeeper V28 separate R3 and R30. V28 stated to surveyor R30 is the one who said f--- off. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 3/6/25 at 10:08 AM surveyor immediately informed V1, Administrator, of the verbal altercation that was witnessed by surveyor and informed V1 the [NAME] unit housekeeper V28 also witnessed the resident-to-resident altercation. V1 replied to surveyor I will report and investigate it. As of 3/10/25 (State Agency) (Illinois Department of Public Health) did not have any records containing an initial report of verbal abuse between R3 and R30. On 3/10/25 at 11:08 V11, Regional MDS Consultant, stated he cannot find any of the abuse investigations including the one between R3 and R30. On 3/10/25 at 11:52 AM V25, Chief Executive Officer, confirmed the facility does not have an initial report of the verbal abuse that was observed by this surveyor between R3 and R30 on 3/6/25. V25 also stated there is no investigation for this. 8. R3's progress note dated 3/5/25 (recorded as late entry on 3/6/25 at 1:10 AM) authored by V2, ADON, documented resident was seen in the middle of hall this nurse saw resident scream at another resident and other resident turned and smacked R3 in the face this nurse immediately [TRUNCATED]

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49494 Based on observation, interview, and record review the facility failed to ensure that allegations of verbal abuse, physical abuse, and sexual abuse were reported within 2 hours after the allegation was made, and failed to report the results of the of the investigations to the State Survey Agency within 5 business days for 7 of 8 residents (R3, R6, R7, R24, R30, R38, R45) reviewed for abuse and neglect in the sample of 82. This failure has the potential to affect all 73 residents residing at the facility. Findings Include: 1. R45's face sheet, print date of 3/11/24, documented R45 has diagnoses including osteoarthritis, type 2 diabetes mellitus with diabetic neuropathy, bipolar disorder, major depressive disorder severe with psychotic symptoms, generalized anxiety disorder, hypertension, chronic embolism, and thrombosis of deep veins of lower extremity, adult failure to thrive, and personal history of suicidal behavior. R45's MDS (Minimum Data Set), dated 1/16/25, documented R45 is cognitively intact and requires supervision or touch assistance with all ADLS (activities of daily living). R45's Preadmission Screening and Resident Review document, dated 1/9/25, documented R45 has been diagnosed with bipolar disorder with difficulty concentrating, easily angered, feelings of worthlessness, moods go from one extreme to another, tearful, trouble sleeping, anxious thoughts, and seeing or hearing things that others do not see or hear. It continues, R45 falls into the category of having a diagnosis that the PASRR (Preadmission Screening and Resident Review) was designed to assess. Your condition is likely to require expert treatment in the future. That diagnosis is: a serious mental health condition. Your care needs are appropriate to be serviced in any nursing facility setting. You are in need of a nursing home because: you need help with bathing, grooming, dressing, transfers, using the restroom, medication management and other tasks. You are diagnosed with bipolar disorder which significantly impacts your daily life. You may benefit from medication management and psychiatric support. R45's care plan, print date of 3/11/25, documented R45 is at risk for abuse and neglect related to diagnosis of bipolar depression, and suicidal ideations. Interventions include immediately report any episodes of unknown injury, abuse or change in resident's behaviors to Administrator for immediate intervention and review. R45's care plan does not address her history of aggression towards other residents nor staff. R45's care plan does not address her history of mood swings, anxiety, nor her history of hearing and seeing things that others do not see or hear related to her diagnosis of bipolar disorder. On 3/3/25 at 1:12 PM V1, Administrator, stated she had a resident, R45, attack a CNA (Certified Nurse Assistant), V20, last night and the CNA, V20, bit R45 in self-defense. V1 stated she just found out about the incident a short time ago when she arrived at work. V1 asked the surveyor if she should report the incident since the employee was defending herself. Surveyor advised V1 to follow the facility policy. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/3/25 at approximately 3:15 PM V1, Administrator came to the room where the surveyors were located and asked if she could talk with us for a minute. V1 sat down in the chair and said she just found out that on Sunday an altercation happened between staff and a Resident. She said the CNA was just defending herself. V1 said she knows for a fact the CNA was just defending herself because she watched the video. She said R45 came up the hallway with a pillowcase that had something in it and there was a CNA standing there and she tried to hit the CNA with the pillowcase, so the CNA was just defending herself. V1 stated the CNA bit R45's finger and there was a laceration from this. V1 said R45 ended up going out to the hospital to be evaluated. V1 asked since it was self-defense did, she still need to do an investigation, and do I still need to suspend the CNA? Surveyor stated to V1 what does your policy say you need to do? The facility's Long-Term Care Facility Serious Injury Incident Report, dated 3/3/25, documented on 3/3/25 it was reported to the administrator that there was an incident between resident R45 and employee V20. R45 made verbal threats and then physically assaulted employee V20. R45 was sent to the hospital and the police were also notified. There is an ongoing investigation and the resident R45 was moved to the other hall when she returned from the hospital. On 3/4/25 at 1:50 PM V5 LPN (Licensed Practical Nurse) stated she did not work last weekend but when she returned to work on Monday, 3/3/25, R45 was already moved to a room on the other side of the building. V5 stated she was told R45 was moved because something happened over the weekend between R45 and a CNA. On 3/4/25 at 2:03 PM V4 LPN stated R45 was moved to the west side of the building because she hit an employee. On 3/4/25 at 2:12 PM Surveyor interviewed and observed R45. R45 stated she had a fall on Saturday night, 3/1/25, because her marijuana gummy interacted with her medication. R45 stated the night nurse V22 and the CNA V20 picked up her up off the floor with a harness and she did not like the way they got her up off the floor. R45 stated she was upset about the way they picked her up, so she went to talk to them when they came to work on Sunday evening, 3/2/25, and the CNA V20 scratched her face, hit her in the eye, and bit her finger. R45 was observed with the following injuries: multiple scabbed scratches to her left outer eye with the following measurements #1) 1-inch scabbed scratch left outer eye, #2) 1-inch scabbed scratch below left eye, #3) 1/2-inch scabbed scratch above left eyebrow, and #4) 1.5-inch scabbed scratch left side of face/cheek bone. R45 was also observed with a 2 cm scabbed scratch on the middle of her nose, a 2 cm scabbed scratch to the tip of her nose, a 2-inch scabbed scratch below her right eye, R45's right eye was observed to be black/bruised with edema and a moderate amount of yellow drainage. R45's right pinky finger was observed with 1/2 inch laceration. R45 stated again all these injuries were caused by V20 CNA. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/4/25 at 2:18 PM V8 CNA stated she worked day shift on Sunday, 3/2/25 from 6 AM to 6 PM. V8 stated R45 was sent to the hospital on 3/1/25 because R45 was allegedly high from taking a gummy, fell , and had to go to the hospital. V8 stated R45 returned from the hospital on her shift on 3/2/25 and that R45 stated she was looking for V20 CNA because R45 was angry at V20 for the way she and the night nurse picked her up off the floor when she fell . V8 stated she warned V20 that R45 was looking for her. V8 stated she clocked out on Sunday a few minutes after 6 PM and as she was walking out of the facility the police and ambulance pulled into the facility, so she went back in to assist with resident care. V8 stated she did not witness the altercation between V20 and R45. V8 stated when she returned to work her next shift R45 was moved to the other side of the facility because V20 always works the side of the building that R45 lived on prior to the altercation. V8 stated she was told the injuries to R45's face and finger was from the CNA V20 defending herself from R45. On 3/4/25 at 2:25 PM Surveyor requested all the facility abuse investigations for the past 3 months and V1, Administrator, replied they are not done, some of them are at my home. I have not investigated anything yet about what occurred between R45 and V20. I was not notified about the incident until a I got to work on Monday, 3/3/25 about noon. V1 stated she didn't think she had to report the altercation between R45 and V20 because it was self-defense by the employee. Surveyor asked V1 if she has looked at R45's injuries and V1 replied no I have not, I know she has a scratch on her face and a bite on her finger from the employee defending herself. Surveyor requested an incident report for R45's injuries and V1 replied there is no incident report for R45's injuries from the altercation. V1 again stated she did not know about the incident between V20 and R45 that occurred on 3/2/25 until she got to work on 3/3/25 so it was not reported to (State Agency) (Illinois Department of Public Health) within 2 hours. Surveyor asked V1 where the altercation occurred and V1 replied by the nurse's station. Surveyor asked V1 to review the video surveillance of the incident and V1 replied I have not reviewed it; I will see if I can pull it up. Surveyor asked V1 if she suspended the employee pending further investigation and V1 replied no I have not because I thought the CNA was defending herself. Surveyor asked V1 how she is keeping the resident's safe from abuse since the facility has residents with mental illness and V1 replied I am trying to get R45 discharged if the facility would have called me about the incident with her and the CNA I would have given her an involuntary discharge. V1 stated I called the Ombudsman, and she said it would be okay to discharge R45 to a homeless shelter. Surveyor asked V1 if she thought a homeless shelter could meet R45's medical and mental health needs and V1 replied I don't know. Surveyor then requested R45's pre-screen for nursing home placement documents. V1 stated she will look for them. V1 stated R45 hit the CNA V20 with a pillowcase containing soda cans because R45 didn't like how the CNA picked her up with the mechanical lift. Surveyor asked V1 what her facility assessment says about meeting the needs of the residents with mental illness since the facility has so many residents with mental illness and V1 replied I haven't had time to do a facility assessment. Our Social Service consultant said our Subpart S is fine. Surveyor asked if the facility is offering the residents with serious mental illness any group therapy, one on one meetings, or activities related to Subpart S and V1 replied no, were not doing any of that. Surveyor requested to observe the video surveillance footage of the altercation between V20 CNA and R45. On 3/4/2025 at 3:13 PM, V1, Administration stated, I can't believe I might get another IJ because a staff member was defending herself. This is ridiculous! On 3/4/25 at 4 PM V1, Administrator, stated I cannot get the video footage, I am having issues with the system, it keeps jumping to 2016. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/4/25 at 3:23 PM, V2, ADON (Assistant Director of Nursing) stated I was coming into work that day and when I walked into the door somebody was calling my name. There had been an altercation between V20 LPN and R45. I called the police and V19 came out. He took statements. I did not take any statements. I am not really sure what happened. I did not witness anything. I was told V20 was defending herself against R45. I did call the police. Staff gave him statements; I did not take any statements. I did not do any investigation. I did call V1, Administrator, and left a message. The police came out and V19 was the investigator from the local police department. R45's local hospital records, dated 3/2/25, documented R45 presents to the emergency department with chief complaint of altercation with staff member. EMS (Emergency Medical Services) reports the patient was hitting staff members with pillowcase filled with soda cans. The patient also attempted to punch staff member and got her right pinky finger caught in the staff members mouth the patient also got scraped on her left cheek. It continues, the patient was given a dose of Augmentin as the laceration to her finger was secondary to a human bite due to it being secondary to human bite the wound will be allowed to close by secondary intent as the risk of infection. Patient will also be started on Augmentin. Patient was seen by crisis and evaluated the patient was safety planned for discharge back to the facility. Discharge Plan: clinical impression: aggressive behavior, abrasion of face, human bite of finger. Instructions: Antibiotic form, human bite, abrasion, acute wounds. Please keep the wound on your finger clean, it should be allowed to heal by secondary intent and keep a clean dressing on it changing it twice a day. Physician order for Amoxicillin 125 mg tablet Q12H (every 12 hours) for 10 days. R45's hospital discharge instructions, dated 3/2/24, documented human bites are often more serious than animal bites. Wounds are more likely to become infected because of the germs in a person's mouth. On 3/6/25 at 8:25 AM R45 stated her finger hurts from the bite and the nurses have not been cleaning it or checking it. R45 then stated I was mad at V20 CNA and V22 LPN about the way they picked me up off the floor the night before, so I did swing at V20 and then she scratched my face all up and bit my finger. This made me anxious and more depressed. On 3/6/25 at 8:33 AM V23 LPN stated I was working the night V20 CNA and R45 got into it. I was getting ready to leave and go home. I was coming down the hallways and I heard a loud commotion of people screaming at each other. I was the first one on the scene. R45 was holding onto V20's hair and V20 was holding on with hand to her hair and the other hand she was pushing on R45. R45 has scratches on her face that were open and bleeding. The scratches were on her whole face. I do not recall V20 yelling for help. I am not sure I would have heard them because the alarm was going off too. I did not see R45 holding any pillowcase. I don't know anything about a pillowcase. On 3/6/25 at 8:25 AM R45 stated her finger hurts more than it did two days ago from the bite by V20 CNA. R45 stated I was mad at V20 CNA and V22 LPN about the way they picked me up off the floor the night before, so I did swing at V20 and then she scratched my face all up and bit my finger. This made me anxious and more depressed. On 3/6/25 at 8:34 AM V24 CNA stated she did not witness the initial altercation between R45 and V20 CNA, but she did see the nurse run so she did also and then she observed R45 and V20 with their hands in each other's hair. V24 stated she has never received any training from this facility on how to handle aggressive residents. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/6/25 at 8:52 AM V26 CNA stated the new owner told the staff the facility will be taking my psych patients, but the facility has never trained us on how to handle residents with aggression. On 3/6/25 at 9:47 AM R45 stated to surveyor we still don't have a nurse; my back pain is at a 9. I need a nurse to look at my finger, it looks worse. The nurses have not been checking it nor cleaning it. R45's finger was uncovered, with a laceration that appeared inflamed with a small amount of yellow drainage coming from it. On 3/6/25 at 10:37 AM V25, Regional Director, stated she was told V1 had a copy of the video with the altercation between V20 CNA and R45 but V1 said she doesn't have the video. V20 stated she was informed about the staff/resident incident on Monday morning by V2, ADON and that V2 informed her she did notify V1 on Sunday right after the altercation. V20 stated staff should not put their hands on another resident resulting in injuries like occurred with R45. On 3/6/25 at 10:45 AM V1, Administrator, stated she did not suspend V20 CNA pending investigation the night the altercation occurred between V20 and R45. V1 stated she suspended V20 on Monday after she learned about the incident. V1 stated V20 worked the 12-hour night shift after the altercation happened around 6:15 PM. V1 stated she will have to fire V20 for the altercation. On 03/06/25 at 11:01 AM, V24, CNA, said on the day of the incident with R45 and V20, CNA she was in the building. V24 said R45 had been making statements all day she was going to get V20 when she got here. V24 said when V20 got here all the staff went and told her what R45 was saying and not to go by her. V24 said she did not see any type of pillowcase in R45 hands during this altercation. On 3/10/25 at 11:08 AM V11, Regional MDS Consultant, stated V1, Administrator, was a no call no show, we can't get her to answer her phone, and we cannot find any of the abuse investigations you requested. On 3/10/25 at 11:52 AM Surveyor requested the final investigation with witness statements for the altercation between V20 CNA and R45 from V11 and V25. V11 stated I am not going to lie we have nothing. V25 stated V20 was fired last week by V1. V25 stated I guess V1 fired V20 because of what happened between her and R45. Surveyor requested V20's employee file and V25 replied there is nothing documented in V20's employee file regarding her termination. V25 stated V1 did not complete an investigation on the altercation between V20 and R45. The local police department report, dated 3/7/25 and authored by V19, documented I spoke with R45, and she stated the following: R45 believed V20 twisted her ankle as she was attempting to place her in bed due to her level of intoxication on 3/2/25. She told nursing staff that if she saw V20 CNA she was going go get her. V20 was pushing a medical cart past her when she grabbed V20 by her face and pulled her forwards herself and that's when they started fighting. I observed R45 to have two lacerations to her face and one to her finger. R45 advised she would like to be checked out by EMS for her injuries. It continues, I did not observe any marks on V20, but she stated that she believed that her tooth was knocked loose and that her mouth was bleeding prior to our arrival on the scene. It continues, staff stated they would move R45 to the other side of the facility for the evening and would keep V20 working on the other side of the facility. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/10/25 at 2:09 PM V2, ADON, stated the night V20 CNA and R45 had the altercation, she came into work because she was assigned to the floor on night shift, and she did not witness the incident, but she observed R45 with a cut under her left eye and it was bleeding. V2 stated I was told R45 attacked V20. V20 should have backed away from the resident when R45 came at her. On 3/13/25 at 10:22 AM V11 stated the facility has no record of any staff education being completed on the facility abuse prevention policy since the new owner took over the facility about a year ago. Surveyor then requested R45's safety plan that was documented in R45's discharge instructions from the hospital on 3/3/25. V11 stated this is the first time he has heard of it and that there is no safety plan documented in R45's care plan. On 3/13/25 at 10:54 AM V11 stated the facility does not have any residents on psychosocial programs, they have not identified the residents who quality for Subpart S programs, and that he spoke to the facility's Social Service Consultant yesterday, and the consultant informed him she has been telling the facility's Social Service Director for months that the facility needs to get the psychosocial programs implemented. On 3/13/25 at 12:40 PM V15, Social Service Director, stated she was not aware of R45 needing a safety plan put into plan, so no plan was implemented. V15 stated R45 was never put on a psychosocial program for her diagnosis of bipolar disorder. V20's Time Detail Report, dated 3/1/25 - 3/3/25, documented V20 was allowed to work and did work from 6:05 PM on 3/2/25 until 6:17 AM on 3/3/25 after the altercation between V20 and R45 that resulted in R45 sustaining injuries that required emergency medical care. The facility failed to submit an initial report within 2 hours of the altercation between V20 and R45. The altercation between R45 and V20 occurred at approximately 6:15 PM on 3/2/25 and the initial report of this incident was not submitted to (State Agency) (Illinois Department of Public Health) until afternoon on 3/3/25. The facility failed to complete a full investigation of this incident and failed to submit a final investigation to the (State Agency). 2. On 3/6/25 at 12:49 PM V1, Administrator, came to surveyor and stated I have another reportable, it's going to be reported late. R45 called the police last night and reported to them she felt threatened by V22 LPN. V1 stated a staff member called her and told her about this last night but she does not remember who called her nor what time. V1 stated I did not suspend V22, I don't know why, it was stupidity on my part. V22 did work the entire night shift. V1 then provided surveyor with the initial report documented on the facility's Long-Term Care Facility & Serious Injury Incident Report form, report dated 3/6/25. This form documented incident date 3/5/25, on 3/5/25 R45 reported to the police that she felt threatened by employee V22. V22 was suspended and R45 is currently under 1:1 supervision for her well being. The allegation is being investigated and the final report will be submitted upon completion. On 3/10/25 at 10:43 AM V21, Ombudsman, stated on 3/5/25 at approximately 12:15 PM she reported to V1, Administrator, that R45 reported to her that night nurse V22 had pressed his genitals against her back while providing care to her. V21 stated V1 replied oh so do I have to fire him too and V21 stated she replied to V1 I would like you to investigate it. As of 3/17/25 the facility had not submitted an initial report of this allegation nor did the facility submit a final investigation to (State Agency) of this allegation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/10/25 at 11:52 AM V11, Regional MDS Consultant, stated last Wednesday (3/5/25) he heard V22 LPN raise his voice and state to R45 if she hurts another staff member again, he will beat her to death. V11 stated V22 was terminated a few days later but he did work the night shift that night (3/5/25) after V22 threatened R45. V25, Regional, was present and stated this was not reported to (State Agency), there is no investigation for this, nor is there any documentation in V22's employee file. On 3/11/25 at 12:35 PM Surveyor asked V2, ADON, if she or V1 knew about the allegation R45 reported to the ombudsman on 3/5/25. V2 replied R45 told me about it. R45 told me that the man nurse V22 rubbed his genitals up against her back. I told R45 to tell V1 and I know V1 knew about it because I heard her talking to V22 about it. On 3/11/25 at 1:13 PM V25, Regional CEO, stated she was aware of the allegation made by R45 against nurse V22 about him allegedly rubbing his genitals up against R45 during care. V25 stated we have no final investigation nor witness statements for this. V25 then asked the surveyor if she should investigate this, and the surveyor instructed V25 to follow the facility's policy. On 3/12/25 at approximately 11:00 AM V11 provided a written statement authored by him that documented on 3/5/25 at approx. 11:30 AM I witnessed V22 LPN walk into the Administrator's office and V22 told V1 that he wanted to talk to R45 in her office, V1 said ok, that's fine. V1 then closed her door. I heard V22 raise his voice and state that he wasn't going to allow her to attack another female staff member and if she did, he was going to beat her to death. I got up and immediately knocked on the door to pull V22 out of that room, but I heard V1 tell V22 don't answer it, it's just V11. V22 continued to yell at R45 for approx. two minutes telling her that he won't allow her to attack anyone else and he said to her try it again and see what happens. V22 then said, I heard you are saying that I sexually assault you, are you crazy. I heard R45 say you put your balls on my head. V22 yelled loudly no I didn't, you're crazy, I would never do that. R45 said I'm leaving then V22 opened the door and left. I immediately went into V1's office and told her he needs either immediately suspended or terminated. She told me Well he is off duty, I told her it didn't matter because he will have to come to work and R45 will have to be around him. She said to me that she was the administrator and that she has been doing this many years and she knows what she is doing besides he was just standing up for a staff member that got seriously hurt and told me again to keep my mouth shut about thing I don't know what I'm talking about. V1 then told me she was going to call V25 and picked up her phone and told me to get out of her office and close the door. On 3/12/25 at 11:19 AM V25, Regional Chief Executive Officer, stated she was aware of the abuse allegations by R45 against V22 LPN including the abuse witnessed by V1 and V11. V1 stated this and all of the abuse allegations should have been reported and investigated. V25 stated she told V1 to immediately fire V22 after he threatened R45, and she did not. V25 stated when they originally took over this facility they were going to try and make it more of a mom-and-pop facility but then they realized with the current star ratings they would continue to specialize in psychiatric care. Surveyor requested staff education documentation on how to care for residents with mental illness and V25 stated she would have to look and see if there has been any education provided. V25 again confirmed that the facility does not have any of the abuse investigations for the ones requested by the survey team including the abuse by V22 against R45 that was witnessed by V1 and V11. V25 stated the facility does not have any termination records for V20 nor V22 and that V1 actually let V22 resign. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/12/25 at 12:05 PM V3, Medical Director/Owner, stated he was aware of the sexual abuse allegation made by R45 against V22 LPN and if he was aware of the verbal threat V22 made to R45 when he stated he was going to beat her to death in the presence of V1 and V11. V3 stated he was aware and that he investigated it by talking to V22 on the phone that night (3/5/25) and that V22 stated it was not true. Surveyor asked V3 if he had documentation of his investigation for survey team to review and V3 replied he did not document it. V3 stated V22 was on duty working as a nurse the night he interviewed V22 via phone on 3/5/25. V3 stated V22 was terminated. Surveyor then asked V3 if the statement made by V25, Regional Chief Executive Officer, about V22 being allowed to resign rather than be terminated was true and V3 replied yes that is true. V22's Time Detail Report, dated 3/1/25 - 3/6/25, documented V22 was allowed to work on 3/5/25 from 5:57 PM until 6:25 AM on 3/6/25 after V22 threatened to beat R45 to death and R45 accused V22 of sexual abuse in the presence of management staff, V1 and V11. The facility failed to submit an initial report and failed to submit a final investigation of this abuse to the (State Agency). As of 3/17/25 the facility did not have an investigation of the witnessed abuse by V22 against R45 nor of the allegation of sexual abuse by R45 against V22. 3. R45's progress note, dated 2/22/25 at 11:19 AM, documented this nurse was summoned to front lobby by staff. Observed resident and peer arguing and yelling obscenities at one another. Resident was sitting on buttocks on floor, legs outstretched, wheeled walker nearby, peer was standing in front of wheeled walker. When asked what happened, resident stated she approached peer and asked, So I heard you were supposed to be slapping me today? Resident then states that peer pushed her to the floor. This nurse assisted resident back to her feet. Resident and peer redirected to different areas. It continues, Administration, ADON (Assistant Director of Nursing), and MD made aware. R38's face sheet, print date of 3/11/25, documented R38 has diagnoses including demyelinating disease of central nervous system, cerebrovascular disease, multiple sclerosis, major depressive disorder, and hypertension. R38's MDS, dated [DATE], documented R38 is cognitively intact, ambulates with a walker, and requires supervision with ADLS. R38's progress note, dated 2/22/25 at 11:16 AM, documented this nurse was summoned to front lobby by staff. Observed resident and peer arguing and yelling obscenities at one another. Resident was standing in front of her wheeled walker and peer was sitting on buttocks on floor, legs outstretched, wheeled walker nearby. When asked what happened resident stated peer approached resident with aggression and attempted to grab her neck. She, in turn pushed peer to the floor. This nurse assisted peer back to feet. Resident and peer redirected to different areas. Resident denies any pain or discomfort related to event at this time. Administration, ADON, and MD made aware. R38's progress note, dated 2/22/25 at 11:20 AM, documented resident assessed by this nurse and no injuries noted r/t incident involving a peer. Resident denies pain r/t incident when asked what happened resident stated peer came up to her and attacked me by grabbing my neck. Resident states she wants to press charges, local police called, and officer came out to speak with resident. The facility's event report for R38, dated 2/22/25 at 11:27 AM, documented type of event that occurred was an allegation of abuse from peer, peer grabbed/scratched her neck. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/10/25 at 12:07 PM R38 stated the day she got attacked by R45 that R45 kept walking by her near the dining room, then R45 said something, I am not sure what she said, then she grabbed me by my neck. She scratched my neck when she grabbed it. I shoved her away and she fell down onto the floor. I about fell in the process. The police came but I ended up not pressing charges against R45. I just wanted her out of here and now she is at another facility. The facility's Long-Term Care Facility Serious Injury Incident Report (Initial), dated 2/22/25, documented R38 alleges that she was struck by fell ow resident R45 in the dining room. The two but at this time the writer does not know the outcome or the name of the responding officer. On 3/10/25 at 11:08 AM V11, Regional MDS Consultant, stated V1, Administrator, was a no call no show today and that they cannot find any of the abuse investigations including the resident-to-resident abuse investigation dated 2/22/25 for R38 and R45. On 3/10/25 at 11:52 AM V25, Chief Executive Officer, confirmed the facility does not have an abuse investigation for the altercation between R38 and R45 that was documented on 2/22/25. On 3/11/25 at 12:13 PM V33 CNA stated she was in the dining room the day R38 and R45 got into a fight. V33 stated she heard yelling and when she looked up, she saw R45 lying on the floor and R38 standing near R45. V33 stated she heard R38 say R45 came at her and scratched her neck. As of 3/17/25 the facility failed to complete and failed to submit a full investigation of the altercation between R38 and R45 nor did the facility implement interventions to safeguard R38 and R45. R45 was transferred to another facility on 3/7/25. 4. R30's face sheet, print date of 3/3/25, documented R30 has diagnoses including schizophrenia, dementia, depression, generalized anxiety disorder, unspecified mood disorder, and weakness. R30's MDS, dated [DATE], documented R30 is severely cognitively impaired and requires partial/moderate assistance with mobility. Review of R30's records revealed R30 was physically abused and injured R36 on 1/24/25. This abuse was substantiated by the facility. R30 is vulnerable secondary to diagnosis of dementia and history of wandering into other resident's rooms and personal spaces. R30's records do not document any interventions were implemented to keep R30 safe from further abuse. 5. R24's face sheet, print date of 3/10/25, documented R24 has diagnoses including cerebral infarction due to thrombosis of bilateral vertebral arteries, type 2 diabetes mellitus, history of cardiac arrest, hyperlipidemia, essential dysfunction of bladder, history of malignant neoplasm of thyroid, and complete traumatic amputation of left foot. R24's MDS, dated [DATE], documented R24 is cognitively intact and requires partial to moderate assistance with mobility and ADLS. R24's care plan, print date of 3/10/25, documented R24 has a history of verbal and physical aggression. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Long-Term Care Facility Serious Injury Incident Report, initial report dated 3/4/25, documented a resident-to-resident incident was reported between two residents, R24 and R30, R24 allegedly grabbed the arm of R30. There were no injuries and the two were separated. On 3/10/25 at 11:08 AM surveyor asked V11, Regional

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49494 Based on observation, interview, and record review the facility failed to operationalize their policy to conduct thorough investigations of allegations of sexual, physical, and verbal abuse. This failure has the potential to affect all 73 residents residing in the facility. The Immediate Jeopardy began on 3/2/25 when a physical altercation occurred between V20 CNA and R45. R45 required emergency medical treatment and antibiotics due to the injuries caused by V20 including a bite to R45 resulting in a laceration of her finger. R45 also sustained facial lacerations and a black eye during this altercation. V1, Administrator, was aware of this allegation/encounter and failed to initiate an abuse investigation and remove V20 from the facility. V20 remained onsite, caring for residents the remainder of her shift. On 3/5/25 V1 and V11, Regional MDS Consultant, witnessed V22 LPN raise his voice and stated to R45 he wasn't going to allow her to attack another female staff member and if she did, he was going to beat her to death. R45 then made an allegation of sexual abuse by V22 in the presence of V1 and V11. V1 did not immediately suspend V22 and allowed V22 to work the night shift on 3/5/25. On 3/5/25 The facility Ombudsman V21 also reported the allegation of sexual abuse by R45 against V22 to V1. V1 did not report, investigate, nor suspend the nurse V22 and allowed him to care for residents on the night shift. As of 3/12/25, no abuse investigation has been initiated regarding the above allegations involving V22. V25, Regional Chief Executive Officer, was notified of the Immediate Jeopardy on 3/13/25 at 8:45 AM. Based on observation, interview, and record review the immediate jeopardy remains at the time of the exit. Findings Include: 1. R45's face sheet, print date of 3/11/24, documented R45 has diagnoses including osteoarthritis, type 2 diabetes mellitus with diabetic neuropathy, bipolar disorder, major depressive disorder severe with psychotic symptoms, generalized anxiety disorder, hypertension, chronic embolism, and thrombosis of deep veins of lower extremity, adult failure to thrive, and personal history of suicidal behavior. R45's MDS (Minimum Data Set), dated 1/16/25, documented R45 is cognitively intact and requires supervision or touch assistance with all ADLS (activities of daily living). R45's Preadmission Screening and Resident Review document, dated 1/9/25, documented R45 has been diagnosed with bipolar disorder with difficulty concentrating, easily angered, feelings of worthlessness, moods go from one extreme to another, tearful, trouble sleeping, anxious thoughts, and seeing or hearing things that others do not see or hear. It continues, R45 falls into the category of having a diagnosis that the PASRR (Preadmission Screening and Resident Review) was designed to assess. Your condition is likely to require expert treatment in the future. That diagnosis is: a serious mental health condition. Your care needs are appropriate to be serviced in any nursing facility setting. You are in need of a nursing home because: you need help with bathing, grooming, dressing, transfers, using the restroom, medication management and other tasks. You are diagnosed with bipolar disorder which significantly impacts your daily life. You may benefit from medication management and psychiatric support. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R45's care plan, print date of 3/11/25, documented R45 is at risk for abuse and neglect related to diagnosis of bipolar depression, and suicidal ideations. Interventions include immediately report any episodes of unknown injury, abuse or change in resident's behaviors to Administrator for immediate intervention and review. R45's care plan does not address her history of aggression towards other residents nor staff. R45's care plan does not address her history of mood swings, anxiety, nor her history of hearing and seeing things that others do not see or hear related to her diagnosis of bipolar disorder. On 3/3/25 at 1:12 PM V1, Administrator, stated she had a resident R45 attack a CNA, (Certified Nurse Assistant), V20 last night and the CNA V20 bit R45 in self-defense. V1 stated she just found out about the incident a short time ago when she arrived at work. V1 asked the surveyor if she should report the incident since the employee was defending herself. Surveyor advised V1 to follow the facility policy. On 3/3/25 at approximately 3:15 PM V1, Administrator came to the room where the surveyors were located and asked if she could talk with us for a minute. V1 sat down in the chair and said she just found out that on Sunday an altercation happened between staff and a Resident. She said the CNA was just defending herself. V1 said she knows for a fact the CNA was just defending herself because she watched the video. She said R45 came up the hallway with a pillowcase that had something in it and there was a CNA standing there and she tried to hit the CNA with the pillowcase, so the CNA was just defending herself. V1 stated the CNA bit R45's finger and there was a laceration from this. V1 said R45 ended up going out to the hospital to be evaluated. V1 asked since it was self-defense did, she still need to do an investigation, and do I still need to suspend the CNA? Surveyor stated to V1 what does your policy say you need to do? The facility's Long-Term Care Facility Serious Injury Incident Report, dated 3/3/25, documented on 3/3/25 it was reported to the administrator that there was an incident between resident R45 and employee V20. R45 made verbal threats and then physically assaulted employee V20. R45 was sent to the hospital and the police were also notified. There is an ongoing investigation and the resident R45 was moved to the other hall when she returned from the hospital. On 3/4/25 at 1:50 PM V5 LPN (Licensed Practical Nurse) stated she did not work last weekend but when she returned to work on Monday, 3/3/25, R45 was already moved to a room on the other side of the building. V5 stated she was told R45 was moved because something happened over the weekend between R45 and a CNA. On 3/4/25 at 2:03 PM V4 LPN stated R45 was moved to the west side of the building because she hit an employee. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 3/4/25 at 2:12 PM Surveyor interviewed and observed R45. R45 stated she had a fall on Saturday night, 3/1/25, because her marijuana gummy interacted with her medication. R45 stated the night nurse V22 and the CNA V20 picked up her up off the floor with a harness and she did not like the way they got her up off the floor. R45 stated she was upset about the way they picked her up, so she went to talk to them when they came to work on Sunday evening, 3/2/25, and the CNA V20 scratched her face, hit her in the eye, and bit her finger. R45 was observed with the following injuries: multiple scabbed scratches to her left outer eye with the following measurements #1) 1-inch scabbed scratch left outer eye, #2) 1-inch scabbed scratch below left eye, #3) 1/2-inch scabbed scratch above left eyebrow, and #4) 1.5-inch scabbed scratch left side of face/cheek bone. R45 was also observed with a 2 cm scabbed scratch on the middle of her nose, a 2 cm scabbed scratch to the tip of her nose, a 2-inch scabbed scratch below her right eye, R45's right eye was observed to be black/bruised with edema and a moderate amount of yellow drainage. R45's right pinky finger was observed with 1/2 inch laceration. R45 stated again all these injuries were caused by V20 CNA. On 3/4/25 at 2:18 PM V8 CNA stated she worked day shift on Sunday, 3/2/25 from 6 AM to 6 PM. V8 stated R45 was sent to the hospital on 3/1/25 because R45 was allegedly high from taking a gummy, fell , and had to go to the hospital. V8 stated R45 returned from the hospital on her shift on 3/2/25 and that R45 stated she was looking for V20 CNA because R45 was angry at V20 for the way she and the night nurse picked her up off the floor when she fell . V8 stated she warned V20 that R45 was looking for her. V8 stated she clocked out on Sunday a few minutes after 6 PM and as she was walking out of the facility the police and ambulance pulled into the facility, so she went back in to assist with resident care. V8 stated she did not witness the altercation between V20 and R45. V8 stated when she returned to work her next shift R45 was moved to the other side of the facility because V20 always works the side of the building that R45 lived on prior to the altercation. V8 stated she was told the injuries to R45's face and finger was from the CNA V20 defending herself from R45. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 3/4/25 at 2:25 PM Surveyor requested all the facility abuse investigations for the past 3 months and V1, Administrator, replied they are not done, some of them are at my home. I have not investigated anything yet about what occurred between R45 and V20. I was not notified about the incident until a I got to work on Monday, 3/3/25 about noon. V1 stated she didn't think she had to report the altercation between R45 and V20 because it was self-defense by the employee. Surveyor asked V1 if she has looked at R45's injuries and V1 replied no I have not, I know she has a scratch on her face and a bite on her finger from the employee defending herself. Surveyor requested an incident report for R45's injuries and V1 replied there is no incident report for R45's injuries from the altercation. V1 again stated she did not know about the incident between V20 and R45 that occurred on 3/2/25 until she got to work on 3/3/25 so it was not reported to (State Agency) (Illinois Department of Public Health) within 2 hours. Surveyor asked V1 where the altercation occurred and V1 replied by the nurse's station. Surveyor asked V1 to review the video surveillance of the incident and V1 replied I have not reviewed it; I will see if I can pull it up. Surveyor asked V1 if she suspended the employee pending further investigation and V1 replied no I have not because I thought the CNA was defending herself. Surveyor asked V1 how she is keeping the resident's safe from abuse since the facility has residents with mental illness and V1 replied I am trying to get R45 discharged if the facility would have called me about the incident with her and the CNA I would have given her an involuntary discharge. V1 stated I called the Ombudsman, and she said it would be okay to discharge R45 to a homeless shelter. Surveyor asked V1 if she thought a homeless shelter could meet R45's medical and mental health needs and V1 replied I don't know. Surveyor then requested R45's pre-screen for nursing home placement documents. V1 stated she will look for them. V1 stated R45 hit the CNA V20 with a pillowcase containing soda cans because R45 didn't like how the CNA picked her up with the mechanical lift. Surveyor asked V1 what her facility assessment says about meeting the needs of the residents with mental illness since the facility has so many residents with mental illness and V1 replied I haven't had time to do a facility assessment. Our Social Service consultant said our Subpart S is fine. Surveyor asked if the facility is offering the residents with serious mental illness any group therapy, one on one meetings, or activities related to Subpart S and V1 replied no, were not doing any of that. Surveyor requested to observe the video surveillance footage of the altercation between V20 CNA and R45. On 3/4/2025 at 3:13 PM, V1, Administration stated, I can't believe I might get another IJ because a staff member was defending herself. This is ridiculous! On 3/4/25 at 4 PM V1, Administrator, stated I cannot get the video footage, I am having issues with the system, it keeps jumping to 2016. On 3/4/25 at 3:23 PM, V2, ADON (Assistant Director of Nursing) stated I was coming into work that day and when I walked into the door somebody was calling my name. There had been an altercation between V20 LPN and R45. I called the police and V19 came out. He took statements. I did not take any statements. I am not really sure what happened. I did not witness anything. I was told V20 was defending herself against R45. I did call the police. Staff gave him statements; I did not take any statements. I did not do any investigation. I did call V1, Administrator, and left a message. The police came out and V19 was the investigator from the local police department. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R45's local hospital records, dated 3/2/25, documented R45 presents to the emergency department with chief complaint of altercation with staff member. EMS (Emergency Medical Services) reports the patient was hitting staff members with pillowcase filled with soda cans. The patient also attempted to punch staff member and got her right pinky finger caught in the staff members mouth the patient also got scraped on her left cheek. It continues, the patient was given a dose of Augmentin as the laceration to her finger was secondary to a human bite due to it being secondary to human bite the wound will be allowed to close by secondary intent as the risk of infection. Patient will also be started on Augmentin. Patient was seen by crisis and evaluated the patient was safety planned for discharge back to the facility. Discharge Plan: clinical impression: aggressive behavior, abrasion of face, human bite of finger. Instructions: Antibiotic form, human bite, abrasion, acute wounds. Please keep the wound on your finger clean, it should be allowed to heal by secondary intent and keep a clean dressing on it changing it twice a day. Physician order for Amoxicillin 125 mg tablet Q12H (every 12 hours) for 10 days. R45's hospital discharge instructions, dated 3/2/24, documented human bites are often more serious than animal bites. Wounds are more likely to become infected because of the germs in a person's mouth. On 3/6/25 at 8:25 AM R45 stated her finger hurts from the bite and the nurses have not been cleaning it or checking it. R45 then stated I was mad at V20 CNA and V22 LPN about the way they picked me up off the floor the night before, so I did swing at V20 and then she scratched my face all up and bit my finger. This made me anxious and more depressed. On 3/6/25 at 8:33 AM V23 LPN stated I was working the night V20 CNA and R45 got into it. I was getting ready to leave and go home. I was coming down the hallways and I heard a loud commotion of people screaming at each other. I was the first one on the scene. R45 was holding onto V20's hair and V20 was holding on with hand to her hair and the other hand she was pushing on R45. R45 has scratches on her face that were open and bleeding. The scratches were on her whole face. I do not recall V20 yelling for help. I am not sure I would have heard them because the alarm was going off too. I did not see R45 holding any pillowcase. I don't know anything about a pillowcase. On 3/6/25 at 8:25 AM R45 stated her finger hurts more than it did two days ago from the bite by V20 CNA. R45 stated I was mad at V20 CNA and V22 LPN about the way they picked me up off the floor the night before, so I did swing at V20 and then she scratched my face all up and bit my finger. This made me anxious and more depressed. On 3/6/25 at 8:34 AM V24 CNA stated she did not witness the initial altercation between R45 and V20 CNA, but she did see the nurse run so she did also and then she observed R45 and V20 with their hands in each other's hair. V24 stated she has never received any training from this facility on how to handle aggressive residents. On 3/6/25 at 8:52 AM V26 CNA stated the new owner told the staff the facility will be taking my psych patients, but the facility has never trained us on how to handle residents with aggression. On 3/6/25 at 9:47 AM R45 stated to surveyor we still don't have a nurse; my back pain is at a 9. I need a nurse to look at my finger, it looks worse. The nurses have not been checking it nor cleaning it. R45's finger was uncovered, with a laceration that appeared inflamed with a small amount of yellow drainage coming from it. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 3/6/25 at 10:37 AM V25, Regional Chief Executive Director, stated she was told V1 had a copy of the video with the altercation between V20 CNA and R45 but V1 said she doesn't have the video. V20 stated she was informed about the staff/resident incident on Monday morning by V2, ADON and that V2 informed her she did notify V1 on Sunday right after the altercation. V20 stated staff should not put their hands on another resident resulting in injuries like occurred with R45. On 3/6/25 at 10:45 AM V1, Administrator, stated she did not suspend V20 CNA pending investigation the night the altercation occurred between V20 and R45. V1 stated she suspended V20 on Monday after she learned about the incident. V1 stated V20 worked the 12-hour night shift after the altercation happened around 6:15 PM. V1 stated she will have to fire V20 for the altercation. On 03/06/25 at 11:01 AM, V24, CNA, said on the day of the incident with R45 and V20, CNA she was in the building. V24 said R45 had been making statements all day she was going to get V20 when she got here. V24 said when V20 got here all the staff went and told her what R45 was saying and not to go by her. V24 said she did not see any type of pillowcase in R45 hands during this altercation. On 3/10/25 at 11:08 AM V11, Regional MDS Consultant, stated V1, Administrator, was a no call no show, we can't get her to answer her phone, and we cannot find any of the abuse investigations you requested. On 3/10/25 at 11:52 AM Surveyor requested the final investigation with witness statements for the altercation between V20 CNA and R45 from V11 and V25. V11 stated I am not going to lie we have nothing. V25 stated V20 was fired last week by V1. V25 stated I guess V1 fired V20 because of what happened between her and R45. Surveyor requested V20's employee file and V25 replied there is nothing documented in V20's employee file regarding her termination. V25 stated V1 did not complete an investigation on the altercation between V20 and R45. The local police department report, dated 3/7/25 and authored by V19, documented I spoke with R45, and she stated the following: R45 believed V20 twisted her ankle as she was attempting to place her in bed due to her level of intoxication on 3/2/25. She told nursing staff that if she saw V20 CNA she was going go get her. V20 was pushing a medical cart past her when she grabbed V20 by her face and pulled her forwards herself and that's when they started fighting. I observed R45 to have two lacerations to her face and one to her finger. R45 advised she would like to be checked out by EMS for her injuries. It continues, I did not observe any marks on V20, but she stated that she believed that her tooth was knocked loose and that her mouth was bleeding prior to our arrival on the scene. It continues, staff stated they would move R45 to the other side of the facility for the evening and would keep V20 working on the other side of the facility. On 3/10/25 at 2:09 PM V2, ADON, stated the night V20 CNA and R45 had the altercation, she came into work because she was assigned to the floor on night shift, and she did not witness the incident, but she observed R45 with a cut under her left eye and it was bleeding. V2 stated I was told R45 attacked V20. V20 should have backed away from the resident when R45 came at her. On 3/13/25 at 10:22 AM V11 stated the facility has no record of any staff education being completed on the facility abuse prevention policy since the new owner took over the facility about a year ago. Surveyor then requested R45's safety plan that was documented in R45's discharge instructions from the hospital on 3/3/25. V11 stated this is the first time he has heard of it and that there is no safety plan documented in R45's care plan. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 3/13/25 at 10:54 AM V11 stated the facility does not have any residents on psychosocial programs, they have not identified the residents who quality for Subpart S programs, and that he spoke to the facility's Social Service Consultant yesterday, and the consultant informed him she has been telling the facility's Social Service Director for months that the facility needs to get the psychosocial programs implemented. On 3/13/25 at 12:40 PM V15, Social Service Director, stated she was not aware of R45 needing a safety plan put into plan, so no plan was implemented. V15 stated R45 was never put on a psychosocial program for her diagnosis of bipolar disorder. V20's Time Detail Report, dated 3/1/25 - 3/3/25, documented V20 was allowed to work and did work from 6:05 PM on 3/2/25 until 6:17 AM on 3/3/25 after the altercation between V20 and R45 that resulted in R45 sustaining injuries that required emergency medical care. The facility failed to complete a full investigation of this incident and failed to submit a final investigation to the (State Agency) (Illinois Department of Public Health). 2. On 3/6/25 at 12:49 PM V1, Administrator, came to surveyor and stated I have another reportable, it's going to be reported late. R45 called the police last night and reported to them she felt threatened by V22 LPN. V1 stated a staff member called her and told her about this last night but she does not remember who called her nor what time. V1 stated I did not suspend V22, I don't know why, it was stupidity on my part. V22 did work the entire night shift. V1 then provided surveyor with the initial report documented on the facility's Long-Term Care Facility & Serious Injury Incident Report form, report dated 3/6/25. This form documented incident date 3/5/25, on 3/5/25 R45 reported to the police that she felt threatened by employee V22. V22 was suspended and R45 is currently under 1:1 supervision for her well being. The allegation is being investigated and the final report will be submitted upon completion. On 3/10/25 at 10:43 AM V21, Ombudsman, stated on 3/5/25 at approximately 12:15 PM she reported to V1, Administrator, that R45 reported to her that night nurse V22 had pressed his genitals against her back while providing care to her. V21 stated V1 replied oh so do I have to fire him too and V21 stated she replied to V1 I would like you to investigate it. As of 3/17/25 the facility had not submitted an initial report of this allegation nor did the facility submit a final investigation to (State Agency) of this allegation. On 3/10/25 at 11:52 AM V11, Regional MDS Consultant, stated last Wednesday (3/5/25) he heard V22 LPN raise his voice and state to R45 if she hurts another staff member again, he will beat her to death. V11 stated V22 was terminated a few days later but he did work the night shift that night (3/5/25) after V22 threatened R45. V25, Regional, was present and stated this was not reported to (State Agency), there is no investigation for this, nor is there any documentation in V22's employee file. On 3/11/25 at 12:35 PM Surveyor asked V2, ADON, if she or V1 knew about the allegation R45 reported to the ombudsman on 3/5/25. V2 replied R45 told me about it. R45 told me that the man nurse V22 rubbed his genitals up against her back. I told R45 to tell V1 and I know V1 knew about it because I heard her talking to V22 about it. (continued on next page)

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Au Well Care Home, Inc	152 Wilma Drive Maryville, IL 62062

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 3/11/25 at 1:13 PM V25, Regional CEO, stated she was aware of the allegation made by R45 against nurse V22 about him allegedly rubbing his genitals up against R45 during care. V25 stated we have no final investigation nor witness statements for this. V25 then asked the surveyor if she should investigate this, and the surveyor instructed V25 to follow the facility's policy. On 3/12/25 at approximately 11:00 AM V11 provided a written statement authored by him that documented on 3/5/25 at approx. 11:30 AM I witnessed V22 LPN walk into the Administrator's office and V22 told V1 that he wanted to talk to R45 in her office, V1 said ok, that's fine. V1 then closed her door. I heard V22 raise his voice and state that he wasn't going to allow her to attack another female staff member and if she did, he was going to beat her to death. I got up and immediately knocked on the door to pull V22 out of that room, but I heard V1 tell V22 don't answer it, it's just V11. V22 continued to yell at R45 for approx. two minutes telling her that he won't allow her to attack anyone else and he said to her try it again and see what happens. V22 then said, I heard you are saying that I sexually assault you, are you crazy. I heard R45 say you put your balls on my head. V22 yelled loudly no I didn't, you're crazy, I would never do that. R45 said I'm leaving then V22 opened the door and left. I immediately went into V1's office and told her he needs either immediately suspended or terminated. She told me Well he is off duty, I told her it didn't matter because he will have to come to work and R45 will have to be around him. She said to me that she was the administrator and that she has been doing this many years and she knows what she is doing besides he was just standing up for a staff member that got seriously hurt and told me again to keep my mouth shut about thing I don't know what I'm talking about. V1 then told me she was going to call V25 and picked up her phone and told me to get out of her office and close the door. On 3/12/25 at 11:19 AM V25, Regional Chief Executive Officer, stated she was aware of the abuse allegations by R45 against V22 LPN including the abuse witnessed by V1 and V11. V1 stated this and all of the abuse allegations should have been reported and investigated. V25 stated she told V1 to immediately fire V22 after he threatened R45, and she did not. V25 stated when they originally took over this facility they were going to try and make it more of a mom-and-pop facility but then they realized with the current star ratings they would continue to specialize in psychiatric care. Surveyor requested staff education documentation on how to care for residents with mental illness and V25 stated she would have to look and see if there has been any education provided. V25 again confirmed that the facility does not have any of the abuse investigations for the ones requested by the survey team including the abuse by V22 against R45 that was witnessed by V1 and V11. V25 stated the facility does not have any termination records for V20 nor V22 and that V1 actually let V22 resign. On 3/12/25 at 12:05 PM V3, Medical Director/Owner, stated he was aware of the sexual abuse allegation made by R45 against V22 LPN and if he was aware of the verbal threat V22 made to R45 when he stated he was going to beat her to death in the presence of V1 and V11. V3 stated he was aware and that he investigated it by talking to V22 on the phone that night (3/5/25) and that V22 stated it was not true. Surveyor asked V3 if he had documentation of his investigation for survey team to review and V3 replied he did not document it. V3 stated V22 was on duty working as a nurse the night he interviewed V22 via phone on 3/5/25. V3 stated V22 was terminated. Surveyor then asked V3 if the statement made by V25, Regional Chief Executive Officer, about V22 being allowed to resign rather than be terminated was true and V3 replied yes that is true. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	V22's Time Detail Report, dated 3/1/25 - 3/6/25, documented V22 was allowed to work on 3/5/25 from 5:57 PM until 6:25 AM on 3/6/25 after V22 threatened to beat R45 to death and R45 accused V22 of sexual abuse in the presence of management staff, V1 and V11. The facility failed to submit an initial report and failed to submit a final investigation of this abuse to the (State Agency). As of 3/17/25 the facility did not have an investigation of the witnessed abuse by V22 against R45 nor of the allegation of sexual abuse by R45 against V22. 3. R45's progress note, dated 2/22/25 at 11:19 AM, documented this nurse was summoned to front lobby by staff. Observed resident and peer arguing and yelling obscenities at one another. Resident was sitting on buttocks on floor, legs outstretched, wheeled walker nearby, peer was standing in front of wheeled walker. When asked what happened, resident stated she approached peer and asked, So I heard you were supposed to be slapping me today? Resident then states that peer pushed her to the floor. This nurse assisted resident back to her feet. Resident and peer redirected to different areas. It continues, Administration, ADON (Assistant Director of Nursing), and MD made aware. R38's face sheet, print date of 3/11/25, documented R38 has diagnoses including demyelinating disease of central nervous system, cerebrovascular disease, multiple sclerosis, major depressive disorder, and hypertension. R38's MDS, dated [DATE], documented R38 is cognitively intact, ambulates with a walker, and requires supervision with ADLS. R38's progress note, dated 2/22/25 at 11:16 AM, documented this nurse was summoned to front lobby by staff. Observed resident and peer arguing and yelling obscenities at one another. Resident was standing in front of her wheeled walker and peer was sitting on buttocks on floor, legs outstretched, wheeled walker nearby. When asked what happened resident stated peer approached resident with aggression and attempted to grab her neck. She, in turn pushed peer to the floor. This nurse assisted peer back to feet. Resident and peer redirected to different areas. Resident denies any pain or discomfort related to event at this time. Administration, ADON, and MD made aware. R38's progress note, dated 2/22/25 at 11:20 AM, documented resident assessed by this nurse and no injuries noted r/t incident involving a peer. Resident denies pain r/t incident when asked what happened resident stated peer came up to her and attacked me by grabbing my neck. Resident states she wants to press charges, local police called, and officer came out to speak with resident. The facility's event report for R38, dated 2/22/25 at 11:27 AM, documented type of event that occurred was an allegation of abuse from peer, peer grabbed/scratched her neck. On 3/10/25 at 12:07 PM R38 stated the day she got attacked by R45 that R45 kept walking by her near the dining room, then R45 said something, I am not sure what she said, then she grabbed me by my neck. She scratched my neck when she grabbed it. I shoved her away and she fell down onto the floor. I about fell in the process. The police came but I ended up not pressing charges against R45. I just wanted her out of here and now she is at another facility. The facility's Long-Term Care Facility Serious Injury Incident Report (Initial), dated 2/22/25, documented R38 alleges that she was struck by fell ow resident R45 in the dining room. The two but at this time the writer does not know the outcome or the name of the responding officer. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 3/10/25 at 11:08 AM V11, Regional MDS Consultant, stated V1, Administrator, was a no call no show today and that they cannot find any of the abuse investigations including the resident-to-resident abuse investigation dated 2/22/25 for R38 and R45. On 3/10/25 at 11:52 AM V25, Chief Executive Officer, confirmed the facility does not have an abuse investigation for the altercation between R38 and R45 that was documented on 2/22/25. On 3/11/25 at 12:13 PM V33 CNA stated she was in the dining room the day R38 and R45 got into a fight. V33 stated she heard yelling and when she looked up, she saw R45 lying on the floor and R38 standing near R45. V33 stated she heard R38 say R45 came at her and scratched her neck. As of 3/17/25 the facility failed to complete a full investigation of the altercation between R38 and R45 nor did the facility implement interventions to safeguard R38 and R45. R45 was transferred to another facility on 3/7/25. On 3/17/25 at 10:57 AM V15, Social Service Director/Medical Records, stated R45 was not seen by her psychiatrist nor the nurse practitioner while residing at the facility. V15 stated she does not know why R45 was never seen by psychiatry. 4. R30's face sheet, print date of 3/3/25, documented R30 has diagnoses including schizophrenia, dementia, depression, generalized anxiety disorder, unspecified mood disorder, and weakness. R30's MDS (Minimum Data Set), dated 1/29/25, documented R30 is severely cognitively impaired and requires partial/moderate assistance with mobility. Review of R30's records revealed R30 was physically abused and injured R36 on 1/24/25. This abuse was substantiated by

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety 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** 35156 This citation has 2 deficient practice statements A. Based on interview and record review, the facility failed to assess and treat a change of condition for 1 of 3 residents (R37) reviewed for change of condition. This failure resulted in R37 having a significant change in condition for 2 days without interventions that ultimately required an emergency transfer and 42 day stay in the hospital that included an Intensive Care Unit stay with mechanical intubation. The Immediate Jeopardy began on 12/9/2025 when staff failed to send R37 out when she began experiencing a change of condition. On 3/20/2025 at 1:58 PM, V25, Regional/CEO Marketing and were notified along with V57, Unknown Helper who was later became the Regional Director of Operations (RDO) of the Facility were notified of the Immediate Jeopardy. The surveyor confirmed by observation, interview, and record review, the Immediate Jeopardy was not removed at the time of the exit. Findings include: R37's not dated Facesheet documents R37 was admitted to the facility on [DATE] at 8:00 PM. R37's Hospital Discharge Orders dated 12/6/2024 document, Follow up with (V58, Gastroenterology) on 12/17/2025 at 3:15 PM. Health Concerns: Severe recurrent major depression without psychotic features, alcohol abuse, and hepatic encephalopathy. (R37) is a [AGE] year-old female with a past medical history significant for chronic liver disease, chronic pancreatitis, chronic depression, panic attacks, anxiety, diabetes mellitus, who was initially admitted to the psychiatric unit with complaints of suicidal ideations, depression, and alcoholism. Patient reports that she has a history of alcoholism, had 5 years sober but relapsed four months ago. States she was going through a messy divorce and has been homeless. Today, 11/25/2024 rapid response called in the setting of decline in patient's mental status. Per nursing staff patient is normally alert and orientated x 4. The patient is transferred to the ICU for further care and management of her acute hepatic encephalopathy. R37's Hospital Discharge records also document on 12/6/2024 her ammonia levels were 67 (high). R37's Medical Records does not document R37 never saw the gastroenterologist for the follow up appointment, per hospital discharge orders. R37's Physician Order Sheet (POS) for December 2024 documents a diagnosis of Metabolic encephalopathy (Primary), Cardiomegaly (Admission), Alcoholic cirrhosis of liver with ascites. Type 2 diabetes mellitus without complications, Acute and chronic respiratory failure, unspecified whether with hypoxia or hypercapnia, Other chronic pancreatitis, Malignant neoplasm of unspecified part of unspecified bronchus or lung, Hepatic encephalopathy, Acute on chronic systolic (congestive) heart failure, Severe sepsis with septic shock, Hypomagnesemia, Hypokalemia, Mood disorder due to known physiological condition with mixed features, Alcohol abuse, uncomplicated (Prelim.), Generalized anxiety disorder(History of), and Hyperlipidemia, unspecified. R37's POS also has an active order for Lactulose 20 GM (grams)/30 ML (milliliters) three times a day. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R37's medical records did not have an interim Care plan for December 2024 when she first arrived. On 3/19/2025 at 9:34 AM, V11, Regional MDS Coordinator (Minimum Data Set (MDS) stated, There was no interim Care Plan for R37 when she was admitted in December 2024 because the admitting nurse failed to do a Care Plan on her. We do not have any interim Care Plan for her. On 3/19/2025 at 9:44 AM, V13, Certified Nursing Assistant (CNA) stated, When (R37) first got here she was having a lot of falls. She was really weak when she first got here. She is not currently here and is out at the hospital. I think she was sent out to the hospital for SOB (shortness of breath). R37's Progress Notes dated 12/7/2024 at 2:48 PM, IFU (Incident Follow Up) DAY 1 R/T (related to) Fall. Resident got up from w/c (wheelchair) without assistance resulting in her falling onto the floor. Resident was assessed and had no c/o pain or discomfort and able to move all extremities WNL (within normal limits) during ROM (Range of Motions). Neuros were also WNL. Skin assessment was done, and resident had no new skin issues noted to skin. Resident continues to get up from w/c (wheelchair) without assistance and is currently sitting at the nurse's station. Staff was encouraged to keep resident in common areas to prevent fall. MD (Medical doctor) was notified of this incident. R37's Progress Notes dated 12/8/2024 at 5:29 PM, Resident has been resting in bed throughout the shift. Resident responds to verbal stimuli but doesn't open her eyes and is hard to arouse. MD (Medical Doctor) was notified and stated that this may be residents' baseline and he will be in to see her tomorrow. Resident resting in bed at this time with equal rise and fall of chest with s/s of pain and discomfort. R37's oxygen level was documented at 98%. (Author was V41). On 3/20/2025 at 4:11 PM, V41, Licensed Practical Nurse (LPN) stated, When (R37) first got here I was not familiar with (R37). I noticed she was not responding to verbal stimuli, and I contacted (V3, Medical Director). (V3) told me (R37's) symptoms were part of her diagnosis. (R37) was tolerating her medicine and I was trying to keep any eye on her, and I left a message to the next nurse to let her know that (V3) would be in to see her. I was aware she had encephalopathy and when I talked with (V3) he said this was normal and to make sure (R37) continued to take her lactulose. In my mind I felt something was off, but because I did notify the doctor and was trusting (V3) because he said he would be in the next day. I was listening to (V3) and thought he knew something I did not. I was not sure what (R37's) baseline was because she was newly admitted . I know she had a fall maybe the first or second day. I guess when she was not being aroused, I should have just sent her out. It's hard to tell in a situation like this because I trusted (V3). R37's Progress Notes dated 12/9/2024 at 2:46 AM, Resident slow to respond this shift, tried several times to arouse resident with no success, resident refused to eat dinner but did consume one cup of water medication given to resident through oral syringe. Resident has no c/o pain but grimaces when touched, resident also having tremors. (No notification to MD was documented). (Author was V51) On 3/20/2025 at 4:51 PM, V51, LPN stated, I don't remember (R37) at all. I don't remember anything about her. I don't remember why I did not send her out because normally if a resident was not arousable and was not eating I would notify the doctor immediately and send them out. I am not sure what happened in her case and why she was not sent out. Looking at the chart I should have sent her out. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R37's Progress Notes dated 12/9/2024 at 5:54 PM, Resident appetite poor this shift. Resident hard to arouse this shift. Resident slept this shift. Resident in bed with oxygen at 2L (liters) per nasal canula. Resident aroused and was able to drink small amounts of fluids. Resident in bed with head elevated. Call light in reach. Oxygen level was documented 93%. (Author V4). On 3/21/2025 at 8:24 AM, V4, Licensed Practical Nurse (LPN) stated, I don't remember much about that day, it was all the way back in December. I am not sure but usually if I see a resident is not being aroused, I will notify the doctor and monitor them and if it gets worse or does not improve, I will send them out. I think she was new or maybe she had been here before, I just can't remember. I think her report said that was her baseline, so I didn't realize she was declining. R37's Progress Notes do not document any Physician Notes and/or any documentation that R37 was seen by V3, Medical Doctor. R37's Progress Notes at 12/9/2025 at 7:34 PM, This nurse was told in report that resident was on 2L (liters) of oxygen per nasal cannula. During beginning of shift room check, this nurse checked residents' oxygen level which was reading between 85%-89%. 911 called. EMT's at facility at 6:45 PM to transport resident to (Local Hospital via ambulance). ADON (Assistant Director of Nursing) and Dr (doctor notified). (Author V52). On 3/24/2025 at 9:00 AM, V52, LPN stated, I remember the incident because I had been off and when I came back (R37) was on oxygen and she was not on oxygen before I left so when I got the report I went straight to her room and I found her completely different, confused, and when I took her oxygen levels they were not good so I called 911 and notified the ADON and the doctor and had her sent out. Anytime a resident starts to get confused, stops eating, things like that I just send them out to be safe. I have only been a nurse for a year, but I would rather be safe than sorry. R37's Ambulance Prehospital Care Report dated 12/10/2024, documents, dispatched to nursing home for [AGE] year-old female with a chief complaint of other. Chief complaint of low oxygen saturation. AOS (ambulance x service) found pt (patient) sitting upright in bed of facility. Pt (patient) ABC's (Airway, breathing, and circulation) cleared and patient alert to verbal stimuli but confused. Facility staff on scene advised that they did not know much history of the patient. All they knew was that the patient was brought to the facility from (Psych Hospital) due to alcoholism. R37's Progress Notes document she did not return to the facility until 1/20/2025 (42 days in the hospital). R37's Hospital Records Progress Notes dated 1/14/2025 to 1/16/2024 document, hospitalization patient required ICU (Intensive Care Unit) level of care. Labs significant for an ammonia level were initially 173 but have improved during her hospital stay. Urine culture grew pan-sensitive E. coli for which she received cephalexin. She received rifaximin and lactulose at (Local Hospital). She was also getting doxycline and vancomycin, presumably due to recent CXR with findings concerning for PNA (pneumonia) and there was increased in 02 requirements. She was intubated on 12/13 due to increased O2 requirements. She was sent to (Another Hospital) for evaluation by GI for liver transplant on 12/16. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R37's Progress Note at 1/20/2025 at 6:55 PM, Resident arrived at facility via ambulance. Resident ambulated to room without difficulty. Resident takes medication whole without difficulty. Skin warm and dry. No SOB (shortness of breath) noted. Resident anxious and pacing throughout facility. Resident denies pain and discomfort. Resident medication sent to pharmacy. Resident educated on use of call light and reoriented to facility. Resident diet given to kitchen and dinner served without difficulty. Resident in room at this time. R37's Progress Notes Date & Time 2/4/2025 at 9:53 AM, recorded as late entry on 2/23/2025 at 9:54 AM, R37 was documented as being seen for the first time by the physician since being admitted to the facility. History of present illness: Patient is a [AGE] year-old female being seen and examined today for DM type 2, severe depression. R37's Progress Notes also documents an order for labs for HgbA1C, CDC, BMP, PT/INT, and vitamin D levels. R37's Medical Records were reviewed and do not document any labs for R37 since she admitted on [DATE]. On 3/18/2025 at 4:33 PM, V25, Regional Corporate Marketing stated, We do not have any labs on R37 for 2024 or 2025. R37's Progress Notes dated 2/4/2025 at 1:18 PM, documents, (V3, Medical Director) here earlier today to see resident and new orders received for labs to be drawn one time for CBC, BMP, and vitamin D level. Resident aware of new orders. This is the first and only physician notes related to R37. V3's Lab orders were not followed, and the facility could not provide any labs for R37 that were ordered on 2/4/2025. R37's Progress Notes dated 2/20/2025 at 1:30 AM, Resident came to ADON (Assistant Director of Nursing) office for medication, resident appeared to be out of breath this nurse had resident to sit down, assessed resident's oxygen sat, resident was sating at 83 % on room air this nurse asked admin to stay with patient while immediately going to get O2 tank, this nurse put resident on 2 liters of 02 via nasal cannula and called emergency services for resident , resident was sent to (Local Hospital) for evaluation MD (Medical Doctor) notified, will follow up and pass on in report to oncoming nurse. R37's Progress Notes dated 2/21/2025 at 9:09 AM, Called (Local Hospital) for update on resident. Resident admitted to hospital for COPD exacerbation. On 3/19/2025 at 11:12 AM, V2, Assistant Director of Nursing stated, I remember (R37) coming to me because she had only walked a little way and she was so out of breath and I asked her of she was okay and she said, 'she did not know' and she was breathing so hard, I checked her 02 (oxygen) levels and she was low so I immediately contacted the Physician and sent her out. When she first got here she was weak, but she was able to walk and get around. She was interviewable, and able to do most things by herself. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R37's Hospital Records dated 12/10/2025 at 1:22 PM, [AGE] year-old female with past medical history of alcohol cirrhosis, chronic pancreatitis, and psychiatric disorder who presented to the ER from (Former name of Facility) due to low oxygen saturation and altered mental status. R36's Lab document her ammonia level was 62 High; (Normal 3-30). R37 was admitted and then transferred to another hospital on 12/16/2024 for liver transplant evaluation. R37's Hospital records also documents Medical records obtained from (Local Hospital) which showed an admission from 11/21/2024 until 11/25/2024. She presented with complaints of suicidal ideations, depression and alcoholism. It is noted that she was transferred to the ICU (intensive care unit) but without documentation as to why/what the circumstances are. Labs and imaging reports are provided from the hospitalization . Additional documentation later arrives. She was initially admitted to the psychiatric unit and on 11/25/2024 rapid response was called given a decline in the patient's mental status. Ammonia level was elevated, and patient was transferred to the ICU for further care and management of her presumed acute hepatic encephalopathy. She had a history of chronic alcoholism and had a period of sobriety 5 years but had relapsed in the past 4-5 months. Patient was placed on CIWA (Clinical Institute withdrawal assessment) protocol PRN (as needed) for ammonia was noted to be 109. Lactulose 20 grams was started every 1 hour until laxative effect occurs, then advised decrease dose to 30 ML (milliliters)/20 grams orally 3-4 times daily. R37's Discharge Records and Medical records obtained from (Local Hospital ICU) dated 1/20/2025 Lab instructions to Nursing, Patient should have the following tests performed: Comprehensive Metabolic Panel, Magnesium Blood, and Phosphorous Blood in 3 days. Ensure high protein BID (two times a day), Please ensure patient has follow-up with pulmonary and/or report CT chest to evaluate pulmonary nodule that appeared concerning for carcinoma. R37's Medical Records do not document any labs were done, and/or any follow up appointments were completed for pulmonary, and no CT chest was done related to pulmonary nodules appearing concerning for carcinoma (cancer). On 3/21/2025 at 9:40 AM, V34, Interim Director of Nursing (DON) stated, I was now in this position back in December. I am not sure what or why (R37) was not sent out. I would expect any resident that was having difficulty being aroused, not eating, for staff to contact the doctor, and have them sent out to the hospital right away. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/20/2024 at 9:54 AM V3, Medical Director/Owner stated, I would expect all hospital discharge orders to be followed. All referrals need to be followed unless it is something that we can treat in house. For example, if a Patient comes to the facility with kidney failure, I have the ability to treat kidney issues so I would not need to refer them out. If I can do it, then we will attempt to do it. If not, I would expect them to be referred. All referrals need to be followed unless it is something that we can treat in house. For example, if a Patient comes to the facility with kidney failure, I have the ability to treat kidney issues so I would not need to refer them out. If I can do it, then we will attempt to do it. If not, I would expect them to be referred. With new liver failure patients, patient has any different needs, depends on the extent. If the patient is symptoms or asymptomatic. Sometimes, a resident can be in late-stage failure and not be symptomatic. I do believe a resident needs to be followed up if they are having symptoms. This would mean there would be need to check ammonia levels as people can have high levels and they are fine. Again, it depends on the resident and if the symptoms are having symptoms. If a resident has liver failure, then that needs to be taken care. Ammonia is not specific, we do not always follow, I would expect to follow up if a patient is getting, ascites - confusion, and altered mental status. If a resident is having any of these symptoms, then that would indicate issues with the liver and would need to be addressed. If a resident is experiencing an altered mental status then I would expect to be notified. I would expect to be notified via phone call for all change of conditions. If a physician is unavailable what are the standards practice of nursing for 911 to be called out. That has never happened, staff have always been able to get ahold of me. If there was a reason they could not get ahold of me, but there would be no reason they can always get ahold of me. For any resident experiences significant change of condition, things would be things like the resident can't be aroused, not eating, these are things that I would expect to be notified of right away. R37's Medication Administration Record (MAR) for December 2024 documents an order for lactulose solution, 20 grams/30 ml (milliliters); oral three times a day, 6:30 AM- 9:00 AM, 12:30 PM-3:00 PM and 6:30 PM- 9:00 PM. 44556 B. Based on interview and record review the facility failed to identify, assess, and implement physician ordered skin assessments for existing and new non pressure wounds for 1 of 1 resident (R42) reviewed for non-pressure related impaired skin integrity. This failure resulted in R42 having an emergency transfer to the hospital due to excruciating pain to her left foot for 2 days, which later identified an untreated dorsal wound of 2-3 months, a 17-day hospital stay that included an intensive care unit and ultimately required an above the knee amputation (AKA) of her left leg due to severe infection of R42's left foot. The Immediate Jeopardy began on 02/22/25 at 1:55 AM, when Due to the facility's failure to identify, assess, and implement physician ordered skin assessments for existing and new non pressure wounds R42 developed a diabetic ulcer to her planter left foot and a severe infection which required R42 to be hospitalized , have surgical debridement, and amputation of the left leg above the knee. V25, Regional Chief Executive Officer (CEO) and V57, Regional Director of Operations (RDO) were notified of the Immediate Jeopardy on 03/21/25 at 11:30 AM. The surveyor confirmed by observation, interview, and record review, the Immediate Jeopardy was not removed at the time of the exit. Findings Include: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R42's Face Sheet, admitted [DATE], documented R42 has diagnoses of but not limited to non-pressure chronic ulcer of other part of right foot with other specified severity, non-pressure chronic ulcer of right heel and midfoot with other specified severity, Dependence on renal dialysis, End stage renal disease (ESRD), Type II diabetes mellitus (DM), Peripheral vascular disease, and Gangrene. R42's Minimum Data Set, dated dated [DATE], documented R42 is moderately cognitively impaired with a Brief Interview for Mental Status (BIMS) of 08 out of 15 and requires partial/moderate assistance with her activities of daily living (ADL). R42's Care Plan, admitted [DATE], was reviewed and has no documentation regarding R42 being at risk for impaired skin integrity or having any kind of wounds when admitted to the facility. R42's Baseline care Plan, dated 09/10/24, documented R42 was at risk for skin impairment. R42's Braden Scale Assessment for risk of pressure ulcers, was reviewed and noted to be incomplete. ADD DATE R42's Initial Assessment, dated 09/09/24, was reviewed and under the section labeled skin there was no documentation noted. 03/24/25 at 3:15 PM, V11, Regional MDS said he was unable to get R42's initial skin assessment to print off. He said the nurse who did the admission opened the assessment but didn't fill it out. On 03/24/25 at 2:00 PM, R42's Treatments Administration/Weekly Skin Assessments for the past three months were requested. On 03/24/25 at 3:15 PM, Only two months of Skin Assessments were given and documented R42 did not have her weekly skin assessment done on 02/17/25. R42's Local contracted wound specialist notes, dated 12/31/24, documented R42's initial consult noted upon admission on 09/09/24 to have a right heel ulcer secondary to DM-II. R42's Local wound specialist notes, dated 01/14/25, documented right plantar heel diabetic grade 1 ulcer. Goal: Complete adequate wound hygiene with dressing changes to prevent infection met and display healing by reduction in measurement/characteristic every 2 weeks. Wound status: Resolved. Treatment: Cleanse with normal saline (NS) or wound cleanser, apply cover with silicone bordered foam change daily and PRN for prevention. R42's Progress Notes, dated 02/21/2025 at 04:04 PM, documented resident has complaint of (c/o) left foot pain. As needed (Prn) Norco was given with relief. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R42's Progress Notes, dated 02/22/2025 at 01:55 AM, documented resident yelling out, crying related to (R/T) pain to left foot. Most pain is to top of foot. PRN Norco and Tylenol not effective. Resident C/O the left foot pain has been going on all day and she has never had this type of pain, it's Excruciating. The nurse asked the resident if she would like to go to the hospital and resident states Yes, and I need to go now, I can't take anymore call placed to 911. 2:00 AM ambulance with two attendants arrive to facility to transport resident to emergency room (ER). Resident tells ambulance staff at this time that she wants to go to local hospital r/t that is the only hospital she ever goes to. V3, Physician and nursing supervisor notified. There was no documentation of any kind of assessment done at the time of this incident. R42's Electronic Medical Record was reviewed further, and no documentation was found where an assessment had been done on R42's left foot when she complained of Excruciating pain. R42's Progress Notes, dated 02/22/2025 at 11:53 AM, local hospital called, stated resident is being admitted with diagnosis (dx) of osteomyelitis to left foot. R42's Emergency Department (ED), dated 02/22/25, documented Chief complaint: Foot Pain, R42 is a [AGE] year-old female who presents Left (L) foot pain for one day without trauma. Wound to foot times (x) 2-3 months without evaluation or treatment. Physical Exam: Wound to L plantar foot, edema to L foot with tenderness to dorsal foot extending proximally. Pedal pulse auscultated with doppler. Plan: Necessary labs/imaging/medications ordered to initiate patient (pt) care. R42's X-Ray results, dated 02/22/25, documented Impression: 1. Osteomyelitis and septic arthritis involving the second metatarsophalangeal (MTP) joint. Dislocation of the second MTP joint. 2. Probable osteomyelitis involving the medical aspect of the base of the proximal third phalanx. 3. Potential osteomyelitis of the distal tip of the distal third phalanx. 4. Soft tissue swelling suggestive of cellulitis. There are areas of soft tissue air/gas. R42's Magnetic Resonance Imaging (MRI) results, dated 02/23/25, documented Impression: 1. Septic arthritis of second MTP joint with osteomyelitis of the second metatarsal head and probable large multilocular abscess around the first MTP joints tracking proximally around the second metatarsal shaft. 2. Findings highly suspicious for infectious tenosynovitis (a bacterial infection of a tendon and its surrounding sheath and can be a medical emergency if left untreated.) of the second digit extensor tendon and tracking proximally along the associated extensor digitorum longus tendons to the level of the distal tibia. This may be tracking farther proximally. 3. Findings in the forefoot muscles which are nonspecific but favored to represent diabetic myopathy as opposed to infectious myositis. R42's Intensivist Consult, dated 02/25/25, documented History (Hx) of Present Illness: R42 is a(n) [AGE] year-old female with past medical history significant for arterial insufficiency of lower extremity, CAD (coronary artery disease) s/p (status post) CABG (coronary artery bypass grafting x (times) 4 2014, carotid artery stenosis s/p left CEA (carcinoembryonic antigen), CKD (chronic kidney disease), DM, ESRD, on HD (hemodialysis), DVT (deep vein thrombosis) 2014, PE (pulmonary embolism) 2018, HLD (hyperlipidemia), PAD (peripheral artery disease), PVD (portal vein embolization), CVA (cerebrovascular accident) with residual left-sided weakness and TIA (transient ischemic attack) who presented on 02/22 with complaints of left foot pain x 2-3 months. X-ray completed in ED showing osteomyelitis and septic arthritis of the left foot. Patient was started on broad-spectrum antibiotics and admitted for further management. Vascular surgery consulted. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/25 patient was taken for left second toe amputation, left foot debridement and left lower leg debridement per V45, Vascular Surgeon. This afternoon RRT (rapid response team) was called due to patient becoming more encephalopathic with low blood pressure. On arrival patient resting in bed in no acute distress, pale in color. Current BP (blood pressure) 101/52. Patient noted to be in A-fib (atrial fibrillation) with RVR (rapid ventricular response) heart rate 110-130s. Patient does arouse to verbal and tactile stimulation however does not answer any questions or follow any commands. Patient does move all extremities. Patient unable to receive dialysis treatment today due to hypotension. Patient was given 1 L (liter) of crystalloids and HD and transferred back to the floor. Upon review of labs, patient noted to have H&H (hemoglobin & hematocrit) 6.4/19.2. Left foot with dressing intact, no active bleeding noted however nursing reports dressing did have to be changed up to 4 times overnight due to saturating with blood. H&H rechecked on arrival to ICU (intensive care unit). Repeat 6.4/19. 8. 1 unit of PRBC's (packed red blood cells) ordered for transfusion. R42's Surgical Report, dated 02/25/25, documented Procedures Performed: 1. Debridement (a medical procedure that involves removing dead, infected, or damaged tissue from a wound) left foot necrotic skin, subcutaneous tissue, muscle, bone. 2. Debridement left lower leg necrotic skin, subcutaneous tissue, muscle. R42's Operative Report, dated 03/01/25, documented Indications for procedure was severe left diabetic foot infection with possible left below-knee amputation versus left above -knee amputation. It further documents R42 was taken to the operating room given adequate general endotracheal anesthesia, and left lower extremity was draped in standard sterile surgical fashion. R42 was noted to have extensive necrosis of the left anterior compartment with infections spreading to the proximal calf. R42 had a left femoropopliteal bypass graft to the below-knee popliteal artery, and they did not see a way to preserve the bypass graft and perform and adequate amputation to control infection. They then removed R42's left leg above the knee. R42's Progress Notes, dated 03/10/2025 at 04:45 PM, documented R42 returned to the facility via ambulance. R42 returned to the facility with new order for pain medication and an inhaler. R42 also had an AKA with 29 staples in place. Vital Signs (V/S) stable 97.7-76-16-142/80 O2 saturation at 97% on room air. On 03/18/25 at 12:40 PM, R42 Stated she doesn't remember if she had a wound to her left foot/leg before it was amputated. She said all she remembers is waking up in the hospital and it was gone. R42 pulled back the sheet and R42 had an above the knee amputation of the left leg. On 03/20/25 at 10:55 AM, V41, Licensed Practical Nurse (LPN) Said when the certified nursing assistant (CNAs) have someone who has a change in their skin they will report it to the nurse. She said the nurses are responsible for doing the skin assessment. She said each resident has a set day and set shift they are to be done on. V41 said R42's foot didn't have any redness and she complained of pain often, but it would go away with pain medication. She said she didn't see anything out of the ordinary. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 03/20/25 at 11:20 AM, V41, LPN follow up interview. V41 said R42 used a wheelchair to get around and she would pivot to transfer but if she needed assistance she would ring. V41 said when they have someone who has a new skin issue the nurse will notify the doctor and then they will give it to whoever is in management at the time Director of Nursing/Assistant Director of Nursing (DON/ADON) and they will handle it from there. She said when the nurse calls the doctor, he will put an order into place until wound care specialist sees them. This surveyor presented a picture of R42's wound on her left foot. V41 stated if it had looked like that, I would have sent her out. She said her assessment should have been included in her nurse's notes. She said she know she looked at it and it didn't see that. This surveyor explained R42's electronic chart had been reviewed and no documentation of an assessment being done was found. V41 said I want to say I looked at it. she would have contacted the doctor right away and she would have sent her (R42) out right away. She said I must have not done a skin assessment because she was just complaining of pain. She said R42 is alert and able to tell you what's wrong. She said none of the CNAs reported anything to her about R42 having any skin issues. V41 said that is just horrible. V41 said they have no one in charge of wounds other than the wound care specialist and there is no one to stay on top of it. On 03/24/25 at 3:15 PM, V11, Regional MDS said he was unable to get R42's initial skin assessment to print off. He said the nurse who opened the admission assessment didn't fill it out. On 03/24/25 at 3:20 PM, V23, LPN said when a resident isn't available to do their skin assessment, they will mark it in the resident's EMR, and it will highlight the assessment in red. She said if knows she is working the next day she will do it then. She said she also lets the next shift know it wasn't done. On 03/24/25 at 3:25 PM, V41, LPN said when the resident isn't available to do their skin assessment there is a tab at the top that says resident not available, and they just click that. She said if they refuse, they will just put refused. V41 said they usually don't do the skin assessments the next shift just the shift it is scheduled on unless they pass it on. On 03/25/25 at 8:19 AM, V23, LPN said they do skin assessments on residents who are independent if they will let them. They will also let the nurses know they are ok and then chart no skin issues in the chart. She said they will also chart unable to check skin. On 03/25/25 at 8:30 AM, V4 LPN said if they have a resident who isn't available for their skin assessment there is a box in the EMR you can mark that says unavailable. She said they will assess the resident when they get back to the facility. V4 said on residents who are independent they will do a skin assessment and do as much as they will allow/tolerate. She said she will chart what the resident let her look at and then chart refuse for the rest. On 03/25/25 at 11:27 AM, V61, Nurse Practitioner (NP) for wounds said she would e [TRUNCATED]

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F 0686 Level of Harm - 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** 44556 Based on interview and record review, the facility failed to implement new care plan interventions to prevent pressure ulcers, provide ongoing monitoring of a new pressure ulcer, complete weekly skin assessments as ordered, and implement dietitian recommendations for 1 of 3 residents (R50) reviewed for pressure ulcers in a sample of 81. This failure resulted in R50 acquiring a new pressure ulcer to an area that had previously been documented as resolved. Findings Include: R50's Face Sheet, admitted [DATE], documented R50 has diagnoses of but not limited to Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits, hypertension (HTN), Type II diabetes mellitus (DM), Hyperosmolality and hypernatremia, and chronic kidney disease. R50's Minimum Data Set (MDS), dated [DATE], documented R50 is severely cognitively impaired and requires partial/moderate assistance with his ADLs including bed mobility and he is always incontinent of bowel and bladder. Although severe cognitive impairment is documented on this assessment, R50 was observed as being alert and ortiented to person, place, time, and situation during all, multiple encounters occurring during this survey from 2/22/25 - 3/25/25. R50's Care Plan, with an admitted [DATE], documented Problem: R50 has the potential for impaired skin integrity due to decreased independent mobility and unstageable pressure injury on coccyx upon admission. Interventions include but not limited to notify MD (Medical Doctor) & family prn (as needed) of changes in skin status, notify nurse immediately of any new areas of skin breakdown, redness, blisters, bruises, discoloration observed during routine care, and weekly body assessments. These interventions have a start date of 06/17/2024 and last edited on 08/15/2024. Problem: R50 was admitted with a pressure ulcer to coccyx, left below knee amputation (L BKA). R50's co morbidities include type 2 diabetes, chronic kidney disease (CKD). Interventions include but not limited to R50's pressure ulcer will show signs of healing and remain free from infection, obtain, and monitor lab/diagnostic work as ordered. Report results to medical doctor (MD) and follow up as indicated, Registered Dietitian (RD) to review and make recommendations as needed (PRN), if resident refuses treatment, confer with the resident, interdisciplinary (IDT) and family to determine why and alternative method to gain compliance, and assess/record/monitor wound healing. Measure length, width, and depth where possible. Assess and document status of wound perimeter, wound bed, and healing progress. Report improvements and declines to the MD. These interventions have a start date of 06/24/2024 and last edited on 10/09/2024. R50's care plan had no documentation regarding his nutritional status. Review of R50's Electronic Medical Record (EMR) was completed and had documentation R50 was being seen by a local contracted wound specialist from 07/02/24 through 01/14/25. R50's Wound Report, from the local contracted wound clinic, dated 01/14/25, documented R50's wound to his coccyx and left knee was resolved. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R50's Weekly Skin Assessments for the months of November 2024, December 2024, January 2025, and February 2025 were reviewed and had documentation R50 refused his weekly skin assessments on 11/06/24, 11/13/24, 12/05/24, 12/12/24, 01/01/25, 01/15/25, 01/29/25, 02/12/25, and 02/26/25. R50's Weekly Skin Assessment, dated 02/06/25 at 12:43 AM, documented Observation Details: Section 1 Does the resident have any new or existing skin conditions? Yes, is checked. Provide brief description including location of existing skin condition(s). Area to left stump, left knee, and coccyx. Treatments continue as ordered. R50's Progress Notes, dated 02/06/2025 at 12:45 AM, documented weekly skin assessment performed this shift. No new skin issues to note at this time. Treatments continue as ordered. Will continue to monitor under weekly skin assessments. R50's Progress Notes, dated 02/06/2025 at 4:45 PM, documented this nurse was called down to resident room. Upon entering it was noted that resident has wound areas to buttocks. Resident has 3 stage two areas to buttocks- (upper left cheek) 3x2.8x<0.1; (upper right cheek) 4.4x1.3x<0.1; (lower right cheek) 2.4x2.2x<0.1. Areas are red/pink wound bed without slough. Medical Doctor (MD) notified; new treatment (tx) order started. Resident is aware of new orders. Review of R50's EMR was reviewed and had no other documentation regarding the measuring and monitoring of R50's wounds from staff or the local contracted wound clinic. R50's Physician's Orders, dated 02/06/25, documented Cleanse buttock wounds with NS (Normal Saline)/wound cleanser, cover with silver alginate, and silicon foam bordered drsg (dressing). Change daily and PRN Once a day. This order was discontinued on 03/07/25. R50's Physician's Orders, dated 03/07/25, documented Cleanse left buttock wounds with NS/wound cleanser, apply Dakin's 0.125% moistened gauze and Santyl to wound, cover with silicone foam bordered drsg. Change daily and PRN once a day 6:00 AM-6:00 PM. This order was discontinued on 03/11/25. R50's Physician's Orders, dated 03/11/25, documented Left buttock, Cleanse with NS, apply Santyl and Dakin's 0.25% moistened gauze, cover with silicone bordered foam, and change daily and PRN once a day 6:00 AM- 6:00 PM. R50's Progress Notes, dated 11/13/2024 at 10:38 AM, documented R50 was seen by the Registered Dietitian (R.D.) R50 continues treatment for multiple wounds: Unstageable wound to left (L) Below the Knee Amputation (BKA), Stage IV pressure ulcer (p.u). to Coccyx, Stage III p.u. to L Knee. The R.D. recommend they decrease enteral feeding from continuous feeding to having his feeding run from 6 PM-6 AM then R50 would get Glucerna 1.2 bolus 237 milliliter (ml) after meals if by mouth (p.o.) intake is <50%. She also recommended Provide double portion meat each meal. Provide 60 ml Sugar Free Ready Care three times a day (TID) with (w)/ Med Pass and provide 30 ml liquid Protein via g-tube twice a day (BID). Discontinue (D/C) nothing by mouth (NPO) status in Matrix. R.D. following. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R50's Progress Notes, dated 02/11/2025 at 12:57 PM, documented Recommend decrease enteral feeding to 75 ml Glucerna 1.2/hour (h)r continuous from 6 pm - 6 am and Flush with 100 ml water (H20) every (q) 4 hours (hr.). Bolus 237 ml Glucerna 1.2 after meals if p.o. intake is <50%. Provide 90 ml Sugar Free Ready Care TID w/ Med Pass. Provide 30 ml liquid Protein via g-tube BID. D/C NPO status in Matrix. Suggest Resident is taken to Main Dining Room (MDR) for meals where he can receive assistance and encouragement. On 03/12/25 at 11:28 AM, V5, Licensed Practical Nurse (LPN) performed wound care on R50 at this time. The wound was approximately 14cm x 5cm. Wound bed slough/eschar, the surrounding tissue was pink in color. There was a [NAME] amount of drainage noted to the bath blanket that was underneath him. R50 hollered out in pain when they turned him over to apply the new dressing. No odor at this time but R50 had just been gotten out of the shower. On 03/04/25 at 3:10 PM, Requested the facility's Wound Care Log for the past three months from V1, Administrator. On 03/11/25 at 8:45 AM, This surveyor requested the wound care log multiple times on different days. Requested it form V1, Administrator, V2, Assist Director of Nursing (ADON), V11, Regional MDS, and V25, Regional/Chief Executive Officer (CEO) and none was produced. On 3/11/25 at 10:18 AM, V2, ADON came and asked this surveyor what I was needing when I requested the wound log. V2 said they don't have a log, but she could pull a resident up on the computer and print information off. This surveyor requested R50's wound information. V2 was asked if the facility had any documentation regarding the size of R50's wound and what his treatment consist of. V2 said she would print something out. On 03/11/25 at 10:59 AM, V2 brought this surveyor R50's local wound specialist notes from [DATE] and [DATE]. On 03/11/25 at 10:15 AM, V23, Licensed Practical Nurse (LPN) stated R50 was being seen by a local contracted wound clinic for his wounds, but the wounds healed, and he was discharged from their care. She said she was the nurse the Certified Nursing Assistants (CNAs) reported the new wounds to when they were found. She said they were pink and not opened. She said they looked like Stage 1. V23 said she contacted the doctor and got a treatment put into place right away but this time the wound just progressed fast. On 03/11/25 at 10:36 AM, R50 said he never refuses to be turned or repositioned that's just them saying that. R50 said his wounds had healed up but they came back. He stated You know why? Not from refusing but from them not changing me on time. R50 was oberved as being alert and oriented to person, place, time and situation at the time of this interview. On 03/12/25 at 11:28 AM, V5, LPN stated the local contracted wound specialist comes in every Tuesday and takes measurements and then the nurses responsible for doing the daily dressing changes. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 03/13/25 at 9:58 AM, V39, Registered Dietitian read over her recommendation on R50 and said R50 was started on the liquid protein for a severe wound to his coccyx. She said she recommended the Sugar Free Ready care with meals to be given orally with meds for more nutritional support. V39 was questioned why she made the same recommendations in the month of October 2024, and February 2025 and V39 stated probably because her recommendations weren't started, and the same orders are still in place. V39 stated she gives the recommendations to V1, Administrator. She said she was to send everything to her and then she (V1) would take care of them due to there not being a director of nursing (DON) to give them to. V39 stated she would expect the staff to follow through with her recommendations or to tell her why they didn't. She said she wasn't notified of her recommendations not being followed. V39 said of course nutrition is going to help with wound healing. On 03/25/25 at 11:27 AM, V61, Wound Nurse Practitioner said she would expect the nurses to assess the residents from head to toe when they have a weekly skin assessment ordered. She said weather it is done while in the shower or at the residents' convenience their skin should be checked. V61 said she sees most, if not all of the residents who have wounds here at the facility. She said they ask the dietitian to come and consult and make recommendations for the residents. V61 said protein and vitamins are the building base with healing. It can affect if the wound gets better or not. V61 said it would have absolutely helped for R50 to receive liquid protein. V61 said she would expect the nurses to put in the recommendations under the primary care physician (PCP) then carry them out as an order. She said she has had personal issues in this facility where she would give a specific order and it wasn't put in. She said she treated R50 for an area on his coccyx and healed it around January 2025. V61 said she wasn't contacted about the new area on R50's coccyx until March and when she saw it, she said it was really bad. V61 said yes potentially if she had known about R50's wound sooner she could have healed it. She said the faster you put interventions into place the better outcome you'll have. The facility's policy Prevention of Pressure Ulcers, revised date of 01/2002, documented The purpose of this procedure is to provide guidelines for skin care to assist in preventing the development of pressure ulcers in residents identified to be at risk. It further documented 1. Risk Factor: Bed fastness/Chair fastness Preventive Actions: assess the resident's risk factors on admission, quarterly, and with a significant change in status using the risk scale identified by facility protocol. Assess the resident's skin condition per facility skin and wound care program. It also documented For a person in bed: change position at least every two hours; use a special mattress that contains foam, air, gel, or water, as indicated; and raise the head of the bed as little and for as short a time as possible, and only as necessary for meals, treatments and as medically necessary. It further documented 4. Poor Nutrition Preventive Actions: Monitor nutrition and hydration status. Encourage proper dietary and fluid intake. If a normal diet is no possible, talk with physician about supplements. The policy also documented Evidence based research also indicates the following MDS assessment indicators identify residents at risk for pressure ulcers: a. How a resident eats and drinks. It further documented i. Significant changes in weight (>5% in 30 days or >10% in the previous 180 days). j. Pressure relieving chair/bed, k. Turning/repositioning, l. Nutrition or hydration program to manage skin care problems. It also documented The following are additional clinical conditions, treatments, and abnormal lab values that indicate that a resident is at risk: a. Continuous urinary incontinence or chronic voiding dysfunction, b. Severe chronic obstructive pulmonary disease, c. paraplegia/quadriplegia, d. sepsis, e. terminal cancer, f. chronic or end stage renal, liver, or heart disease. It also documented m. Head of bed elevated the majority of the day due to medical necessity. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Facility's Long-Term Care Facility Application for Medicare and Medicaid (CMS 671) dated 3/7/25 documents there are 73 residents living in the Facility.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35156 This citation has 2 deficient practice statements A. Based on observation, interview and record review the Facility failed to ensure hot water temperatures are maintained at safe levels in areas that are accessible to residents. This has the potential to affect all 76 residents living in the facility. Findings include: On 3/6/2025 at 8:14 AM, Water temperatures were taken with a metal calibrated thermometer. On 3/4/2025 at 8:24 AM, R60 and R61 share a room with R63 and R64. The Water temperature after running the water for one minute was 118.0 Fahrenheit (F). On 3/4/2025 at 8:29 AM, Room R55 shares a room with R56, and R57 and the water temperature after running for one minute was 116.5 F. On 3/4/2025 at 9:01 AM, R70 and R71 share a room with R73 and the water temperature after running the hot water for one minute was 115.9 F. On 3/4/2025 at 8:54 AM, Room R47, and R48 share a room with R51 and R52 and the water temperature after running hot water for one minute was 115.9 F. On 3/4/2025 at 9:12 AM, Room R15, R16 share a room with R17, R18 and the water temperatures after running hot water for one minute was 115.5 F. On 3/4/2025 at 9:20 AM, R2 and R4's water temperature after running hot water for one minute was 116.4 F. On 3/6/2025 at 3:21 PM, V24, Certified Nursing Assistant (CNA) stated, Residents use both showers on both halls it does not matter what halls they are on, they use both sides of the showers. On 3/6/2025 at 5:19 PM, V12, Certified Nursing Assistant (CNA) stated, Residents use both sides of the shower, they do not have a designated shower room. They use both showers. On 3/10/2025 at 2:12 PM, water temperatures were monitored throughout the Facility using a calibrated digital metal stemmed thermometer. On 3/10/2025 at 2:17 PM, R67, R68 and R69's Room water temperature after running hot water for one minute was 116.5 F. On 3/10/2025 at 2:19 PM, R55, R56 and R7's water temperature after running hot water for one minute was 120.6 F. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 3/10/2025 at 2:22 PM R46's water temperature after running hot water for one minute was 116.1 F. On 3/10/2025 at 2:39 PM, the [NAME] Shower Room water temperature after running hot water for one minute was 116.4 F. On 3/7/2025 at 2:36 PM, V29, Maintenance Man stated, I started working here on 1/23/2025 and from day one I have been having issues with the water temperatures here in this building. Ideally water temperature should be above 104 and below 115. On 3/7/2025 at 3:53 PM, V1, Administrator stated, The plumbers were out here on 2/28/2025 and they were replacing a mixing valve because we did not have hot water. I do not have an invoice yet. We thought that fixed the issues with not having hot water. I know we have been having issues with the hot water since January 2025. On 3/11/2025 at 8:04 AM, V25, Regional Corporate of Marketing stated, (V1) is not here at this point we are not sure if she is even returning. (V29) is not here today either. As far as the water temperatures the Plumbing People were here yesterday, and the water temperatures are good now. I am not aware of any issues with the water temperatures today. On 3/11/2025 at 2:00 PM, Water temperatures were taken with a metal calibrated thermometer. On 3/11/2025 at 2:17 PM, R69's water temperature after running hot water for one minute was 116.5 F. On 3/11/2025 at 2:19 PM, R55, R56 and R7 share a bathroom and the water temperature after running hot water for one minute was 120.6F. On 3/11/2025 2:22 PM, R21's water temperature after running hot water for one minute was 116.1 F. On 3/11/2025 at 2:27 PM, R74's water temperature after running hot water for one minute was 119.1 F. On 3/11/2025 at 2:30 PM, the west shower room water temperature after running hot water for one minute was 118.6. On 3/11/2025 at R4's water temperature after running hot water for one minute was 119.1 F. The Resident Right Policy with a revision date of 11/18 documents, Your facility must be safe, clean, comfortable and homelike. The Facility's Long-Term Care Facility Application for Medicare and Medicaid (CMS 671) dated 3/7/25 documents there are 73 residents living in the Facility. 49494 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	B. Based on observation, interview, and record review the facility failed to provide adequate supervision to prevent falls, consistently complete incident reports for falls, consistently assess thoroughly, analyze each fall incident to determine the root cause of the falls, implement interventions to reduce risk of further falls, and revise the resident's care plan to reflect new or changed interventions after each fall for 8 (R11, R25, R28, R30, R37, R45, R47, and R69) of 8 residents reviewed for falls in a sample of 81. Findings Include: 1.R28's face sheet, print date of 3/18/25, documented R28 has diagnoses including traumatic subdural hemorrhage, epilepsy, anxiety, hypertension, asthma, dementia, cognitive communication deficit, and bipolar disorder. R28's MDS (Minimum Data Set), dated 12/18/25, documented R28 is severely cognitively impaired, requires moderate assistance with ADLS (activities of daily living), and substantial to maximum assistance with transfers to and from his wheelchair. R28's last fall assessment, dated 8/28/24, documented R28 scored a total of 15 indicating R28 is at high risk of falls and requires a falls prevention program. R28's care plan, undated, documented R28 is at risk of falls related to walking too fast, pain, bipolar disorder, epilepsy, and asthma. R28 has experienced actual falls on 3/20/24 and 10/16/24. The last fall reduction intervention added to R28's care plan was on 10/23/24. R28's EMR, (Electronic Medical Record), progress note, dated 1/9/25 at 1:43 PM, documented resident was walking throughout the facility when he tripped and fell on to the floor. Fall was witnessed by staff and resident bumped his head onto the wall. No swelling or redness was noted to the head. Neuros were WNL (within normal limits). Resident was assessed and had skin tears to right hand and a laceration in between the right index finger and thumb. Areas was cleaned and a dry dressing was applied. Resident was also able to move extremities WNL during ROM (range of motion) with no c/o pain. Resident was sent to local hospital r/t (related to) pain to resident's head and neck. R28's local hospital emergency room progress notes, dated 1/9/25, documented R28 presented from his skilled nursing facility after a ground level fall. Patient fell forward while tripping on his feet and struck his head against the door frame and slid down. He has complained of some right-shoulder pain as well as left-sided hand pain. It continues, you were seen today for closed head injury, left hand pain, right shoulder pain, and neck pain. R28's EMR progress note, dated 1/9/25 at 8:30 PM, documented resident returned to facility transported by local EMS (emergency medical service) with two attendants via stretcher. It continues, dressings noted to left hand. Resident assisted to standing position and placed in wheelchair at nurse's station. Resident propelling self throughout the facility. R28's event report, dated 1/9/25, documented event still open. This document does not document a root cause analysis of this fall, nor does it document an intervention was added to prevent further falls. This fall nor an intervention were added to R28's care plan. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R28's event report, dated 1/12/25, documented at 2:30 AM This nurse hears a resident yelling down the hallway we need some help down here, R28 fell . This nurse observes resident lying on the floor on his right side in the doorway of room. Resident states he was going to get coffee from another resident in his room. Neuro checks WNL (within normal limits). ROM, (range of motion), WNL. C/O (complaint of) pain to back of head. States my noggin hurts. Small abrasion approx. nickel size noted to back of head with scant amount bleeding. Area cleansed with wound cleanser, TAO (triple antibiotic ointment) and cold compress applied. Resident does not take anticoagulants. Resident refuses ER visit for further evaluation stating he is ok. Resident up in w/c (wheelchair), for safety, with assist x2. This document notes event still open. This document does not document a root cause analysis, nor a new fall prevention measure was put into place. This fall nor an intervention were added to R28's care plan. R28's event report, dated 1/27/25 at 11:00 PM, documented this nurse called to resident's room by roommate. Resident observed lying in floor on right side near bathroom door. Resident unable to say how he fell . Roommate states resident his head on the way down. Resident assessed. It continues, 11:10 PM ADON (Assistant Director of Nursing) and MD notified. Order to send resident to ER for evaluation given. 1/28/25 at 12:51 AM EMS (emergency medical services) phoned facility stating they will not be able to transport resident related to high volume of 911 calls. Local hospital called and stated they do not have a room available related to emergency arrivals. MD notified. Will continue with neuro checks and monitor resident. This form documented evaluation: event still open. This form does not document a root cause analysis of the incident, nor does it document an intervention to reduce the risk of further falls. R28's care plan does not have any documentation regarding this event, nor does it document a fall intervention to prevent the risk of further falls. R28's progress note, dated 1/29/25 at 12:25 AM, documented this nurse called to resident area. This nurse informed that resident had a witnessed fall. Resident observed sitting on buttocks in front of chair. Resident has no c/o pain or discomfort. It continues, resident assisted to standing and placed in chair. Resident's shoes observed to be on the wrong feet. R28's EMR does not contain an event report for this fall, no root cause analysis, nor an intervention to reduce the risk of further falls. R28's care plan does not document this fall nor an intervention after this fall occurred. R28's event report, dated 2/18/25 at 11:25 AM, documented resident as nurse's station and started reaching for chair and lost balance. Fall witnessed. Resident did not hit head. Resident right arm and hand was wedged in between chair and wheel in an abnormal position. Resident has 1x1 cm skin tear to right top of hand. Cleansed area and skin well approximated. Covered with dry dressing. Resident assisted up with assistance of three. Resident c/o pain to right arm and hand. MD notified and x-ray ordered. Evaluation: event still open. This event report does not document a root cause analysis nor an intervention to reduce the risk of R28 experiencing further falls. R28's care plan was not updated to include this fall nor an intervention to reduce the risk of further falls. R28's event report, dated 3/7/25 at 10:02 AM, documented seizure in dining room, event details fall. Resident fell face forward in dining room. Resident had grand mal seizure that lasted approximately 1 1/2 minutes until became postictal. Resident has hematoma to right forehead. Scant amount of blood noted and cleansed with NS (normal saline) and covered with bandage. 911 called by administrator. Resident had second seizure that lasted 2 minutes. 10:25 AM EMS arrived at facility at 10:10 AM. Resident placed in neck brace by EMS. Evaluation: event still open. This report does not document a root cause analysis nor an intervention to reduce the risk of further falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R28's event report, dated 3/24/25 at 1:14 PM, documented resident rolled himself to nursing station and stated he had a fall in his room. Resident has a laceration to forehead. Area was cleaned and dry dressing applied. Resident was able to move extremities WNL during ROM with no c/o pain. Resident has c/o pain to head, neuros were WNL. EMS was called 911. Once EMS arrived at the facility to assess the resident, he refused to be sent to the ER and stated that he feels better. MD and POA (Power of Attorney) was notified of incident. Will continue to monitor. Event still open. This event report does not document a root cause analysis nor an intervention to reduce the risk of R28 sustaining further falls. On 3/24/25 at 11:11 AM surveyor observed R28 propelling self in his wheelchair in the dining room. Resident had a large bandage on his forehead. No fall interventions in place including non skid mat in seat of wheelchair. 2. R30's face sheet, print date of 3/3/25, documented R30 has diagnoses including schizophrenia, dementia, depression, generalized anxiety disorder, unspecified mood disorder, and weakness. R30's MDS, dated [DATE], documented R30 is severely cognitively impaired and requires partial/moderate assistance with mobility. R30's care plan, undated, documented R30 is at risk for falling related to impaired mobility and diagnoses of hypertension and dementia. R30's last fall reduction intervention added to R30's care plan was on 11/14/24. On 3/24/25 at 12:50 PM, V11, Regional MDS Consultant, stated the facility failed to complete a fall risk assessment of R30 during his stay at this facility. R30's event report, dated 11/18/24 at 2:07 PM, documented resident attempted to sit in chair behind nurse's station, resident missed the chair resulting in him falling onto floor. Resident was assessed and had no c/o pain. This event report documented event still open. It does not document a root cause analysis of this fall nor an intervention to prevent future falls. R30's event report, dated 11/23/24 at 5:35 PM, documented resident stood up from w/c (wheelchair), when he tried to sit back down, he missed the w/c resulting in him falling onto the floor. Fall was witnessed by nurse, and resident didn't hit his head. This report documented event still open. This report does not document a root cause analysis was completed of this fall nor was an intervention implemented to reduce the risk of R30 sustaining future falls. R30's EMR progress note, dated 11/29/24 at 11:08 AM, documented resident was self-propelling self in wheelchair onto the floor. Fall was witnessed by staff and residents; resident didn't hit his head. It continues, non-skid mat will be placed in wheelchair to prevent resident from sliding out of wheelchair. This intervention is not documented on R30's care plan. On 3/3/25 at 2:17 PM R30 was observed unsupervised in the dining room with no fall prevention measures in place including non-skid mat in seat of his wheelchair. R30's event report, dated 11/29/24 at 11:04 AM, does not document the event the occurred with R30, no root cause analysis, no interventions, and documented event still open. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R30's progress Note dated 1/9/2025 at 11:39 AM, Resident vomited in sitting area while eating sandwich given to him by staff member resident was removed from area and taken into shower room to be cleaned while removing residents clothing resident slipped on floor face forward and hit his head on shower room floor resident was bleeding from head and has a gash to the left side of his head resident sent out via EMS to local Hospital at 10:30P.M. R30's local hospital emergency room progress notes, dated 1/9/25, documented R30 was seen today for laceration of scalp, head injury, fall, nausea and vomiting. R30's discharge instructions include fall prevention education and recommendations for prevention of further falls. R30's EMR does not document an incident/event report was completed for R30's fall on 1/9/25, no root cause analysis was completed, nor was R30's care plan updated to include a fall prevention intervention was implemented following this fall with injuries. 3. R45's face sheet, print date of 3/11/24, documented R45 has diagnoses including osteoarthritis, type 2 diabetes mellitus with diabetic neuropathy, bipolar disorder, major depressive disorder severe with psychotic symptoms, generalized anxiety disorder, hypertension, chronic embolism, and thrombosis of deep veins of lower extremity, adult failure to thrive, and personal history of suicidal behavior. R45's MDS, dated [DATE], documented R45 is cognitively intact and requires supervision or touch assistance with all ADLS (activities of daily living). R45's care plan, undated, does not document R45's risk for falls, actual falls experienced at facility, nor any interventions to reduce R45's risk for further falls. On 3/24/25 at 12:50 PM, V11, Regional MDS Consultant, stated R45 did not have any fall risk assessments completed during her stay at the facility. V11 stated the floor nurses are supposed to be doing them, but they did not complete one for R45. R45's progress note, dated 2/1/25 at 7:25 PM, documented this nurse called to dining room. Resident had witnessed fall. Resident was observed getting ice from ice chest and lost her footing. Resident went to her buttocks in front of her walker and did not hit her head. Resident has no c/o pain or discomfort. No injury noted. Moves all extremities with no complaints. Resident assisted to standing and placed in chair. MD aware. Orders to monitor resident. R45's event report, dated 2/1/25 at 7:25 PM, documented this nurse called to dining room. Resident had witnessed fall. Resident was observed getting ice from ice chest and lost her footing. Resident went to her buttocks in front of her walker and did not hit her head. Resident has no c/o pain or discomfort. This event report does not document a root cause analysis of this fall nor an intervention to reduce the risk of R45 sustaining further falls. This event report documented event still open. R45's progress note, dated 2/22/25 at 2:37 PM, documented resident had a fall this am during altercation with peer, resident fell backwards onto her bottom, fall witnessed by staff, resident did not hit her head. Resident denies pain related to fall at this time. MD notified. No injuries noted at present. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R45's event report, dated 2/22/25 at 9:30 AM, documented resident had a fall this am during altercation with peer. It continues, event still open. This event report does not document a root cause analysis nor an intervention to reduce the risk of R45 experiencing further falls. R45's progress note, dated 2/25/25 at 7:40 PM, documented this nurse called to dining room. Resident observed lying on floor with a lethargic affect. Another resident states that she saw her fall. She was attempting to sit on her walker, walker was not locked and moved away from resident and resident went to the floor onto her buttocks and did not hit her head. Aide went to phone 911 for transport. R45's local hospital emergency room progress notes, dated 2/25/25, documented R45 was seen for a fall. Patient instructions include fall prevention education, and to follow up with her primary care provider in the next 2-3 days. On 3/24/25 at 3:32 PM V11 stated to surveyor you don't even want to hear this; you are correct about the missing physician progress notes by V3. We have no physician progress notes for R45 from her entire stay. Surveyor asked V11 if this means R45 was not seen by her primary physician, V3, since there is no documentation in the facility EMR and V11 stated that is correct, we will have to educate him about this. R45's EMR does not document an event/incident report, a root cause analysis, nor an intervention to reduce the risk of further falls for R45's fall on 2/25/25. This fall nor an intervention were documented on R45's care plan. R45's progress note, dated 3/1/25 at 8:40 PM, documented this nurse went to resident's room and observed resident lying on the floor near her nightstand. Resident very lethargic and barely responding to commands. Resident not answering questions at this time. Aide called for assistance. Mechanical lift acquired and placed in bed. Unwitnessed fall protocols began. MD notified and order received to send resident to ER for evaluation. R45's event report, dated 3/1/25 at 8:40 PM, documented this nurse went to resident's room and observed resident lying on the floor near her nightstand. Resident very lethargic and barely responding to commands. Resident not answering questions at this time. Aide called for assistance. Mechanical lift acquired and resident placed in bed. Unwitnessed, fall protocols began. MD notified and order received to send resident to ER for evaluation. 911 phones for transport of resident to hospital. It continues, event still open. This event report does not document a root cause analysis nor any fall interventions to reduce the risk of R45 sustaining further falls. R45's local hospital ER progress notes and discharge instructions, dated 3/1/25, documented R45 was seen for fall from ground level, head injury. R45's discharge instructions documented fall prevention education and for R45 to be seen by her primary physician within 3-5 days. R45's care plan, undated, does not document this fall nor any fall reduction interventions. R45's EMR does not document any physician visits from her primary physician V3 during her admission to the facility from 1/9/25 until her discharge on 3/7/25. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 3/18/25 at 11:45 AM V25, Regional Chief Executive Officer, stated V3, ADON (Assistant Director of Nursing) is in charge of falls/fall management. Surveyor requested fall investigations with interventions for R28's falls since 1/9/25 and V25 did not provide any interventions for R28. Surveyor asked V25 if the incidents are still open and do not document a root cause analysis nor an intervention on the incident/event report nor on the care plan if that means it was not done, V25 replied correct. On 3/18/25 at 12:25 PM V2, ADON, stated V2 stated V1, (former Administrator), was supposed to be doing fall management and that she was assisting V1 with it sometimes. Surveyor asked V2 if the event reports document open and if they do not document a root cause analysis of the fall nor an intervention if that means neither was completed and V2 stated that does mean neither were completed. On 3/24/25 at 9:52 AM V11, Regional MDS Consultant, stated if the event reports are still open it means the root cause analysis nor interventions were completed. Stated the floor nurses are always supposed to complete an incident report when a resident has a fall and the DON (Director of Nursing) or ADON are expected to complete the root cause analysis and determine what fall intervention is to be put into place to reduce the risk of further falls. On 3/24/25 at 11:42 AM V11 stated R30 nor R45 have fall risk assessments in their EMRS. The nurses failed to do them. 4. R69's Physician Order Sheet for March 2025 documents a diagnosis of RST elevation (STEMI) myocardial infarction involving other coronary artery of anterior wall; Chronic obstructive pulmonary disease, unspecified; Type 2 diabetes mellitus with unspecified complications; Major depressive disorder, recurrent, severe with psychotic symptoms; Alcohol dependence with intoxication, unspecified (History of); Essential (primary) hypertension; Insomnia; Vitamin deficiency, unspecified; 2019-nCoV acute respiratory disease (History of); Other seasonal allergic rhinitis; and constipation. (R69 is also missing his LLE (lower left extremity which was not documented). R69's Minimum Data Set (MDS) dated [DATE] document he was cognitively intact for decision making of activities of daily living. R69's Care Plan documents under falls: Problem: I have experienced an actual fall on 6/27/24, 12/24/24 and 2/4/25 Category Fall, Start Date 07/06/2023 Last Reviewed/Revised 03/04/2025. The Care Plan does not address any falls for 2025. On 3/14/2025 at 11:29 AM, R69 was in the dining room. Resident is sitting in the dining room and is missing one leg (Lower left extremity). On 3/14/2025 at 11:30 AM, R69 stated he can do most things on his own without help. Resident is in a wheelchair. Resident is missing leg. Resident stated he did have a fall but that was last month. No issues and he did not hurt himself. I did not really fall, I just slid off the bed. Resident is missing his left leg, pants tied off. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R69's Progress Notes dated 1/16/2025 at 3:44 PM, resident yelling help this AM, upon entering resident room resident sitting on the floor leaning his back against his bed, resident assessed, and no injuries noted, resident asked what happened and he stated I was reaching for my pants and slid to the floor. Resident assisted off the floor with gait belt and two assist to his bed. Resident stated he did not hit his head, neuro checks initiated. Resident states he does not want to go to the ER (emergency room). Safety education given r/t (related to) using call light for help and not leaning forward to reach things on the floor, resident voices understanding. Resident currently in room in bed with call light in reach and no complaints of pain or distress at this time. R69's Incident Report dated 1/16/2025 documents, approached this nurse stating resident was found on floor. Upon entering room, this Nursing nurse observed resident sitting on buttocks on floor on side of bed, leg outstretched. Resident alert/oriented times 3 w/intermittent confusion. When asked what happened, resident stated he did not fall, but he slid to floor while attempted to transfer self from bed to wheelchair. ROM (Range of Motion) performed and WNL (within normal limits). Neurochecks initiated and within normal limits. Resident assisted to wheelchair w/assist of 2 staff members. Currently denies any pain/distress. No apparent injury observed. Will continue to monitor. MD, DON, ADON, Admin aware. Made several attempts to notify POA. Mailbox full. Resident remains on incident follow-up with neuro checks going (WNL). No c/o (complaint of) pain or s/sx (Sign or symptoms) of distress. R69's Care Plan and Incident Report does not document any interventions for the 1/16/2024 fall. R69's Nurses Notes dated 2/4/2025 at 3:17 PM, Woman approached this nurse stating resident was found on floor. Upon entering room, this nurse observed resident sitting on buttocks on floor on side of bed, leg outstretched. Resident alert/oriented times 3 w/intermittent confusion. When asked what happened, resident stated he did not fall, but he slid to floor while attempted to transfer self from bed to wheelchair. ROM performed and WNL. Neurochecks initiated and within normal limits. Resident assisted to wheelchair w/assist of 2 staff members. Currently denies any pain/distress. No apparent injury observed. Will continue to monitor. R69's Incident Report dated 2/4/2025, Resident yelling help this am, upon entering resident room resident sitting on the floor leaning his back against his bed, resident assessed, and no injuries noted, resident asked what happened and he stated I was reaching for my pants and slid to the floor. resident assisted off the floor with gait belt and two assist to his bed. Resident stated he did not hit head, neuro checks initiated. Resident states he does not want to go to the ER (emergency room). Safety education given r/t using call light for help and not leaning forward to reach things on the floor, resident voices understanding. Resident currently in room in bed with call light in reach and no complaints of pain or distress at this time. R69's Care Plan and Incident Report does not document any interventions for the 2/4/2025 fall. 5. R11's POS documents a diagnosis of Rhabdomyolysis; Irritable bowel syndrome with diarrhea; Barrett's esophagus without dysphagia; Type 2 diabetes mellitus without complications; Other specified arthritis, multiple sites; Moderate protein-calorie malnutrition; chronic kidney disease, stage 4 (severe); Essential (primary) hypertension; Other specified arthritis, multiple sites; bipolar disorder, unspecified; and Diabetes insipidus. R11's MDS stated 2/27/2025 document R11 was cognitively intact for decision making of activities of daily living. He has no impairment on the upper or lower extremity, uses a wheelchair and requires substantial/maximal assistance- Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort for most of his activities of daily living. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R11's Care Plan: Fall with start date of 3/6/2024: documents, Problem: Resident is at risk for falls due to hx (history of) of falls and rhabdomyolysis. On 3/14/2025 at 1:01 PM, R11 stated, I can transfer myself but sometimes, I need help. I did have a fall, but I did not get hurt. I am fine. I fell last month but I am fine. I do not always get the help I need here. R11's Progress Notes do not have anything related to his fall on 1/31/2025. The first Progress Note related to his fall was on 2/1/2025. R11's Progress Notes dated 2/1/2025 at 2:38 PM, IFU DAY 1 R/T (related to) Fall. Resident was noted on the floor in room in sitting position. Resident stated that he slid out of his wheelchair while self-propelling himself in wheelchair. Neuros were WNL (within normal limits). Resident A&O4 and stated that he didn't hit his head, he only fell on his bottom. Resident was assessed and had no c/o (complaint of) pain and able to move extremities WNL during ROM. Skin assessment was done and resident had no swelling or bruising noted to skin. R11's Incident Report dated 2/1/2025 at 2:33 PM, Documents, IFU Day 1 R/T (Related to) Fall, Resident was noted on the floor in room in sitting position. LPN stated that he slid out of his wheelchair while self-propelling himself in wheelchair. Neuros were WNL. Resident alert and oriented x 4 and stated that he didn't hit his head, he only fell on his bottom. R11's Care Plan and Incident Report does not document any interventions for R11's fall on 1/31/2025. 6. R25's POS for March 2025 documents a diagnosis of Cerebral infarction due to embolism of basilar artery; Type 2 diabetes mellitus without complications; Other specified sepsis; Major Depression, Essential (primary) hypertension; Hidradenitis suppurativa; Other psychoactive substance abuse, in remission; Anemia, unspecified; Anemia, unspecified; Generalized anxiety disorder; Benign prostatic hyperplasia without lower urinary tract symptoms; and Pain. R25's MDS dated [DATE] document R25 was cognitively intact for decision making of activities of daily living. R25's Care Plan does not address any falls. R25's Progress Notes dated 2/16/2025 at 5:43 PM, IFU DAY 1 R/T Fall. Resident stated that he slipped and fell in the shower room and bumped his head. Resident was assessed and resident had no redness or swelling noted to head. Neuros were WNL. Resident had increased pain to his right foot and stated that he thinks it's broken. No redness, swelling or bruising was noted to resident's foot. MD (Medical Doctor) was notified of incident, and resident received a new order for an Xray to the right foot. Order was placed with Mobilex. Resident up walking throughout the facility after being told numerous times not to bear weight on his right foot. Will continue to monitor. R25's Incident Report dated 2/16/2025 at 5:51 PM, documents R25 was in severe pain and was unable to move his lower right extremity. R25's Incident Report does not document what happened and/or any intervention. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 3/24/2025 at 11:13 AM, R25 stated he was lathering himself with soap and the floor was wet and he slipped and fell . He did hit his head and twisted his foot but he is okay now. 7. R37's POS for March 2025 documents a diagnosis of Type 2 diabetes mellitus without complications; Generalized anxiety disorder; Mood disorder due to known physiological condition with mixed features; Severe sepsis with septic shock; Acute on chronic systolic (congestive) heart failure; Alcoholic cirrhosis of liver with ascites and Acute and chronic respiratory failure, unspecified whether with hypoxia or hypercapnia. R37's MDS dated [DATE] documents he was moderately impaired for cognition for activities of daily living and only needs verbal cues for most activities of daily living. R37's Care Plan Last revised date of [TRUNCATED]

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44556 Based on observation, interview, and record review, the facility failed to ensure dietician recommendations were followed and monitor weights for 3 of 3 residents (R22, R24, and R50) who were reviewed for weight loss in a sample of 81. This failure resulted in R22 having a significant weight loss of -21.2 % in one month and -27.3% in six months; R24 having a significant weight loss of -7.6% in one month; and R50 having a significant weight loss of -14.61% in six months. Findings Include: 1. R22's Face Sheet, admitted [DATE], documented R22 had diagnoses of but not limited to Cerebral infarction due to unspecified occlusion or stenosis of right anterior cerebral artery, diabetes mellitus (DM), major depressive disorder, recurrent, moderate (History of), acute kidney failure, unspecified, hypertension (HTN), and Legal blindness. R22's Minimum Data Set (MDS), dated [DATE], documented R22 is severely cognitively impaired and requires staff assistance with eating his meals. R22's Care Plan, admitted [DATE], was reviewed and there is no documentation in R22's care plan regarding weight loss issues. R22's Physician's Orders, dated 07/15/24, documented Diet- Liquids: thin and Low Concentrated Sweets (LCS) regular. R22's Physician's Orders, dated 10/24/24, documented Mirtazapine 7.5 milligrams (mg) one tab at bedtime. R22's Monthly weights for the past six months documented the following: On 10/09/2024 at 10:48 AM, Weight: 146.8 pounds (lbs.) On 11/14/2024 at 02:11 PM, Weight: 115.6 lbs. No monthly weight for December 2024. On 01/09/2025 at 10:28 AM, Weight: 113.6 lbs. No monthly weight for February 2025. On 03/04/2025 at 11:26 AM, Weight: 106.6 lbs. R22's Meal Consumption record for January 2025, had no documentation for breakfast, lunch, or dinner from 01/01/25 through 01/07/25, 01/09/25 through 01/14/25, and 01/16/25 through 01/26/25. On 01/08/25, 01/29/25, and 01/30/25, there was no documentation for lunch or dinner. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	R22's Meal Consumption record for February 2025, had no documentation for the dinner meal from 02/07/25 through 02/15/25 and no documentation for breakfast, lunch, or dinner, from 02/19/25 through 02/28/25. R22's Dietary Notes documented the following: On 12/04/2024 at 11:06 AM, R.D. (Registered Dietitian) Note: Resident followed d/t (due to) weight loss. Current weight = 115.6# indicating a 31.2# significant loss x 1 mo. (month) (-21.2%). He has been back and forth to the hospital the last couple of months w/ AMS (Altered Mental Status), AKI (Acute Kidney Injury), UTI (Urinary Tract Infection), N/V (Nausea/Vomiting). Diet = LCS (Low Concentrated Sweets) with double portions, SF Health Shake with all meals. BS (Blood Sugar) has been in fair control. 7.5 mg (milligram) mirtazapine provided daily. Recommend contact PCP (Primary Care Physician) to see if mirtazapine can be increased to 15 mg daily. R.D. following. On 01/11/2025 at 02:09 PM, R.D. Note: Resident followed d/t continued unplanned weight loss. January weight = 113.6# indicating a 3# loss x 1 mo., 33.2# significant loss x 3 mo. (-22.6%). BMI = 17.2 (underweight). Diet = LCS Mechanical Soft with Double portions, SF Health Shakes at each meal. BS has been in relatively good control. Recommend a D/C LCS diet and change to Regular w/ SF Beverages. Contact PCP and see if mirtazapine can be increased to 15 mg daily. Add PB (Peanut Butter) Sandwich at HS (bedtime). There is no documentation in the physician's orders regarding the Mirtazapine being increased, the diet being changed, or the health shake being started per Dietitian's recommendations. On 03/06/25 at 12:30 PM, R22 was brought his lunch tray to him at this time by V12, Certified Nursing Assistant (CNA). On his tray was two bowls of pureed food with two scoops in each bowl. There was also a plastic cup of applesauce, glass of water, and glass of tea. There was no health shake on his tray. V12 placed R22's tray on his bedside table and left the room. On 03/06/25 at 12:33 PM, V12 went back into R22's room to assist him with his meal. On 03/06/25 at 12:36 PM, V12 came out of the room with R22's tray. There was only a couple of bites eaten out of both bowls, the apple sauce was not opened and lying upside down on the tray. There were a couple drinks offered during the meal assistance. V12 did not offer to get R22 anything else to eat or did not encourage R22 to try and eat more. On 03/10/25 at 12:22 PM, Staff brought R22 his lunch tray. There was a single serving of pureed meatballs, mixed vegetables, mashed potatoes, and Ice cream on the tray. There was no health shake seen on the tray. 2. R24's Face Sheet, with an admitted [DATE], documented R24 has diagnoses of but not limited to Cerebral infarction due to thrombosis of bilateral vertebral arteries, Type 2 diabetes mellitus without complications, Cardiac arrest, and HTN. R24's MDS, dated [DATE], documented R24 is cognitively intact with a BIMS of 15/15 and requires supervision/touching assistance with eating and partial/moderate assistance with ADLs. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	R24's Care Plan, with an admitted [DATE], documented R24 is at risk for alteration in nutrition related to (r/t) DM type 1, interventions include but not limited to R24 will maintain his weight +/- 5lbs through next review date, Weight to be completed monthly and as needed (PRN), RD to evaluate and make diet change recommendations PRN, and Observe and report to Medical Doctor (MD) signs/symptoms (s/sx) of malnutrition: Emaciation, muscle wasting, significant weight loss which is 3 pounds in a week, over 5% in one month, over 10% in 3 months, over 10% in 6 months. R24's Physician's Orders, dated 02/24/24, Dietitian to evaluate as needed for nutritional interventions. Low Concentrated Sweets (LCS) (Regular Diet, Regular Consistency). R24's Meal Consumption Record, dated December 2024, had no documentation for breakfast, lunch, or dinner on 12/01/24 through 12/06/24, 12/08/24 through 12/10/24, 12/13/24 through 12/28/24, and 12/30/24. There was no documentation for dinner on 12/11/24 and 12/31/24. R24's Meal Consumption Record, dated January 2025 had no documentation for breakfast, lunch, or dinner on 01/01/25 through 01/26/25, no breakfast or dinner documentation on 01/27/25, no documentation for dinner on 01/28/25, and no documentation for lunch and dinner on 01/29/25 and 01/30/25. R24's Meal Consumption Record, dated February 2025, had no documentation for dinner on 02/17/25 and 02/18/25, no breakfast, lunch, and dinner on 02/19/25 through 02/28/25. R24's weights for the past six months documented the following: On 09/16/2024 at 12:36 PM, Weight: 132.5 lbs. On 10/09/2024 at 10:48 AM, Weight: 126.4 lbs. On 11/14/2024 at 02:16 PM, Weight: 121.8 lbs. On 01/08/2025 at 02:27 PM, Weight: 127.6 lbs. On 02/05/2025 at 12:25 PM, Weight: 118 lbs. On 03/03/2025 at 08:27 AM, Weight: 119.2 lbs. R24's Progress Notes, dated 02/11/2025 at 01:53 PM, R.D. Note: Resident followed d/t significant weight loss. February weight = 118# a 9.6# loss x 1 mo. (-7.6%). Ht = 64. BMI = 20.2 (low normal for age). Diet = LCS. Receives Yogurt at Breakfast. BS has been in fair control with occasional spike to 300-400. Resident reports that he is very particular about what he eats but he will eat a deli sandwich, peanut butter and jelly (pbj), grilled cheese or yogurt if he doesn't like what is on the menu. This R.D. added Yogurt to his lunch and dinner tray ticket. Recommend PBJ and 2% Milk at Bedtime (HS). 3. R50's Face Sheet, admitted [DATE], documented R50 has diagnoses of but not limited to Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits, HTN, Type II DM, Hyperosmolality and hypernatremia, and chronic kidney disease. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	R50's MDS, dated [DATE], documented R50 is severely cognitively impaired and requires supervision or touching assistance with eating. R50's Care Plan, with an admitted [DATE], has no documentation regarding nutritional status and the use of an enteral feeding tube. R50's Physician's Orders, start date of 10/08/2024, documented the following: Diet- Liquids: Thin, Diet: Mechanical Soft. No end date noted. R50's Physician's Orders were reviewed and there is no documentation to obtain any weights was noted. R50's Meal Consumption Record, dated December 2024, was reviewed, and had no documentation for 12/01/25 through 12/03/24, 12/09/24 through 12/11/24, 12/16/25 through 12/17/24, 12/20/24 through 12/15/24, 12/27/24, 12/28/24, 12/30/24, and 12/31/24. R50's Meal Consumption Record, dated January 2025, was reviewed, and had no documentation for 01/01/25 through 01/07/25, 01/09/25, 01/10/25, 01/13/25, 01/14/25, 01/16/25 through 01/20/25, 01/22/25 through 01/26/25, 01/30/25 though 01/31/25. No documentation noted for dinner on 01/8/25, 01/11, 01/12, 01/15, 01/27, 01/28, and 01/29/25. R50's Meal Consumption Record, dated February 2025, was reviewed, and had no documentation for dinner 02/01/25, through 02/28/25, no documentation on breakfast, lunch, and dinner on 02/10/25, 02/19/25 through 02/19/25 through 02/28/25. On 03/06/2024, R50's monthly weights for the past six months were reviewed and documented the following: 10/09/2024 at 10:48 AM, Weight: 141.7 pounds (lbs.) There is no weight documented for November 2024. There is no weight documented for December 2024. There is no weight documented for January 2025. 02/03/2025 at 03:05 PM, Weight: 128.0 lbs. There is no weight documented for March 2025. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	R50's Progress Notes, dated 11/13/2024 at 10:38 AM, documented Registered Dietitian (R.D.) Note: November weight pending. Regular Mechanical Soft diet with thin liquids continues and 75 milliliter (ml) Glucerna 1.2 is infusing/hour (hr.) x 24 hr. with 50 ml water (H20) Flush every (q) 4 hr. Resident continues treatment for multiple wounds: Unstageable wound to left (L) Below the Knee Amputation (BKA), Stage IV pressure ulcer (p.u). to Coccyx, Stage III p.u. to L Knee. Per recent wound report, wounds are improving. Resident denies any gastrointestinal (GI) discomfort. Recommend decrease enteral feeding to 75 ml Glucerna 1.2/hr continuous from 6 pm - 6 am and Flush with 100 ml H20 q 4 hr. (1080 kilocalorie (kcal), 68-gram (gm) protein, 1321 ml H20). Bolus 237 ml Glucerna 1.2 after meals if by mouth (p.o). intake is <50%. Provide double portion meat each meal. Provide 60 ml Sugar Free Ready Care three times daily (TID) with (w)/ Med Pass. Provide 30 ml liquid Protein via gastrostomy (g)-tube twice a day (BID). Discontinue (D/C) NPO status in Matrix. R.D. following. R50's Progress Notes, dated 02/11/2025 at 12:57 PM, documented Resident continues on a Regular Mechanical Soft diet with thin liquids and enteral feeding. 75 ml Glucerna 1.2 is infusing/hr x 24 hr with 50 ml H20 Flush q 4 hr. Resident continues treatment for wounds to L stump and coccyx. Resident often will refuse meals reporting he feels too full. He denies any GI discomfort. February weight = 128#, reference weights have been inconsistent the last 6 mo. Current weight indicates a 6.5# loss x 6 mo. BMI = 16.4 (underweight). Resident reports he needs assistance with his meal's due to (d/t) hand contractures. Estimated daily nutrient needs based on low end Ideal Body Weight (IBW) (171#): 2184 kcal, 109 gm protein (1.4 gm/kilogram (kg)), 2340 ml fluid. Resident observed taking fluids well orally. Recommend decrease enteral feeding to 75 ml Glucerna 1.2/hr continuous from 6 pm - 6 am and Flush with 100 ml H20 q 4 hr. (1080 kcal, 68 gm protein, 1321 ml H20). Bolus 237 ml Glucerna 1.2 after meals if p.o. intake is <50%. Provide 90 ml Sugar Free Ready Care TID w/ Med Pass. Provide 30 ml liquid Protein via g-tube BID. D/C NPO status in Matrix. Suggest Resident is taken to Main Dining Room (MDR) for meals where he can receive assistance and encouragement. Survey Team Observations: 03/06/25 at 12:01 PM, R50's Tray is covered and at the bedside. 12:09 PM, R50's Tray at bedside, out of reach covered with aluminum foil. 12:20 PM, R50's tray remains at bedside covered. No staff on hall. 12;34 PM, R50's tray covered with aluminum foil and out of reach. 12:41 PM, R50's tray is still covered with aluminum foil at bedside. No fluids touched either. No staff on hall. On 03/06/25 at 1:00 PM, R50's meal tray was sitting on his over the bed table covered with aluminum foil. On 03/10/25 at 9:55 AM, R50's pinky and ring finger on his right hand were contracted and he was unable to straighten them out. Survey Team Interviews (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 03/06/25 at 12:40 PM, V12, CNA said if she has a resident who is a feeding assist and they don't want to eat then They don't eat if they don't want to eat, we don't feed them. On 03/06/25 at 12:52 PM, V1, Administrator stated she would expect the CNAs to encourage residents to eat but not force them and to offer them something else. On 03/10/25 at 9:55 AM, R50 said he needs assistance with eating his meal due to his fingers being contracted and him being unable to hold the utensils in his hand. He said you seen last week they don't help me with my meal. On 03/10/25 at 12:33 PM, V12, CNA stated that R22's meal tray had only a single serving of each item. She said he used to get double portions with his old diet, but she isn't sure if he is supposed to get them since his diet changed. On 3/10/2025 at 4:00 PM, R31 stated, Snacks are usually left at the nurse's station and anyone that wants one just goes to the nurse's station to get them. There is really nothing for anyone that is diabetic. (R22) lives across the hall from me and they do not deliver him any sandwiches. (R22) is in a wheelchair and they are not delivering him or anyone else any peanut butter and or deli sandwiches. (R22) does not know to go and get the snacks, and nobody is taking him any snacks. On 03/11/25 at 10:15 AM, V23, Licensed Practical Nurse (LPN) stated R50 said she wasn't sure if R50 receives any kind of protein supplement she said she would have to look at his orders and find out. V23 said R50 gets continuous tube feedings. On 03/12/25 at 11:50 AM, V2, Assistant Director of Nursing (ADON) stated the dietitian will go over any recommendations with the dietary manager and any important things she will talk with V1, Administrator and then V1 will report it to her and if she isn't here V1 would report it to the nurses what needed to be done. She said they aren't having any issues with weight loss right now everyone is actually gaining weight. On 3/24/2025 at 11:48 AM, R24 stated at night they have snacks that they leave at the nurse's station, and anyone can go and get a snack at night. They do not bring me a snack or prepare any snacks like deli sandwich or peanut butter sandwiches just for me and or any diabetic residents. My blood sugar has been running between 50-60 so maybe something with protein could help me out. They don't prepare anything like that for me or deliver me anything at night. I have to go and get a snack at the nurse's station and most of the time they run out. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Few	On 03/13/25 at 9:58 AM, V39, Registered Dietitian said regarding R50 the Speech Therapist recommended R50 start to eat by mouth so she made the recommendation to change the tube feeding so he could eat throughout the day. V39 stated she would have recommended R50 start on the liquid protein for a couple of reasons. His albumin could have been low, or he had a wound. V39 then read over her recommendation on R50 and said R50 was started on the liquid protein for a severe wound to his coccyx. She said she recommended the Sugar Free Ready care with meals to be given orally with meds for more nutritional support. V39 was questioned why she made the same recommendations in the month of October 2024 and February 2025 and V39 stated probably because her recommendations weren't started, and the same orders were still in place. V39 stated she gives the recommendations to V1, Administrator. She said she was to send everything to her and then she (V1) would take care of them due to there not being a director of nursing (DON) to give them to. V39 stated she would expect the staff to follow through with her recommendations or to tell her why they didn't. She said she wasn't notified of her recommendations not being followed. V39 said she isn't given a list of residents who need to be seen by the dietitian or notified of any weight loss any of the resident has. V39 said yes of course making sure the monthly weights are getting done is important. She said the restorative aid usually does them if the facility has one if not then an aide does them. She said the facility needs to have a deadline of when the weights need to be done. V39 stated she would consider R22's and R50's weight loss significant. The facility's policy Resident Nutrition Services, revised date 03/2004, documented Each resident shall receive the correct diet, with preferences accommodated as feasible, and shall receive prompt meal service and appropriate feeding assistance. It further documented 7. Nursing personnel should evaluate food and fluid intake in residents with, or at risk for, significant nutritional problems. Nursing staff will assess and document the amounts eaten as indicated for individuals with, or at risk for, impaired nutrition. Significant variations from usual eating or intake patterns must be recorded in the resident's medical record. The nurse supervisor and/or unit manager shall evaluate the significance of such information and report it, as indicated, to the attending physician and clinical dietitian. The facility's policy Weighing and Measuring the resident, revised date 08/2002, documented The purpose of this procedure are to determine the resident's weight and height, to provide a baseline and an ongoing record of the resident's body weight as an indicator of the nutritional status and medical condition of the resident, and provide a baseline height in order to determine the ideal weight of the resident. It further documented 1. Report any significant weight loss/weight gain to the nurse supervisor. 2. Notify the nurse supervisor if the resident refuses the procedure. 3. Report other information in accordance with facility policy and professional standards of practice. The facility's policy Resident Nutrition Services, revised date of March 2004, documented Policy Statement Each resident shall receive the correct diet, with preferences accommodated as feasible, and shall receive prompt meal service and appropriate feeding assistance. It further documented Nursing personnel should evaluate food and fluid intake in residents with, or at risk for, significant nutritional problems. Nursing staff will assess and document the amounts eaten as indicated for individuals with, or at risk for, impaired nutrition. Significant variations from usual eating or intake patterns must be recorded in the resident's medical record. The nurse supervisor and/or unit manager shall evaluate the significance of such information and report it, as indicated, to the attending physician and clinical dietitian. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The Facility's Long-Term Care Facility Application for Medicare and Medicaid (CMS 671) dated 3/7/25 documents there are 73 residents living in the Facility.

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F 0693 Level of Harm - Actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44556 Based on observation, interview, and record review, the facility failed to follow dietitian recommendations to assist a resident in achieving their highest practicable well-being for restoration of oral eating for 1 of 1 (R50) residents reviewed for enteral feedings in a sample of 82. This failure resulted in the facility not implementing R50's preference to eat by mouth, with no individualized plan of care for R50 to restore oral nutritional intake, instead subjecting R50 to requiring extended use of gastrointestinal feedings for nutrition. Findings Include: R50's Face Sheet, admitted [DATE], documented R50 has diagnoses of but not limited to Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits, hypertension (HTN), Type II diabetes mellitus (DM), Hyperosmolality and hypernatremia, and chronic kidney disease. R50's Minimum Data Set (MDS), dated [DATE], documented R50 requires supervision or touching assistance with eating. R50's current Care Plan, with an admitted [DATE], has no documentation regarding nutritional status and the use of an enteral feeding tube. R50's Physician's Orders, with a start date of 06/14/2024, documented the following: Diet: Nothing by Mouth (NPO), special instructions: On Glucerna 1.2 at 75 cubic centimeter (cc)/hour (hr) with 50cc flushes every four hours, dietitian to evaluate as needed for nutritional interventions, Glucerna 1.2 at 75cc hour continuous twice a day 6:00 AM-6:00 PM and 6:00 PM-6:00 AM. No end date noted. R50's Modified Barium swallow evaluation, dated 09/10/24 documented there is no laryngeal penetration (the entry of food, liquid, or other substances into the larynx (voice box) without passing through the vocal cords) or aspiration (breathing in a foreign object for example sucking food into the airway.) R50's Physician's Orders, start date of 10/08/2024, documented the following: Diet- Liquids: Thin, Diet: Mechanical Soft. No end date noted. (continued on next page)

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F 0693 Level of Harm - Actual harm Residents Affected - Few	R50's Progress Notes, dated 11/13/2024 at 10:38 AM, documented Registered Dietitian (R.D.) Note: November weight pending. Regular Mechanical Soft diet with thin liquids continues and 75 milliliter (ml) Glucerna 1.2 is infusing/hr. x 24 hr. with 50 ml water (H20) Flush every (q) 4 hr. Resident continues treatment for multiple wounds: Unstageable wound to left (L) Below the Knee Amputation (BKA), Stage IV pressure ulcer (p.u). to Coccyx, Stage III p.u. to L Knee. Per recent wound report, wounds are improving. Resident denies any gastrointestinal (GI) discomfort. Recommend decrease enteral feeding to 75 ml Glucerna 1.2/hr continuous from 6 pm - 6 am and Flush with 100 ml H20 q 4 hr. (1080 kilocalorie (kcal), 68-gram (gm) protein, 1321 ml H20). Bolus 237 ml Glucerna 1.2 after meals if by mouth (p.o). intake is <50%. Provide double portion meat each meal. Provide 60 ml Sugar Free Ready Care three times daily (TID) with (w)/ Med Pass. Provide 30 ml liquid Protein via gastrostomy (g)-tube twice a day (BID). Discontinue (D/C) NPO status in Matrix. R.D. following. R50's Progress Notes, dated 02/11/2025 at 12:57 PM, documented Resident continues on a Regular Mechanical Soft diet with thin liquids and enteral feeding. 75 ml Glucerna 1.2 is infusing/hr x 24 hr with 50 ml H20 Flush q 4 hr. Resident continues treatment for wounds to L stump and coccyx. Resident often will refuse meals reporting he feels too full. He denies any GI discomfort. February weight = 128#, reference weights have been inconsistent the last 6 mo. Current weight indicates a 6.5# loss x 6 mo. BMI = 16.4 (underweight). Resident reports he needs assistance with his meal's due to (d/t) hand contractures. Estimated daily nutrient needs based on low end Ideal Body Weight (IBW) (171#): 2184 kcal, 109 gm protein (1.4 gm/kilogram (kg)), 2340 ml fluid. Resident observed taking fluids well orally. Recommend decrease enteral feeding to 75 ml Glucerna 1.2/hr continuous from 6 pm - 6 am and Flush with 100 ml H20 q 4 hr. (1080 kcal, 68 gm protein, 1321 ml H20). Bolus 237 ml Glucerna 1.2 after meals if p.o. intake is <50%. Provide 90 ml Sugar Free Ready Care TID w/ Med Pass. Provide 30 ml liquid Protein via g-tube BID. D/C NPO status in Matrix. Suggest Resident is taken to Main Dining Room (MDR) for meals where he can receive assistance and encouragement. Survey Team Observations: 03/06/25 at 12:01 PM, R50's Tray is covered and at the bedside. 12:09 PM, R50's Tray at bedside, out of reach covered with aluminum foil. 12:20 PM, R50's tray remains at bedside covered. No staff on hall. 12:34 PM, R50's tray covered with aluminum foil and out of reach. 12:41 PM, R50's tray is still covered with aluminum foil at bedside. No fluids touched either. No staff on hall. On 03/06/25 at 1:00 PM, R50's meal tray was sitting on his over the bed table covered with aluminum foil. On 03/10/25 at 9:55 AM, R50 is lying in bed with his head elevated and enteral feeding infusing at 75cc/hr. On 03/11/25 at 8:35 AM, R50 is in bed with his head elevated enteral feeding infusing per pump at 75cc/hr. (continued on next page)

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F 0693 Level of Harm - Actual harm Residents Affected - Few	Survey Team Interviews: On 03/10/25 at 9:55 AM, R50 said he needs assistance with eating his meal due to his fingers being contracted and him being unable to hold the utensils in his hand. He said you seen last week they don't help me with my meal. R50's pinky and ring finger on his right hand were contracted and he was unable to straighten them out. On 03/11/25 at 10:15 AM, V23, Licensed Practical Nurse (LPN) stated R50 said she wasn't sure if R50 receives any kind of protein supplement she said she would have to look at his orders and find out. V23 said R50 gets continuous tube feedings. On 03/11/25 at 10:36 AM, R50 is lying in his bed with the head elevated and his feeding infusing at 75cc/hr per the pump. At the time of this interview R50 was alert, oriented and observed as being cognitively intact. R50 said he would much rather eat a meal than get fed through the feeding tube. He said sometimes he doesn't feel like eating because he's full due the tube feeding he recieves. R50 said if they got him up and, in his chair, he could go out to the dining room, and he wouldn't need the feedings. R50 said he needs assistance with eating. On 03/13/25 at 9:58 AM, V39, Registered Dietitian said regarding R50 the Speech Therapist recommended R50 start to eat by mouth so she made the recommendation to change the tube feeding so he could eat throughout the day. V39 stated she would have recommended R50 start on the liquid protein for a couple of reasons. His albumin could have been low, or he had a wound. V39 then read over her recommendation on R50 and said R50 was started on the liquid protein for a severe wound to his coccyx. She said she recommended the Sugar Free Ready care with meals to be given orally with meds for more nutritional support. V39 was questioned why she made the same recommendations in the month of October 2024 and February 2025 and V39 stated probably because her recommendations weren't started, and the same orders were still in place. V39 was asked when she makes recommendations who she gives them to. V39 stated she gives the recommendations to V1, Administrator. She said she was to send everything to her and then she (V1) would take care of them due to there not being a director of nursing (DON) to give them to. V39 stated she would expect the staff to follow through with her recommendations or to tell her why they didn't. She said she wasn't notified of her recommendations not being followed. V39 stated she would consider R50's weight loss significant. Review of an article title Gastrostomy tube feeding in adults: the risks, benefits and alternatives, dated June 10, 2011 and found at https://www.cambridge.org/core/journals/proceedings-of-the-nutrition-society/article/gastrostomy-tube-feeding-in-adults-the-risks-benefits-and-alternatives/6C42C3EBD1FFE5E379D6EE1FDF9F0B38 documented: Use of a gastrostomy tube may also impact on quality of life by removing the patient from social interaction at mealtimes or the close attention they receive during assisted oral feeding. The pleasures of oral feeding may also be denied them if a gastrostomy feed is relied upon to provide all nutritional needs Choosing the best method of nutritional support for an individual patient is often challenging. A thorough understanding of the patient's needs, home circumstances and support alongside knowledge of the risks and benefits of each route of administration of enteral nutrition is paramount in making a good decision. This is usually best achieved by a multidisciplinary team including doctors, nurses, dietitians and, where possible, the patient and their carers. For patients at the end of their lives and particularly patients with dementia, the over-riding principle should be to preserve good quality of life for the patient and avoid any intervention which merely prolongs their death. (continued on next page)

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F 0693 Level of Harm - Actual harm Residents Affected - Few	The facility's policy Resident Nutrition Services, revised date of March 2004, documented Policy Statement Each resident shall receive the correct diet, with preferences accommodated as feasible, and shall receive prompt meal service and appropriate feeding assistance. It further documented Nursing personnel should evaluate food and fluid intake in residents with, or at risk for, significant nutritional problems. Nursing staff will assess and document the amounts eaten as indicated for individuals with, or at risk for, impaired nutrition. Significant variations from usual eating or intake patterns must be recorded in the resident's medical record. The nurse supervisor and/or unit manager shall evaluate the significance of such information and report it, as indicated, to the attending physician and clinical dietitian.

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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** 49494 Based on observation, interview, and record review, the facility failed to ensure adequate pain control for 4 of 4 residents reviewed for pain management in a sample of 81. This failure resulted in R25, R28, R31, and R45 experiencing unnecessary pain and suffering for an extended time. This failure has the potential to affect all 73 residents residing at the facility. Findings Include: 1. R31's face sheet, print date of 3/24/25, documented R31 has diagnoses including polyneuropathy, type 2 diabetes mellitus, spondylosis of cervical region, radiculopathy of lumbar region, lumbago with sciatica, hyperlipidemia, and hypertension. R31's MDS (Minimum Data Set), dated 3/6/25, documented R31 is cognitively intact and requires partial to moderate assistance with transfers to and from wheelchair. R31's care plan, undated, documented R31 has pain related to cellulitis, spondylosis of cervical region, lumbago with sciatica, polyneuropathy, and radiculopathy of lumbar region. Interventions include encourage resident to request pain medication before pain becomes unbearable. On 3/11/2025 at 4:55 PM, V40, Local Police stated, I was here when (R31) was upset because V2, LPN/ADON (Licensed Practical Nurse/Assistant Director of Nursing), was not giving (R31) his medication. (R31) was really upset and I could tell (V2) was not going to give it to him (the medication) until she saw me standing there. (V2) said she was running late on passing on medications, but I believe (R31) that she was refusing to give them then when she saw me, she finally gave him his medication. (R31) was not throwing a fit, or yelling, and was calm. (V2) did tell him she could send him to the hospital, but I am not sure it was a threat more like she was busy and did not want to be bothered with him. On 3/11/2025 at 5:05 PM, R31 stated (V2) is late a lot of times passing out medications. She will go and do other stuff instead of passing medications and sometimes I have diarrhea and need my medicine, and she acts like it's not a big deal if I don't get my medication. I know they want me out of here and they are waiting on an excuse to send me out, so they do not have to take me back. On 3/11/2025 at 5:14 PM, V2 stated, (V1, Administrator) was not here today and I am not sure if she would be returning. Last week she told me they were firing her. I heard she was not coming back. Things are crazy and I am only one person. I am late passing out medications and on top of that I had to deal with the police and (R31). I just can't do all of this stuff on my own. I am over two hours late with passing the medication but what am I supposed to do? We still do not have a Director of Nursing (DON) and now we do not even have an Administrator. I don't know what we are going to do. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 3/17/25 at 2:04 PM R31 stated on 3/11/25 V2 ADON (Assistant Director of Nursing) was assigned to his hall and that V2 is usually in her office rather than at the nurse's station when she is assigned to his unit. R31 stated shortly after lunch on 3/11/25 he went to V2's office and requested a pain pill and an anti-diarrheal pill. R31 stated V2 replied to him to go back to his room, and she would bring it to him. R31 stated he waited for 1 hour and V2 still had not brought him the medications he requested so he went back up to V2's office and told her again that he needed his pain and anti-diarrheal medications. R31 stated V2 replied to him she had went to his room and he wasn't there. R31 stated he told V2 she was lying because he had been sitting at the nurse's station the entire time and he would have seen her if she had gone to his room. R31 stated he then told V2 to get off her a_ _ and to give him his pain meds now because he was hurting. R31 stated a half hour later V2 was at the nurse's station and was helping other residents. R31 stated he then told V2 to give him his god d_ _ _ pain meds and that V2 replied you're not getting anything with that attitude. R31 stated V2 then informed him you're not getting anything until you apologize. R31 stated another 2 1/2 hours went by and he called 911 because he was in so much pain. R31 stated he rated his pain at a level of 9 by this time and he has chronic pain everywhere, but it was extremely bad in his back and shoulders on this day. R31 stated V2 has a history of being late with administering medications. On 3/18/25 at 12:25 PM V2, ADON, stated she did give R31 a pain pill and an Imodium on 3/11/25. V2 stated she does not recall how much time went by from when R31 first requested the medications to when he received them, stated maybe 30 minutes. V2 stated she did give R31 the medications he requested in front of the first responders. On 3/24/25 at 9:40 AM R14, (Resident Council President), stated he did witness V2 tell R31 you're not getting any pain meds until you apologize. R14 stated V2 refused his meds until the police came, this was on 3/11/25. On 3/24/25 at 9:57 AM V2, ADON, stated she did not document the pain pill nor the Imodium she administered to R31 on 3/11/25. Stated she thought she charted it in the progress notes. R31's MAR (Medication Administration Record), dated 3/1/25 - 3/13/25, documented an order for hydrocodone-acetaminophen 5-325 mg 1 tablet every 6 hours PRN (as needed). The only time this medication is documented as administered on 3/11/25 was at 5:43 AM. This MAR also documented an order for loperamide 2 mg 1 tab every 6 hours PRN. This MAR does not document any it was administered at any time on 3/11/25. R31's EMR, (Electronic Medical Record), progress notes do not document any notes by V2 on 3/11/25. R31's progress notes, dated 3/11/25 at 4:19 PM, authored by V15, Social Service Director, documented resident at nurse's station yelling and cursing at the nurse. Resident stated to the nurse to do your f_ _ _ _ _ _ job and give me my medicine. On 3/24/25 at 12:58 PM V15, Social Service Director, stated she did witness R31 at the nurse's station on 3/11/25, and that he was yelling for a pain pill. V15 stated she observed V2 also at the nurse's station, but she does not know if R31 received a pain pill or not at this time. (continued on next page)

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	145858	A. Building B. Wing	03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Au Well Care Home, Inc	152 Wilma Drive Maryville, IL 62062

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F 0697 Level of Harm - Actual harm Residents Affected - Few	2. R25's face sheet, print date of 3/20/25, documented R25 has diagnoses including hidradenitis suppurativa, pain, cerebral infarction due to embolism of basilar artery, type 2 diabetes mellitus, depression, gastro-esophageal reflux disease, benign prostatic hyperplasia, anxiety, hypertension, and cellulitis. R25's MDS, dated [DATE], documented R25 is cognitively intact. R25's care plan, undated, documented R25 is at risk for pain related to some impaired mobility and diagnoses of hidradenitis suppurativa, CVA (cerebral vascular accident), and diabetes mellitus. Interventions include administer pain meds as ordered. On 3/6/25 at 9:00 AM surveyor was at the [NAME] unit nurse's station and heard R25 state where is the nurse, my pain is at a 10. I need pain meds now. My back and thighs hurt. On 3/6/25 at 9:03 AM V25, CEO (Chief Executive Officer) stated we are working on getting a nurse for this side. I have a call out to an agency. R25's MAR, dated 3/1/25 - 3/20/25, documented R25 has an order for morphine tablet extended release 60 mg twice a day at 8 AM and 8 PM. R25's MAR does not document the 8 AM morphine was administered on 3/6/25. On 3/24/25 at 9:45 AM R25 stated he went to the hospital on 3/6/25 because his pain was out of control due to his diagnosis of hidradenitis suppurativa. R25 stated I have been here for 3 months, and I have not seen my primary doctor, V3, since I was admitted here. I don't even know what the man looks like. He cut my pain meds down without even seeing me. I am still having issues getting my pain meds. Last week I didn't get my morphine that is scheduled at 2 PM until almost 5 PM and I heard my nurse V4 tell the kitchen guy I am going to make him wait because he is always asking for pain meds. R25's EMR progress notes do not document anything about R25's uncontrolled pain, nor that he was admitted to the hospital on 3/6/25. R25's EMR does not document any progress notes between 2/28/25 through 3/11/25. R25's progress notes, dated 3/12/25 at 9:23 PM, documented resident returned to facility via ambulance at 8:55 PM. ABT (antibiotic) and new orders upon return. R25's regional hospital records, dated 3/6/25 -3/12/25, documented R25 is male with PMH (past medical history) with diagnoses of diabetes mellitus and hidradenitis suppurative who presented for worsening buttock pain. R25's EMR documented R25 was admitted to the facility on [DATE]. R25's EMR does not have any physician progress notes documented by V3 since R25's admission when reviewed on 3/24/25. On 3/19/25 at 8:45 AM R25 approached surveyor and stated V4 LPN (Licensed Practical Nurse) went back to her regular crap of making me wait on pain meds after you got done watching her do med pass yesterday. R25 stated I asked her for a pain pill, and I had to wait from 3 PM until 5 PM until I received it. My pain level was at a 10 plus when I finally received it. I overheard V4 say to a kitchen employee who she is friends with that she was going to make me wait because I am always asking for pain meds. This makes me feel like I am not being heard. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	R25's MAR, dated 3/1/25 - 3/20/25, documented an order for morphine tablet extended release 30 mg scheduled at 2:00 PM daily. On 3/18/25 at 4:34 PM V4 documented at 4:34 PM late administration, charted late, comment given on time. On 3/24/25 at 9:40 AM R14, (Resident Council President), stated he did witness V4 say to a kitchen guy that R25 is always asking for pain meds so he is going to have to wait. R14 stated he witnessed V4 give R25 a pain pill about 5 PM on 3/18/25. On 3/24/25 at 12:50 PM at V11, Regional MDS Consultant, stated the nurses are supposed to document medication administration as soon as they administer the residents' meds and if it was signed out late then it is administered late. 3. On 3/6/25 at 9:03 AM surveyor was at the [NAME] unit nurse's station and observed there was no nurse assigned on this unit. V25, Regional Chief Executive Officer, stated to this surveyor we are working on getting a nurse for this side, V3 (MD, Owner, Medical Director) worked the night shift at the hospital last night so he is not coming in. I have a call out to an agency. I will have the other nurse pass medications when she gets done on the other side of the building. On 10:19 AM V23 LPN (Licensed Practical Nurse) was observed pushing her medication cart over to the [NAME] side unit and began administering medications. V23 stated I try to be a team player, but this is too much. These meds were due at 8 AM. R28's face sheet, print date of 3/18/25, documented R28 has diagnoses including traumatic subdural hemorrhage, epilepsy, anxiety, hypertension, asthma, dementia, cognitive communication deficit, and bipolar disorder. R28's MDS dated [DATE], documented R28 is severely cognitively impaired, requires moderate assistance with ADLS (activities of daily living), and substantial to maximum assistance with transfers to and from his wheelchair. R28's care plan, undated, documented R28 has a seizure disorder due to epilepsy, R28 to take medications as ordered by my md (medical doctor). Interventions include take medications as ordered by MD, obtain, and monitor lab/diagnostic work as ordered and report results to my physician. R28's care plan also documented I have potential for pain/discomfort related to laceration without foreign body, right lower leg, sequela, epilepsy, umbilical hernia, contusion of right lower leg, and TBI (traumatic brain interventions). Interventions include I prefer to have pain controlled by medication as ordered by my MD. On 3/6/25 at 9:27 AM R28 was sitting in his wheelchair by the [NAME] unit nurse's station and R28 stated to V26 CNA, (Certified Nurse Assistant), I need a pain pill, my back hurts. V26 stated to R28 there is no nurse over here this morning to pass pills. R28 was moaning and grimacing in pain. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	R28's MAR, dated 3/1/25 - 3/10/25, documented R28 has a physician order for hydrocodone-acetaminophen 5-325 mg; 1 tablet every 6 hours scheduled at 12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM. R28's MAR documented scheduled date 3/6/25, scheduled time 6:00 AM, charted date/time 3/6/25 at 10:29 AM by V23 LPN (Licensed Practical Nurse), reasons/comments: late administration/charted late. The 12:00 PM dose has a charted date/time of 3/6/25 at 1:42 PM, late administration/charted late. Surveyor was present and V23 did not start administering medications on the [NAME] unit 10:15 AM. On 3/19/25 at 9:02 AM V23 LPN stated she did not administer R28's pain medicine until 10:29 AM and 1:42 PM on 3/6/25. 4. R45's face sheet, print date of 3/11/24, documented R45 has diagnoses including osteoarthritis, type 2 diabetes mellitus with diabetic neuropathy, bipolar disorder, major depressive disorder severe with psychotic symptoms, generalized anxiety disorder, hypertension, chronic embolism, and thrombosis of deep veins of lower extremity, adult failure to thrive, and personal history of suicidal behavior. R45's MDS, dated [DATE], documented R45 is cognitively intact and requires supervision or touch assistance with all ADLS (activities of daily living). R45's care plan, undated, documented R45 is at risk for pain related to some impaired mobility and diagnoses of osteoarthritis, diabetes mellitus, and neuropathy. Interventions in administer pain meds and treatments as ordered, assess effectiveness of pain medication, encourage to report any pain, monitor for non-verbal indicators of pain, and assess pain characteristics: duration, location, quality. On 3/6/25 at 9:47 AM R45 stated to surveyor we still don't have a nurse; my back pain is at a 9. I need a nurse to look at my finger, it looks worse. I didn't get all my meds yesterday. R45's MAR, dated 3/1/25 - 3/20/25, documented R45 has physician orders including acetaminophen 500 MG every 4 hours PRN (as needed) and oxycodone 7.5 - 325 mg tab four times a day PRN. This MAR does not document either of these medications were administered on 3/6/25. This MAR documented R45 rated her pain at a 9 on 3/7/25 at 12:06 AM. On 3/24/25 at 12:50 PM V11, Regional MDS Consultant, stated the nurses are expected to administer PRN pain medications as soon as a resident requests them. On 3/24/25 at 12:55 PM V2, ADON, stated the EMR MAR system automatically documents medication late when it goes over the time frame for that medication to be administered. V2 stated the nurses are supposed to be signing each residents meds off as they administer them so they should not be charted late. V2 stated meds are considered administered late if they are signed off after the administration time. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	The facility's Administering Pain Medications Policy, dated 9/2003, documented the purpose of this procedure is to provide guidelines for assessing the resident's level of pain prior to administering non-narcotic or narcotic analgesics. It continues, General Guidelines: 1. The resident's experience of pain is highly individual and subjective. Pain is whatever the resident says it is. 2. Intense pain can result from even minor procedures or surgery. 3. Residents are not at risk for addiction to narcotic analgesics if used as prescribed for moderate to severe pain. 4. Be familiar with the physiologic and behavioral signs of pain. 5. Residents may be reluctant to report pain due to the belief that pain is a normal part of the aging process or because of a reluctance to bother busy staff members. 6. Acute pain should be assessed every 30 to 60 minutes after the onset and reassessed as indicated after analgesic relief is obtained. 7. The pain assessment consists of gathering both subjective and objective data. Steps in the Procedure: 1. Provide for resident privacy. 2. Explain the purpose of the assessment to the resident. 3. Obtain subjective information from the resident: a. Location, b. Pain Intensity, c. Pain Quality, d. Onset and Duration, e. Aggravating factors, f. Alleviating factors, g. Accompanying symptoms. 4. Obtain objective information through assessment: a. Behavioral responses to pain; 1. Facial wrinkling/grimacing; 2. Tightly closed or widely opened and blinking eyes; 3. Crying or moaning; 4. Aggression, hitting, or biting; 5. Increase in body movements; 6. Guarding; 7. Decreased interaction; 8. Need for more rest; and/or 9. Irritability/mental confusion. B. Physiologic responses to pain; 1. Increased blood pressure; 2. Tachycardia; 3. Increased respirations; 4. Diaphoresis; and/or 5. Pupil dilation. It continues, 6. Administer pain medications as ordered. Documentation: the following information should be recorded in the resident's medical record: 1. Subjective evidence of pain. 2. Objective evidence of pain. 3. Condition of the pain site, if appropriate. 4. The drug name, dose, time, date, and route of administration. 5. The resident's response to the medication. 6. The name and title of the individual assessing the resident for pain and administering the medication.

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F 0710 Level of Harm - Actual harm Residents Affected - Some	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49494 Based on record review and interview the facility failed to ensure medical supervision by a physician for 4 of 4 residents (R25, R28, R30, R45) reviewed for physician visits in a sample of 82. This failure resulted in: R45 requiring emergency medical treatment following a series of falls with progressive injuries; R30 requiring emergency medical treatment following a series of falls with progressive injuries; R25 experiencing multiple hospitalization s for uncontrolled pain and infection; and R28 experiencing multiple falls as well as a grand mal seizure event requiring emergency medical treatment. This failure has the potential to affect all 73 residents of the facility. Findings Include: 1.R45's face sheet, print date of 3/11/24, documented R45 was admitted to the facility on [DATE] with diagnoses including osteoarthritis, type 2 diabetes mellitus with diabetic neuropathy, bipolar disorder, major depressive disorder severe with psychotic symptoms, generalized anxiety disorder, hypertension, chronic embolism, and thrombosis of deep veins of lower extremity, adult failure to thrive, and personal history of suicidal behavior. R45's Preadmission Screening and Resident Review document, dated 1/9/25, documented R45 has been diagnosed with bipolar disorder with difficulty concentrating, easily angered, feelings of worthlessness, moods go from one extreme to another, tearful, trouble sleeping, anxious thoughts, and seeing or hearing things that others do not see or hear. It continues, R45 falls into the category of having a diagnosis that the PASRR (Preadmission Screening and Resident Review) was designed to assess. Your condition is likely to require expert treatment in the future. That diagnosis is: a serious mental health condition. Your care needs are appropriate to be serviced in any nursing facility setting. You are in need of a nursing home because: you need help with bathing, grooming, dressing, transfers, using the restroom, medication management and other tasks. You are diagnosed with bipolar disorder which significantly impacts your daily life. You may benefit from medication management and psychiatric support. R45's MDS, dated [DATE], documented R45 is cognitively intact and requires supervision or touch assistance with all ADLS (activities of daily living). R45's care plan, undated, documented R45 requires healthcare monitoring related to diagnoses of hypertension, DVT (deep vein thrombosis), diabetes mellitus, hyperlipidemia, and bipolar disorder. R45's progress notes documented R45 sustained a fall at the facility on 2/1/25, experienced nausea and vomiting symptoms on 2/18/25, sustained a fall during an altercation with another resident on 2/22/25, sustained a fall with injuries that required emergency medical treatment on 2/25/25, experienced lethargy and a fall on 3/1/25 that required emergency medical treatment at the local emergency room , and R45 was treated at the local emergency roiagnom on [DATE] after an altercation with a facility CNA (Certified Nurse Assistant). R45 sustained facial lacerations, a black eye, and a laceration on her finger from a human bite requiring antibiotics from this altercation. (continued on next page)

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F 0710 Level of Harm - Actual harm Residents Affected - Some	R45's local hospital emergency room progress notes, dated 2/25/25, documented R45 was seen for a fall. Patient instructions include fall prevention education, and to follow up with her primary care provider in the next 2-3 days. R45's local hospital ER progress notes and discharge instructions, dated 3/1/25, documented R45 was seen for fall from ground level, head injury. R45's discharge instructions documented fall prevention education and for R45 to be seen by her primary physician within 3-5 days. R45's was transferred to another facility on 3/7/25. R45's EMR, (electronic medical record), does not document any physician visits by V3, R45's primary physician, during her stay at the facility from 1/9/25 - 3/7/25. On 3/24/25 at 3:32 PM V11, Regional MDS Consultant, confirmed to surveyor that R45 was not seen by her physician V3 during her stay at the facility. 2. R30's face sheet, print date of 3/3/25, documented R30 was admitted to the facility on [DATE] with diagnoses of schizophrenia, anxiety, benign prostatic hyperplasia, adult failure to thrive, cholecystitis, abnormal levels of other serum enzymes, bacteremia, depression, dementia, mood disorder, sepsis, anemia, unspecified protein-calorie malnutrition, and hyperlipidemia. R30's EMR progress notes documented R30 sustained falls on 11/18/24, 11/24/24, and 11/29/24. R30's progress note, dated 12/3/24 at 1:12 AM, documented R30 sustained a bloody nose from another resident during an altercation. R30's progress note, dated 1/9/25 at 11:39 PM, documented R30 experienced vomiting and then fell in the shower and sustained a laceration to his head resulting in R30 being sent to the local ER via EMS. R30's progress note, dated 1/24/25 at 8:52 PM, documented R30 was hit in the face by another resident causing R30 to develop a bloody nose and a black eye. R30's progress note, dated 1/26/25 at 5:45 PM, documented R30 was diagnosed with a trochanter fracture after being sent to the local ER for uncontrolled pain and lethargy. R30's progress note, dated 2/12/25 at 10:02 AM, documented R30 was experiencing emesis and diarrhea. The facility's Serious Injury Incident and Communicable Disease Report dated 2/25/25 at 12:45 PM documented R30 was punched in the face by another resident resulting in R30 sustaining a bruise to the right side of his face. R30's progress note dated 3/7/25 at 1:24 PM documented R30 was discharged to another facility. R30's progress notes documented 1 physician visit, dated 10/27/24 and recorded as late entry on 12/17/24, during his stay at this facility from 10/22/24 - 3/7/25. On 3/24/25 at 3:32 PM V11, Regional MDS Consultant, confirmed to surveyor that R30 was seen only 1 time by his primary physician, V3, during his stay at the facility. 3. R25's face sheet, print date of 3/20/25, documented R25 has diagnoses including hidradenitis suppurativa, pain, cerebral infarction due to embolism of basilar artery, type 2 diabetes mellitus, depression, gastro-esophageal reflux disease, benign prostatic hyperplasia, anxiety, hypertension, and cellulitis. R25's MDS, dated [DATE], documented R25 is cognitively intact. R25's care plan, undated, documented R25 is at risk for pain related to some impaired mobility and diagnoses of hidradenitis suppurativa, CVA (cerebral vascular accident), and diabetes mellitus. Interventions include administer pain meds as ordered. (continued on next page)

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F 0710 Level of Harm - Actual harm Residents Affected - Some	On 3/24/25 at 9:45 AM R25 stated he went to the hospital on 3/6/25 because his pain was out of control due to his diagnosis of hidradenitis suppurativa. R25 stated I have been here for 3 months, and I have not seen my primary doctor, V3, since I was admitted here. I don't even know what the man looks like. He cut my pain meds down without even seeing me. I am still having issues getting my pain meds. R25's, EMR progress note, dated 12/30/24 at 5:30 PM, documented R25 was admitted to the facility via stretcher and that R25 has large areas of boils to buttocks and bilateral groin area. R25's progress note, dated 1/3/25 at 5:39 PM, documented R30 was experiencing pain and refused to have his dressings changed due to the pain. R25's progress note, dated 1/19/25 at 6:16 PM, documented R25 has abscess to posterior upper thigh. MD was notified and resident received new orders for Keflex 500 mg po (by mouth) bid (2 times per day) for 7 days. R25's progress note, dated 1/21/25 at 5:29 PM, resident complaining of increased pain due to hidradenitis diagnosis. New areas to groin and thighs noted. Resident states in increased pain and foul-smelling drainage noted. Resident given PRN (as needed) pain medication with no resolve. Resident requesting to be seen at hospital. R25's progress note, dated 1/21/25 at 5:44 PM, documented EMS arrived and resident enroute to local hospital via ambulance and stretcher. R25's progress note, dated 1/28/25 at 4:50 PM, documented R25 was readmitted to the facility. R25's progress note, dated 2/1/25 at 2:27 PM, documented resident had c/o pain r/t abscesses on resident's posterior thigh, coccyx, and groin. PRN oxycodone was given resident still had c/o pain and requested to be sent to regional hospital. EMS (Emergency Medical Services) was called and resident was transported to regional hospital for evaluation. R25's progress note, dated 2/2/25 at 12:13 PM, documented resident was admitted to regional hospital with a diagnosis of pain management. R25's progress note, dated 2/14/25 at 6:20 PM, documented resident readmitted to facility from regional hospital. R25's progress note, dated 2/16/25 at 5:43 PM, documented R25 slipped and fell in the shower room and bumped his head. It continues, resident had increased pain to his right foot and stated that he thinks its broken. MD was notified of incident, and resident received a new order for a x-ray to right foot. R25's EMR progress notes do not document anything about R25's uncontrolled pain, nor that he was admitted to the hospital on 3/6/25. R25's EMR does not document any progress notes between 2/28/25 through 3/11/25. R25's progress notes, dated 3/12/25 at 9:23 PM, documented resident returned to facility via ambulance at 8:55 PM. ABT (antibiotic) and new orders upon return. R25's progress notes do not document anything regarding resident being admitted to the hospital prior to this hospitalization . R25's regional hospital records, dated 3/6/25 -3/12/25, documented R25 is male with PMH (past medical history) with diagnoses of diabetes mellitus and hidradenitis suppurative who presented for worsening buttock pain. On 3/24/25 at 3:32 PM V11 confirmed R25 has not been seen by his primary physician, V3, since he was admitted to the facility on [DATE]. 4. R28's face sheet, print date of 3/18/25, documented R28 has diagnoses including traumatic subdural hemorrhage, epilepsy, anxiety, hypertension, asthma, dementia, cognitive communication deficit, and bipolar disorder. R28's MDS (Minimum Data Set), dated 12/18/25, documented R28 is severely cognitively impaired, requires moderate assistance with ADLS (activities of daily living), and substantial to maximum assistance with transfers to and from his wheelchair. (continued on next page)

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F 0710 Level of Harm - Actual harm Residents Affected - Some	R28's EMR documented 1 physician visit between 11/1/24 - 3/24/25. R28's last documented physician visit by V3 was documented 11/27/24 and recorded as late entry on 12/21/24. R28's EMR does not document any Nurse Practitioner visits during this time. Despite yearly Keppra laboratory values being ordered, the last lab value available for review was from 11/2023. R28's EMR progress note, dated 1/9/25 at 1:43 PM, documented R28 sustained a fall with injuries and was treated at the local ER. R28's progress note, dated 1/12/25 at 2:30 AM, documented R28 sustained a fall with injuries. R28's progress note, dated 1/27/25 at 11:00 PM, documented R28 sustained a fall and hit his head on the way down. R28's event report, dated 2/18/25 at 11:25 AM, documented R28 sustained a fall with injuries. R28's event report, dated 3/7/25 at 10:02 AM, documented R28 developed grand mal seizures and a fall with injuries resulting in R28 being transferred to the local emergency room for further treatment. R28's event report, dated 3/24/25 at 1:14 PM, documented R28 sustained a fall with head injuries. On 3/24/25 at 3:32 PM V11, Regional MDS Consultant, confirmed to surveyor that R28 was seen only 1 time by his primary physician, V3, between the dates of 11/1/24 - 3/24/25. On 3/24/25 at 3:32 PM V11 confirmed R25 has not been seen by his primary physician, V3, since he was admitted to the facility on [DATE]. On 3/24/25 at 11:58 AM V3, primary physician for all residents of the facility, stated I round at the facility all the time. My goal is to see each resident every 60 days during the first 90 days of admission and at least every 60 days thereafter. That is what I have been told are the regulations. I document all of my visits in the facility's EMR progress notes, they should be there. If any are missing let me know. On 3/24/25 at 3:32 PM V11 stated to surveyor you don't even want to hear this; you are correct about the missing physician progress notes by V3. We have no physician progress notes for R45 from her entire stay, no progress notes for R25 since he has been here, R30's last physician progress note was in October of 2024, and R28 does not have any physician progress notes since November of 2024. Surveyor asked V11 if this means these residents were not seen by their primary physician V3 since there is no documentation in the facility EMR and V11 stated that is correct, we will have to educate him about this. Surveyor asked if V3 is the primary physician for all 73 residents of the facility and V11 stated yes. The facility's Physician Services policy, dated 3/2004, documented the medical care of each resident is under the supervision of a licensed physician. 1. The resident's attending physician participates in the resident's assessment and care plan, monitoring changes in resident's medical status, and providing consultation or treatment when called by the facility. 2. The resident's attending physician is responsible for prescribing new therapy, ordering a transfer to the hospital, conducting required routine visits, delegating and supervising follow-up visits from nurse practitioners or physician assistants, etc. to ensure that the resident receives quality care and medical treatments. 3. Physician orders and progress notes shall be maintained in accordance with current OBRA (Omnibus Budget Reconciliation Act) regulations and facility policy. 4. Physician visits, frequency of visits, emergency care of residents, etc. are provided in accordance with current OBRA regulations and facility policy.

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	145858	A. Building B. Wing	03/25/2025

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Au Well Care Home, Inc	152 Wilma Drive Maryville, IL 62062

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49494 Based on record review and interview the facility failed to ensure physician visits were conducted every 30 days for the first 90 days after admission, at least once every 60 days thereafter, and conduct follow-up visits as directed on local hospital emergency room discharge orders for 4 of 4 residents (R25, R28, R30, R45) reviewed for physician visits in a sample of 82. This failure has the potential to affect all 73 residents of the facility. Findings Include: 1.R45's face sheet, print date of 3/11/24, documented R45 was admitted to the facility on [DATE] with diagnoses including osteoarthritis, type 2 diabetes mellitus with diabetic neuropathy, bipolar disorder, major depressive disorder severe with psychotic symptoms, generalized anxiety disorder, hypertension, chronic embolism, and thrombosis of deep veins of lower extremity, adult failure to thrive, and personal history of suicidal behavior. R45's Preadmission Screening and Resident Review document, dated 1/9/25, documented R45 has been diagnosed with bipolar disorder with difficulty concentrating, easily angered, feelings of worthlessness, moods go from one extreme to another, tearful, trouble sleeping, anxious thoughts, and seeing or hearing things that others do not see or hear. It continues, R45 falls into the category of having a diagnosis that the PASRR (Preadmission Screening and Resident Review) was designed to assess. Your condition is likely to require expert treatment in the future. That diagnosis is: a serious mental health condition. Your care needs are appropriate to be serviced in any nursing facility setting. You are in need of a nursing home because: you need help with bathing, grooming, dressing, transfers, using the restroom, medication management and other tasks. You are diagnosed with bipolar disorder which significantly impacts your daily life. You may benefit from medication management and psychiatric support. R45's MDS, dated [DATE], documented R45 is cognitively intact and requires supervision or touch assistance with all ADLS (activities of daily living). R45's care plan, undated, documented R45 requires healthcare monitoring related to diagnoses of hypertension, DVT (deep vein thrombosis), diabetes mellitus, hyperlipidemia, and bipolar disorder. R45's local hospital emergency room progress notes, dated 3/1/25, documented R45 was seen for fall from ground level, head injury. R45's discharge instructions documented fall prevention education and for R45 to be seen by her primary physician within 3-5 days. R45's was transferred to another facility on 3/7/25. R45's EMR, (electronic medical record), does not document any physician visits by V3, R45's primary physician, during her stay at the facility from 1/9/25 - 3/7/25. On 3/24/25 at 3:32 PM V11, Regional MDS Consultant, confirmed to surveyor that R45 was not seen by her physician V3 during her stay at the facility. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. R30's face sheet, print date of 3/3/25, documented R30 was admitted to the facility on [DATE] with diagnoses of schizophrenia, anxiety, benign prostatic hyperplasia, adult failure to thrive, cholecystitis, abnormal levels of other serum enzymes, bacteremia, depression, dementia, mood disorder, sepsis, anemia, unspecified protein-calorie malnutrition, and hyperlipidemia. R30's progress note dated 3/7/25 at 1:24 PM documented R30 was discharged to another facility. R30's progress notes documented 1 physician visit, dated 10/27/24 and recorded as late entry on 12/17/24, during his stay at this facility from 10/22/24 - 3/7/25. On 3/24/25 at 3:32 PM V11, Regional MDS Consultant, confirmed to surveyor that R30 was seen only 1 time by his primary physician, V3, during his stay at the facility. 3. R25's face sheet, print date of 3/20/25, documented R25 has diagnoses including hidradenitis suppurativa, pain, cerebral infarction due to embolism of basilar artery, type 2 diabetes mellitus, depression, gastro-esophageal reflux disease, benign prostatic hyperplasia, anxiety, hypertension, and cellulitis. R25's MDS, dated [DATE], documented R25 is cognitively intact. R25's care plan, undated, documented R25 is at risk for pain related to some impaired mobility and diagnoses of hidradenitis suppurativa, CVA (cerebral vascular accident), and diabetes mellitus. Interventions include administer pain meds as ordered. On 3/24/25 at 9:45 AM R25 stated he went to the hospital on 3/6/25 because his pain was out of control due to his diagnosis of hidradenitis suppurativa. R25 stated I have been here for 3 months, and I have not seen my primary doctor, V3, since I was admitted here. I don't even know what the man looks like. He cut my pain meds down without even seeing me. I am still having issues getting my pain meds. On 3/24/25 at 3:32 PM V11 confirmed R25 has not been seen by his primary physician, V3, since he was admitted to the facility on [DATE]. 4. R28's face sheet, print date of 3/18/25, documented R28 has diagnoses including traumatic subdural hemorrhage, epilepsy, anxiety, hypertension, asthma, dementia, cognitive communication deficit, and bipolar disorder. R28's MDS (Minimum Data Set), dated 12/18/25, documented R28 is severely cognitively impaired, requires moderate assistance with ADLS (activities of daily living), and substantial to maximum assistance with transfers to and from his wheelchair. R28's EMR documented 1 physician visit between 11/1/24 - 3/24/25. R28's last documented physician visit by V3 was documented 11/27/24 and recorded as late entry on 12/21/24. R28's EMR does not document any Nurse Practitioner visits during this time. On 3/24/25 at 3:32 PM V11, Regional MDS Consultant, confirmed to surveyor that R28 was seen only 1 time by his primary physician, V3, between the dates of 11/1/24 - 3/24/25. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/24/25 at 3:32 PM V11 confirmed R25 has not been seen by his primary physician, V3, since he was admitted to the facility on [DATE]. On 3/24/25 at 11:58 AM V3, primary physician for all residents of the facility, stated I round at the facility all the time. My goal is to see each resident every 60 days during the first 90 days of admission and at least every 60 days thereafter. That is what I have been told are the regulations. I document all of my visits in the facility's EMR progress notes, they should be there. If any are missing let me know. On 3/24/25 at 3:32 PM V11 stated to surveyor you don't even want to hear this; you are correct about the missing physician progress notes by V3. We have no physician progress notes for R45 from her entire stay, no progress notes for R25 since he has been here, R30's last physician progress note was in October of 2024, and R28 does not have any physician progress notes since November of 2024. Surveyor asked V11 if this means these residents were not seen by their primary physician V3 since there is no documentation in the facility EMR and V11 stated that is correct, we will have to educate him about this. Surveyor asked if V3 is the primary physician for all 73 residents of the facility and V11 stated yes. The facility's Physician Services policy, dated 3/2004, documented the medical care of each resident is under the supervision of a licensed physician. 1. The resident's attending physician participates in the resident's assessment and care plan, monitoring changes in resident's medical status, and providing consultation or treatment when called by the facility. 2. The resident's attending physician is responsible for prescribing new therapy, ordering a transfer to the hospital, conducting required routine visits, delegating and supervising follow-up visits from nurse practitioners or physician assistants, etc. to ensure that the resident receives quality care and medical treatments. 3. Physician orders and progress notes shall be maintained in accordance with current OBRA (Omnibus Budget Reconciliation Act) regulations and facility policy. 4. Physician visits, frequency of visits, emergency care of residents, etc. are provided in accordance with current OBRA regulations and facility policy.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 35156 Based on observation, interview and record review, the facility failed to ensure a Registered Nurse (RN) and Director of Nursing (DON) was working in the facility. This failure has the potential to affect all 73 residents living in the facility. Findings include: On 3/4/2025 at 8:32 AM, V1, Administrator stated, We have one Registered Nurse (RN) her name is (V34, RN). We still have not hired a fulltime DON (Director of Nursing). At this time, (V3), Medical Director/ Owner does not want to use agency nurses. We do not have a full time DON and (V34) works but she does not work every day. We do not have RN coverage. We do not have a Facility Assessment. On 3/11/2025 at 2:01 PM, All Registered Nurses (RN) timecards were reviewed from 2/27/2025 to 3/11/2025 and does not document any RN working in the facility for 8 consecutive hours, seven days a week. On 3/4/2025 at 8:49 AM, V5, Licensed Practical Nurse stated they did not have a DON and/or a RN working every day in the facility. From 3/4/2025 to 3/22/2025 there was no DON observed working in the Faciltiy. On 3/11/2025 at 5:14 PM, V2 stated, Things are crazy and I am only one person. I am late passing out medications and on top of that I had to deal with the police and (R4). I just can't do all of this stuff on my own. I am over two hours late with passing the medication but what am I supposed to do? We still do not have a Director of Nursing (DON) and now we do not even have an Administrator. On 3/25/2025 at 12:33 PM, V34 stated, I am the only RN in the whole building. I have two twins at home and I only work a few days here and there. There are no other RN's in the entire building only me. We do not have a Director of Nursing and have not had one for a long time. R34's timecard from 2/27/2025 to 3/10/2024 documents she only worked one day 3/9/2025 and she worked 6:39 AM to 10:30 AM, (Four hours) clocked out and then resumed from 11:09 AM, to 6:28 PM, for a total of 7. 32 hours. This was the only day R34 was documented as working. No Facility Assessment was available to reivew. On 3/4/2025 at 4:30 PM, V1 stated there was no policy on RN and or DON coverage. The Facility's Long-Term Care Facility Application for Medicare and Medicaid (CMS 671) dated 3/7/25 documents there are 73 residents living in the Facility.

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35156 Based on observation, interview and record review, the facility failed to provide behavioral health service for residents with mental illness, and to maintain/improve resident's psychosocial well-being. This failure has the potential to affect all 73 residents residing in the facility. The Immediate Jeopardy began on 12/20/2024 when R4 began exhibiting self injurious behaviors of banging her head. On 3/18/2025 at 1:59 PM, V25, Regional/CEO Marketing and V57, Unknown Helper later Regional Director of Operations (RDO) were notified of the Immediate Jeopardy. The surveyor confirmed through observation, interview, and record review, the Immediate Jeopardy was not removed at the time of the exit. Findings include: R55's Face Sheet documents the resident was admitted to the facility on [DATE]. R55's Physician Order Sheet (POS) for February 2025 documents a diagnosis of Schizophrenia, unspecified; Hyperlipidemia, unspecified; Other chronic pain; Encounter for prophylactic measures, unspecified; Muscle spasm of back; Essential tremor; Acquired absence of right leg below knee; Essential (primary) hypertension; Other specified depressive episodes; and anxiety disorder. R55's Illinois PASRR (Preadmission Screening and Resident Review) Summary of Findings, dated 5/24/2019 documents R55 has a long history of schizophrenia and inpatient/outpatient services. Patient has multiple previous psychiatric hospitalization , as well as least one hospitalization . The Nursing Facility Placement with a report date of 5/23/2019 documents, Poor judgement placing self or others at risk. Behavioral Level 'high'. The Preadmission Screening dated 5/23/2019 documents, Special Services: Professional observations (MD (Medical doctor/ RN (Registered Nurse), for medication monitoring, adjustment and/or stabilization, Instrumental activities of daily living training/reinforcement, illness self-management, incentive program to improve participation in treatment. R55's Minimum Data Set (MDS) dated [DATE] documents R55 was severely impaired for cognition and is rarely understood. R55 was documented as having hallucinations and delusions. She has verbal behavior symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others) with the behavior of this type occurring daily, Other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) occurring daily. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R55's Care Plan edited date of 1/27/2024 documents with Problem: Abuse/Neglect: (R55) is at risk for abuse and neglect related to DX (diagnosis of) Schizophrenia, anxiety disorder, hyperlipidemia. (R55) requires assistance with ADL's. (Activities of Daily Living). Problem with a start date of 11/15/2023 documents, I frequently yell at staff and make unreasonable demands of the staff for more food and have an increase in weight. Approach with the start date of 5/9/2024 documents: Address my wants and needs in a timely manner. Attempt to anticipate my wants and needs and provide me care as indicated. Encourage me to use my call light when a true need exists. (Resident is severely impaired). Offer me a psychiatric referral and provide me psychiatric services as indicated. Edited 5/10/2024, Provide me with support and reassurance. Problem Start Date 5/2/2022, Category: Psychosocial well-being, I have issues with non-compliance: I refuse to allow staff to provide personal care, I refuse medications at times, I have a history of picking my scabs on (LLE) lower left extremity, I have been known to refuse allowing staff to treat wounds. Edited 8/15/2024. Approach date 5/9/2024, Emphasize on my positive behaviors. Encourage me to verbalize my reasons for non-compliance and provide interventions as indicated. Provide me with positive feedback when I am compliant. Complete behavior tracking per facility protocol related to my non-compliance. Encourage me/my representative to be involved in discussions related to interventions for my non-compliance. Edited 5/10/2024, Provide me with education on my need to comply with care and the negative outcomes that could occur if my non-compliance continues. Edited date of 8/15/2024, I am at risk for declines in cognition and communication due to dx (diagnosis of) schizophrenia. Problem start date 3/2/2020, category Psychosocial well-being: documents, I have behavioral symptoms not directed towards others by self-piercing ears and nostrils and pulling earring out causing trauma. Problem start date 3/3/2020, Category: Psychosocial well-being: I have physically acted out toward others, i.e. hitting, edited 8/15/2024. Approach start date 5/9/2024, Assess whether the behavior endangers the resident and/or others. Intervene if necessary. Avoid over stimulation (e.g., noise, crowding, other physically aggressive residents. Convey an attitude of acceptance toward the resident. If resident has delusions/hallucinations, do not try to reason with or confront resident, offer reassurance. Maintain a calm environment and approach to the resident. R55's Care Plan does not address her isolating herself to her room, the cleanliness of her room and/or her throwing her feces outside of her room. R55's Care Plan was not current and up to date related to her behaviors. R55's Psychiatric Notes document the last time she was seen by the Psychiatrist was 2/21/2024. R55's Medical Records do not document after 2/21/2024 that the Psychiatrist was even contacted regarding her behaviors. On 3/4/2025 at 9:34 AM, V1, Administrator stated, there was no longer a psychiatrist providing services to the residents in the facility for mental health and (R55) had not seen any psychiatrist since 2/21/2024. On 3/4/2025 at 7:50 AM, outside of R55's room there is shredded paper and feces thrown on the ground. R55's room has piles of shredded paper all over the floor of her room with garbage and there is no space that is not covered with trash, cups, magazines, wadded tissue papers, dirty cups, and plates, rocks, and there is an unpleasant smell of garbage in her room. There was a bed linen folded up and put underneath the bathroom door and her dresser was moved against the door. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 3/4/2025 at 7:55 AM, V6, Housekeeping stated, (R55) has a habit of throwing her feces outside in the hallway. She does not like us to come into her room to clean it and I try and wait for her to go smoke so I can grab her stuff and I do the best I can under the circumstances. She gets angry easy and will cuss you out for moving stuff out of her room. We are told to just leave her alone. I have not really had a chance to clean her room and we do the best we can do. Her room is a disaster! I have not been trained on how to deal with someone refusing to have her room clean. I just try and give her space and stay out of her way. On 3/4/2025 at 8:15 AM, R55 would gaze at you with her eyes and then cuss at you then retreat to her room and slam all the doors when asked questions regarding her care. No staff intervened and all staff gave her space. R55 continued to mutter and talk in a loud voice as if talking to someone and slamming doors. R55 was slamming doors and muttering out loud, all day long. On 3/7/2025 at 12:05 AM, V15, Social Service Director stated, I just started working here back in June and/or July. I do not have my certification and I am not currently enrolled in any classes. I am hoping to be the Administrator. (V1), the DON (Director of Nursing) and Administration work as a team to address any issues in the building. V11, Regional MDS is also part of that team. We have a heavy population of residents with behaviors. I am not currently doing any group meetings and we do have several residents that are alcoholics and/or were addicted to drugs. No groups have started yet. I am not doing any behavioral interventions at this time. I do not believe I have been trained specifically for behaviors, but I do work with (Counseling group). We currently do not have a DON working in the facility either. On 3/7/2025 at 12:23 PM, V17, Activity Director stated, I am the bus driver, in charge of medical records and Activity Director. I try and do three to four activities a day. They range from meditation, exercises, things like that. I do not do anything special for residents with behaviors. I have not been trained on how to deal with residents with behaviors. From 3/4/2025 to 3/8/2025 during the day shift from 8:00 AM to 5:00 PM, R55 was not provided any incentive by staff to improve participation in treatment, and/or anything related to her refusing medications. R55 was left to do whatever she wanted to do without staff intervention. On 3/6/2025 at 9:33 AM, V23, Licensed Practical Nurse (LPN) stated, (R55) is not redirectable, refuses medications, throws feces in the hallways. (R30) was moved into this hallway. (R30) is a wanderer, and he does make others mad. I had never seen (R55) and (R30) getting into arguments. (R30) was not anywhere near (R55) and (R55) all of sudden went down the hallway, this was on Valentine's Day, and before I knew what she was doing she grabbed (R30's) legs and flipped him over. I did an assessment on (R30) and he was not injured that I was aware of. On 3/6/2025 at 1:49 PM, V24, Certified Nursing Assistant (CNA) stated, (R55) does what she wants to do. She is in her own world. (R30) was down the hallways and she saw (R30) and even though she has one leg, she can stand up and she went down the hallways and grabbed (R30) who was not doing nothing and flipped him over in his wheelchair. I had never seen them in a quarrel and/or fighting before. I am not sure what set her off but sometimes she just blows up and we don't know why. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R55's Progress Notes with a Late Entry and created date of 2/14/2025 at 11:25 AM, This nurse was sitting at the nurse's station and observed resident sitting in hallway when she began to throw objects at staff. Resident has been refusing medications for over a week. Resident behaviors continued and this resident flipped another resident out of his wheelchair. Resident was separated from that resident and taken back to her room. R55's Initial Report dated 2/11/2025 at 12:00 PM, This is a late report. This writer was made aware of the possible altercation reading a progress note. Resident (R55) allegedly flipped another resident out of their wheelchair. The victim is not known at this time. The allegation will be investigated, and the report will be submitted upon completion. No final report and or interventions were documented for R55. R55 was not being offered psychiatric referrals and or psychiatric services as indicated by her care plan. On 3/7/2025 at 4:30 PM, R55 was asking for some water and holding out a dirty cup. On 3/72025 at 4:31 PM, V24, Certified Nursing Assistant handed her a cup of water and R55 stated she wanted the water poured into her cup. On 3/7/2025 at 4:32 PM, V24 stated, I can't put clean water in your dirty cup but if you really want in that cup and not this cup you can pour it yourself because I can get into trouble pouring dirty water into a clean cup. On 3/7/2025 at 4:35 PM, R55 started to turn around as if she was going back to her room but she then turned around and threw the cup which contained rocks and dirty water substance at surveyor. R55's Progress Notes dated 3/7/2025 at 5:47 PM, document, Ambulance and Police arrive to facility to transport resident to (Hospital). Resident combative with (Ambulance staff), kicking, hitting, throwing items at the police officer. Resident verbally aggressive with facility staff and EMS (emergency medical services) cursing and racial slurs. EMS staff had to use physical restraints related to aggression. On 3/18/2025 at 7:39 PM, R55's Progress Notes document she returned to the facility. On 3/19/2025 at 8:30 AM, R55 was pleasant, her clothes were clean, she would smile at you and she would greet you. She would said thank you to staff when they asked her if she needed anything. On 3/19/2025 at 10:32 AM, V2, Assistant Director of Nursing stated, When (R55) came back from the hospital she was a different person. Now she is refusing her medications again and is right back where she was before she was sent out. On 3/21/2025 at 8:34 AM, R55 was no longer wearing clean clothes, she would glare at you and would not answer any questions and she was picking at her face and arms and exhibiting banging of doors and swearing. 2-R3's POS for February 2025 documents a diagnosis of Parkinson disease without dyskinesia, with fluctuations, type 2 diabetes mellites with unspecified complications, Paranoid schizophrenia, development disorder of scholastic skills. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R3's MDS dated [DATE] documents, R3 entered from a short-term general hospital and is cognitively intact for decision making. R3 has delusions. R3 has impairment on his upper and lower extremities and uses a wheelchair. R3 has verbal behavior symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others) with the behavior of this type occurring 1 to 3 days. R3 has an active diagnosis of schizophrenia is taking antipsychotic medication, and antidepressants. R3's Care Plan: Behavioral symptoms problem start date of 12/16/2024 documents, (R3) has a history of making sexually inappropriate comments towards staff. Approach: Education will be given to resident no not making inappropriate comments to staff. Category: Behavioral symptoms edited 1/24/2025, May have episodes of making accusatory statements towards staff. Behavioral Symptoms edited 11/23/2024, Resident exhibits verbally abusive behavioral symptoms toward staff by calling them vulgar names such as the 'N' word when providing care to resident. R3's Care Plan does not address his SMI. R3's Last Psychiatric assessment was completed on 8/26/2024. Behavioral programs were requested for R3, R4, R55 and R79. No proof of Psychosocial programs for R3, R4, R55, and R79, were provided by the Facility. On 3/7/2025 at 3:53 PM, V1, Administrator stated the facility had no Behavioral programs for residents. The only thing they were currently doing in the facility was the counseling through (Counseling Services). We have nothing in place, and that's tough because this facility has a lot of residents with behaviors. I believe that is why we have so many abuse allegations and then there are so many allegations I can't keep up because there are no programs in place for these residents that are constantly acting out. On 3/13/25 at 10:54 AM V11, MDS Corporate stated the facility does not have any residents on psychosocial/ Behavioral programs, they have not identified these residents, and that he spoke to (V29) from (Consultant Activities and Social Service) yesterday and V29 informed him she has been telling the SSD (Social Service Director) for months that the facility needs to get some type of behavioral/psychosocial programs implemented for this population. On 3/10/2025 at 4:04 AM, V5, Licensed Practical Nurse (LPN) stated, We do not have any Behavior programs targeted to our residents with mental illness. (R55) is impossible to redirect, she won't take her medications, and we are just supposed to monitor and watch her to make sure she is not hurting anyone which she is always doing. We have not had any special training on how to deal with behavioral issues with residents. On 3/10/2025 at 4:05 AM, V14, Licensed Practical Nurse stated, (R55) is in the hospital. She is impossible to redirect and is constantly refusing her medications. The police came out here last night and (R55) threw some yellow substance in a cup at the police and we think it was urine. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 3/12/2025 at 4:14 PM, V4, LPN stated, I have been working here in this facility for over two years. I was here before (V3, Owner/Medical Director) taken over. At first (V3) told us we were going to have less Behaviors residents and focus more on mom-and-pop skilled care, then he said we were going to have a specialized unit of ventilators and dialysis. We did have one resident that came in with a vent and I was working that night, and we did not have the right equipment for her, and I had her sent out. I am not aware of any other resident being admitted with a ventilator. There has not been any training to staff related to behaviors, how to approach, what to do or how to handle, no groups and/or special activities. No contracts, we are not doing anything for the residents with behaviors and that is half of our building. We have not had any training on how to deal with this type of population. On 3/12/2024 at 4:21 PM, V8, Certified Nursing Assistant (CNA) stated she had been working for the facility for three months and there are no programs especially for those residents with behaviors. She was not aware of any special activities and/or groups that they attend, or anything targeted at their behaviors. She had not had any training on how to deal with residents with behavioral issues. R55's Behavior Tracking for February 2025 documents behavior tracking. Behavior: I am on anti-psychotic meds r/t (related to) dx (diagnosis) of schizophrenia, depression, and anxiety. Goal: I will remain med compliant and take meds as prescribed to reduce symptoms of these behaviors. Behavior: I am on anti-depressants r/t of depression. Goal: I will remain med compliant and take meds as prescribed to reduce. Behavior: I resist care and refuse to let staff do skin checks. Goal: I will cooperate with redirection from staff to allow skin checks to be done when scheduled. Behavior: I have physically acted out towards others i.e hitting. Goal: I will not physically hit others through next review. Behavior: I have verbally abused others i.e cursing. Goal: I will not verbally abuse others through next review. Behavior: I have behavioral symptoms not directed towards others by self-piercing ears and nostrils and then pulling them out causing trauma. Goal: I will have no incidents of pulling out own piercing's causing trauma through next review. Behavior: I have delusions r/t dx of schizophrenia. Goal: I will remain med compliant and take meds as prescribed to reduce symptoms of these behaviors. Behavior: I have issues with non-compliance and picking my scabs on LLE. (Lower left extremity). Goal: I will understand my need to comply with my treatment plan through next review. R55's Behavior Tracking did not address what staff will do if she refuses her medication as prescribed. R55's Behavior tracking did not address her self-isolation. R55's Behavior Tracking did not address her self-isolation in her room. On 3/12/2024 at 4:29 PM, V30, CNA stated she has been working at the facility for 2 months and there had not been any training on how to approach and/or intervene with the residents with behaviors. She was not aware of any classes they were attending or activities. R3 Progress Notes dated, 3/4/2025 at 1:50 PM, Resident yelling about sister, nieces, and nephews. PRN (as needed) medication given. Continues to yell and have outburst. Notified MD (Medical Doctor). Awaiting response. R3's Progress Notes dated 3/5/2025 at 1:10 AM, [Recorded as Late Entry on 03/06/2025 01:10 AM] Resident was seen in the middle of hall this nurse saw resident scream at another resident and other resident turned and smacked (R3) in the face this nurse immediately separated the two residents and notified MD (Medical Doctor) and also made POA (Power of attorney) and sent this resident to hospital due to increasing behaviors. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 3/11/2025 at 10:02 AM, R3 was by the vending machine and was yelling and screaming that he wanted his money, and he wanted a soda. He continued to yell and scream and was very agitated and upset. On 3/11/2025 at 1:49 PM, R3 was observed yelling and screaming that he wanted a soda and his money and (V2) would not give it to him. R3's Progress Notes dated 3/11/2025 at 3:30 PM, [Recorded as Late Entry on 03/12/2025 05:31 PM], Resident was in hall way yelling very loudly , this nurse asked resident to please stop yelling and asked resident what did he need, resident became more upset and start calling this nurse multiple disrespectful names this nurse gave resident PRN medication and also put a call out to POA and (V3, MD), this nurse was advised to send resident to (Local Hospital), EMS (emergency Medical Services)refused to take resident due to him being alert and refusing to go with EMS, Police also present and spoke with resident about calming down, this nurse informed MD and POA resident still upset and yelling PRN not effective. R3's Social Service Notes dated 3/11/2025 4:14 PM, This writer met with resident in the hallway. Resident was yelling. Resident stated that his sister is stealing his money and trying to ruin his life. This writer talked with resident to redirect him. Resident stated this writer is bitc* and go get his money now. This writer attempted to call resident mother as this helps at times to calm him down. A call was placed to both phone numbers with no answer at this time. (No other intervention was documented). On 3/11/2024 at 5:01 PM, Resident was in the hallway and there were police presence and EMT staff. V2 was standing next to R3 and stated to police that '(R3) was upset because he wanted his soda and money' and after she began saying this (R3) began calling V2 names, 'Bitc* and tell her to give me my money.' R3 began to escalate as V2 began talking with the police and R3 was yelling louder and louder, 'I want her out of here she won't give me my money.' V2 then told police (R3) was upset over his soda and she had talked with his mother, and they wanted him sent to the (Psych Hospital) and they wanted to do an involuntary discharge on him. On 3/11/2025 at 5:11 PM, V35, EMS (Emergency Medical Services) staff member took R3 to his room and was able to redirect him. He spoke with R3 calmly and asked R3 if he wanted to go out to the hospital and R3 stated no he did not want to go. He asked R3 some basic questions which R3 answered, and he stated if he did not want to go out to the hospital then they would not force him to go to the hospital. R3 was left alone and his behaviors of screaming and yelling stopped. On 3/11/2025 at 5:32 PM, V2, Assistant Director of Nursing stated, I know (R3) was upset earlier because he wanted a soda. I talked with his guardian earlier in the day, and she told me not to give (R3) another soda and I know he was upset. He did get a soda around 2 PM. He has been spiraling ever since. We think maybe he has a UTI (urinary tract infection) but he won't let me get a UA (urinary analysis) on him. On 3/11/2025 at 5:38 PM, V35 stated, We are in this facility daily because of so may residents with behaviors issues. I was able to calm (R3) down. They just sent him out to the hospital but then they send him right back. He is calm now and that is what we want. We are in this building so much for things like this that escalate because staff are not equipped to calm these residents down on their own. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 3/11/2025 at 5:48 PM, 40, Police (Local) stated, We are constantly being called to the facility because of resident behaviors. I don't know what kind of training staff have had but I can say they need more training in dealing with this population. On 3/25/2025 at 10:03 AM, R3 was near the door of V57's office. The door is closed and R3 is yelling over and over again, My sister is ruining my life, My sister is ruining my life. On 3/25/2025 at 10:05 AM, in the dining room across from R3 their were residents in the dining room having a meeting. On 3/25/2024 at 10:11 AM, R14 approached R3 and asked him, Hey Buddy, can you calm done we can't hear, and we are trying to have a meeting. On 3/25/2025 at 10:12 AM, R3 continued to scream. On 3/25/2025 at 10:13 AM, R18 stated, (R3) is constantly screaming like this every day, day after day. We can't even have a meeting without him yelling. It's a pain in the as* listening to him scream all day long. On 3/25/2025 at 10:14 AM, R24 stated, (R3) has a lot of behaviors and he screams a lot. He constantly wants attention. I had to move rooms because the screaming was affecting me. 44556 3. R4's Face Sheet, with admitted [DATE], documented R4 diagnoses of but not limited to bipolar disorder, other genetic related intellectual disability, personality d/o, Suicidal ideation, Poisoning by unspecified drugs, medicaments, et biological substances, intentional self-harm subsequent encounter. R4's Minimum Data Set (MDS), dated [DATE], documented R4 is cognitively intact with a Brief Interview for Mental Status (BIMS) of 15 out of 15 and requires supervision with her Activities of Daily Living (ADLs). R4's Care Plan, with admitted [DATE], documented R4 has a history of self-harm, hitting self, and a history of Suicidal Ideations. Interventions are R4 will allow staff to redirect her when she has an episode of self-harm, will remain compliant and have no incidents of this behavior, and will take her medication as prescribed, all with a start date of 12/20/24. R4's Preadmission Screening and Resident Review (PASRR) Screening, dated 12/19/24, documented she was diagnosed with depression and an intentional overdose that requires regular follow up with a mental health provider and management of your medication regimen. It also documented R4 would need Rehabilitative services: You will need to be provided the following services and/or supports Service or Support Provision of a structured environment for those individuals who are determined to need such structure (e.g., structured socialization activities to diminish tendencies toward isolation and withdrawal), Attending groups may provide support, Crisis intervention services or plan, and a safety plan needs to be in place should you have thoughts of self-harm and need support. R4's Progress Notes were reviewed and documented the following: (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 12/20/2024 at 03:05 AM, Resident new admit. This nurse heard a noise like someone was beating on the wall, went down to resident's room and resident was standing hitting ER head against the wall. Resident redirected and educated on harm she may cause to self. Resident verbalized understanding. Resident stated she was in no pain, but she wanted an order for medication for anxiety. V3, Physician notified of behavior and resident's request for medication. Resident in bed sleeping at this time with call light in reach and able to make needs known. On 12/21/2024 at 02:55 PM, Resident reported to this nurse that she was having suicidal thoughts and wants to take hydroxyzine as needed (prn). Resident stated that this medication has helped with her suicidal thoughts in the past. Medical Doctor (MD) was notified, and resident has no new orders at this time. Resident is sitting at nursing station and is showing no signs of self-harm. On 12/21/2024 at 06:36 PM, Resident continues to have suicidal thoughts and requested to be sent to emergency room (ER) for Evaluation. On 01/05/2025 at 12:40 AM, Resident approached the nurse stating she had suicidal thoughts and requests to go to the local hospital for evaluation. MD, Administrator, and Power of Attorney (POA) notified. On 01/05/2025 at 12:43 AM, 911 phoned with request for transport to ER. On 01/09/2025 at 09:00 AM, Resident returned from hospital with continued behaviors. Resident tearful and sitting with activities. Resident continues to require monitoring. On 01/09/2025 at 03:09 PM, SOCIAL SERVICES: This writer met with resident today. Resident is very upset today. Resident has been in this writer office and being redirected when sad thoughts and thoughts of self-harm come to mind. Resident has been referred to local counseling center. On 01/09/2025 at 06:48 PM, Resident in bedroom banging head against wall. Redirected to nurses' station. On 01/10/2025 at 12:12 AM, Resident making threats as soon as writer came on shift related to (r/t) wanting to leave facility resident was observed standing around nursing station at change of shift. Dayshift nurse stated that resident had been one to one with activities due to (D/T) resident behavior but they were gone for the day resident was then asked to remove herself from nurses station then resident started to cry and hit the wall stating she wanted to go to the hospital but wouldn't state what was wrong with her after redirecting resident several times she then stated she called 911 herself and that they were on their way Emergency Medical Services (EMS) came talked to resident and local EMS then stated they were going to take resident outside for moment to speak with her but never returned hospital location was not given to this nurse. On 01/10/2025 at 03:34 PM, Called for update on resident and resident is admitted to local hospital and is currently in restraints. On 1/14/2025 at 02:07 PM, Resident was noted banging her head on wall in her room. Resident was redirected and was assessed. Resident had no redness or swelling noted to the head. Resident requested to be sent to the hospital related to self-harm and suicidal thoughts. EMS was called and resident will be transported to local hospital. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 01/15/2025 at 03:50 AM, EMS stated resident was non-emergency and that she was not going to be picked up and this was communicated to resident. Resident then started yelling, screaming, and hitting walls in room resident then made call to EMS herself EMS and police then showed up ask questions concerning resident status. POA and EMS then decided to take resident to local hospital. On 01/15/2025 at 04:04 AM, Local hospital called, and resident is being sent back to facility with safety plan for behaviors. On 01/18/2025 at 09:08 PM, resident had thoughts of harming herself and called local crisis line. Local Crisis came to the facility and spoke with resident and completed a safety plan with resident. While crisis was speaking with resident, resident stated that she was going to hang herself. Crisis workers called and EMS 911 and resident was transported to local hospital. On 01/19/2025 at 12:56 AM, Nurse received call from Registered Nurse (RN) at local hospital. Resident to be returning to facility. No new orders currently. On 01/19/2025 at 06:03 PM, Resident called EMS 911 R/T suicidal thoughts. Resident was transported to local hospital for evaluation. On 01/21/2025 at 11:28 AM, Nurse was notified by staff resident was hitting her head on the wall in her room, nurse approached resident and resident was sitting on her bed, resident asked what was wrong and she stated her thoughts were strong resident would not elaborate on what exact thoughts were. Resident also noted to have abrasion to forehead from hitting her head on the wall, abrasion cleaned, triple antibiotic ointment (tao) and band aid applied. Neurochecks within normal limit (wnl). V3, Physician notified. Resident given prn medication for increased anxiety, sitting on bed with call light in reach, isolation continues r/t being positive for covid, no cough noted at present, no sob or distress noted at this time. On 01/23/2025 at 12:06 AM, Resident in bedroom and stated her voices were getting strong in her mind. Resident stated she wanted to choke herself with her own hands. Resident was placed on 15-minute checks to ensure safety. Resident given scheduled and PRN medications and advised to do relaxation exercises. Resident was sitting on bed with legs folded and stating thoughts of self-harm. Management and MD notified. Awaiting response from MD. On 01/23/2025 at 12:25 AM, All cords removed from resident to ensure safety due to stating thoughts of choking herself. Resident POA aware. POA states he is ok with current safety plan of 15-minute checks. States only send resident out if she causes actual physical harm to self. On 01/23/2025 at 01:14 AM, Resident in room crying at this time. PRN [NAME][TRUNCATED]

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49494 Based on observation, interview, and record review, the facility failed to ensure residents are free from significant medication errors for 4 of 4 residents (R21, R28, R29, R45) reviewed for significant medication errors in the sample of 81. This failure resulted in R21, R28, R29, and R45 experiencing unnecessary anxiety, emotional distress, pain, and suffering. This has the potential to affect all 73 residents of the facility. Findings Include: On 3/6/25 at 7:55 AM V2, ADON (Assistant Director of Nursing), stated I have been here over 26 hours. A night nurse called off and day nurse. I cannot pass the meds; I need to go home and sleep. V3, Doctor/Owner/Medical Director, might be coming into pass meds. On 3/6/25 at 9:03 AM surveyor was sitting at the [NAME] unit nurse's station and observed there was no nurse assigned on this unit. V25, Regional Chief Executive Officer, stated to this surveyor we are working on getting a nurse for this side, V3 (MD, Owner, Medical Director) worked the night shift at the hospital last night so he is not coming in. I have a call out to an agency. I will have the other nurse pass medications when she gets done on the other side of the building. On 10:19 AM V23 LPN (Licensed Practical Nurse) was observed pushing her medication cart over to the [NAME] side unit and began administering medications. V23 stated I try to be a team player, but this is too much. These meds were due at 8 AM. 1. R28's face sheet, print date of 3/18/25, documented R28 has diagnoses including traumatic subdural hemorrhage, epilepsy, anxiety, hypertension, asthma, dementia, cognitive communication deficit, and bipolar disorder. R28's MDS (Minimum Data Set), dated 12/18/25, documented R28 is severely cognitively impaired, requires moderate assistance with ADLS (activities of daily living), and substantial to maximum assistance with transfers to and from his wheelchair. R28's care plan, undated, documented R28 has a seizure disorder due to epilepsy, R28 to take medications as ordered by my md (medical doctor). Interventions include take medications as ordered by MD, obtain, and monitor lab/diagnostic work as ordered and report results to my physician. R28's care plan also documented I have potential for pain/discomfort related to laceration without foreign body, right lower leg, sequela, epilepsy, umbilical hernia, contusion of right lower leg, and TBI (traumatic brain interventions). Interventions include I prefer to have pain controlled by medication as ordered by my MD. On 3/6/25 at 9:27 AM R28 was sitting in his wheelchair by the [NAME] unit nurse's station and R28 stated to V26 CNA, (Certified Nurse Assistant), I need a pain pill, my back hurts. V26 stated to R28 there is no nurse over here this morning to pass pills. R28 was moaning and grimacing in pain (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	R28's MAR (medication administration record), dated 3/1/25 - 3/10/25, documented R28 has a physician order for hydrocodone-acetaminophen 5-325 mg; 1 tablet every 6 hours scheduled at 12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM. R28's MAR documented scheduled date 3/6/25, scheduled time 6:00 AM, charted date/time 3/6/25 at 10:29 AM by V23 LPN (Licensed Practical Nurse), reasons/comments: late administration/charted late. The 12:00 PM dose has a charted date/time of 3/6/25 at 1:42 PM, late administration/charted late. Surveyor was present and V23 did not start administering medications on the [NAME] unit 10:15 AM. On 3/19/25 at 9:02 AM V23 LPN stated she did not administer R28's pain medicine until 10:29 AM and 1:42 PM on 3/6/25. R28's MAR, dated 3/1/25 - 3/10/25, documents an order for levetiracetam (Keppra) 500mg for diagnosis of epilepsy; amount to administer 3 tabs (1500 mg total) twice a day, first dose between 6:30 AM - 9:30 AM and second dose between 7:00 PM - 9:00 PM. This MAR documented late administration/charted late on 3/6/25 at 10:28 AM. This MAR also documented charted date/time on 3/3/25 at 11:47 PM, 3/4/25 at 11:06 PM, 3/5/25 scheduled time 7:00 PM - 9:00 PM was not charted until 5:51 AM on 3/6/25, 3/7/25 scheduled evening dose not charted until 1:07 AM on 3/8/25, and the evening dose on 3/9/25 was not charted until 11:35 PM. On 3/19/25 at 9:02 AM V23 LPN stated she did not administer R28's Keppra until 10:28 AM on 3/6/25. R28's EMR progress notes, dated 3/7/25 at 10:02 AM, documented R28 fell face forward in dining room. Resident had grand mal seizure that lasted approximately 1 1/2 minutes until became postictal. Resident has hematoma to right forehead. Scant amount of blood noted and cleansed with NS (normal saline) and covered with bandage. 911 called by administrator. Resident had second seizure that lasted 2 minutes. Awaiting arrival of EMS. (Emergency Medical Services). R28's local hospital records, dated 3/7/25, documented patient to emergency department from this facility via EMS (emergency medical services) for c/o a seizure. Patient was at breakfast when he fell to the floor and had a seizure. Patient has contusions to his forehead. EMS placed patient in a c collar. Patient was alert then patient began to seize, EMS says it lasted 1 minute, EMS gave 5 mg of versed IM (intramuscular). No notation of laboratory samples obtained during this visit to potentially check drug levels were noted. R28's physician order report, dated 2/20/25 - 3/20/25, documented an order for a Keppra level yearly to ensure the anticonvulsant is in therapeutic range to prevent seizure. R28's last Keppra level documented in R28's EMR is dated 11/30/23. Surveyor requested R28's most recent Keppra level on 3/17/25 and as of 3/20/25 the facility has not presented any Keppra level results since the one that was completed on 11/30/23. On 3/18/25 at 2:32 PM V2, ADON, stated the facility has no record of R28's last Keppra level other than the one in the EMR dated 11/30/23. On 3/19/25 at 1:27 PM V44, Pharmacist at facility pharmacy, stated the timing of levetiracetam is very important. V44 stated if one dose of this medication is given more than an hour late it can result in the patient experiencing breakthrough seizures. V44 also stated a missed dose of this medication may result in the resident developing seizures. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Au Well Care Home, Inc	152 Wilma Drive Maryville, IL 62062

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 3/18/25 at 11:45 AM V25, Regional Chief Executive Officer, stated V23 LPN should not have documented charted late on 3/6/25 because the medications were late due to no nurse on the [NAME] side unit. V25 stated the nurses are supposed to be signing the medications off immediately after administration. On 3/18/25 at 12:25 PM V2 ADON (Assistant Director of Nursing) stated V23 should have documented medications administered late instead of charted late. V2 stated the facility nurses are supposed to sign off the medications as administered immediately after they give the medications to the residents unless there is an emergency that delays them from charting the medications immediately. On 3/19/25 at 9:02 AM V23 LPN stated she did administer the medications late on the [NAME] unit on 3/6/25 when there was no nurse. V23 stated she should have documented administered late not charted late and does not know why she charted documented late. 2. R29's face sheet, print date of 3/19/25, documented R29 has diagnoses including schizophrenia, anxiety disorder, major depressive disorder, and hypertension. R29's MDS, dated [DATE], documented R29 is moderately cognitively impaired. R29's care plan, undated, documented R29 is currently on anti-anxiety medications buspirone (buspar) and lorazepam (ativan) related to anxiety. Interventions include give anti-anxiety medications as ordered by physician. This care plan also documented R29 is receiving antipsychotic medications including Clozaril for his diagnosis of schizophrenia with interventions including administer medications as ordered. On 3/6/25 at 9:05 AM surveyor was seated at the [NAME] unit nurse's station when R29 stated to surveyor I need my meds, I am getting really nervous because I haven't had my buspar. On 3/6/25 at 9:52 AM R29 came back to the nurse's station and stated to surveyor, I need a nurse because I haven't had any meds today, I am hearing voices, I have paranoid schizophrenia and I need my meds. Surveyor then went and asked V25 when a nurse would be able to get the medications passed as R29 is wanting his buspar. V25 stated V23 will be over to pass the medications when she gets done on her side. R29's MAR, dated 3/1/25 - 3/10/25, documented R29's Clozaril 50 mg (antipsychotic medication) is ordered to be administered twice a day at 8:00 AM and 8:00 PM. This MAR documented R29's Clozaril was documented as late administration: charted late at 10:41 AM on 3/6/25 by V23. On 3/19/25 at 9:02 AM V23 confirmed R29's Clozaril and all of his medications were administered late on 3/6/25 and that she should have documented late administration. R29's MAR, dated 3/1/25 - 3/10/25, documented R29's buspar 10mg (antianxiety medication) is ordered to be administered at 8 AM, 5 PM, and 8 PM. R29's MAR documented R29's buspar was documented as late administration: charted late at 10:30 AM on 3/6/25 by V23. This MAR also documented a physician order for Ativan .5 mg every day at 8 AM. R29's MAR documented late administration: charted late at 10:31 AM on 3/6/25. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 3/19/25 at 9:02 AM V23 confirmed R29's medications were administered late on 3/6/25 because she was the only nurse in the building. V23 stated she should have charted administered late instead of charted late. V23 stated the time the medications were signed out on the MAR is the time they were administered on 3/6/25. 3. R45's face sheet, print date of 3/11/24, documented R45 has diagnoses including osteoarthritis, type 2 diabetes mellitus with diabetic neuropathy, bipolar disorder, major depressive disorder severe with psychotic symptoms, generalized anxiety disorder, hypertension, chronic embolism, and thrombosis of deep veins of lower extremity, adult failure to thrive, and personal history of suicidal behavior. R45's MDS, dated [DATE], documented R45 is cognitively intact and requires supervision or touch assistance with all ADLS (activities of daily living). R45's care plan, undated, documented R45 has behavioral symptoms, a history of deep vein thrombosis, diabetes, and pain related to osteoarthritis and neuropathy with interventions including administer medications as ordered. On 3/6/25 at 9:47 AM R45 stated to surveyor we still don't have a nurse; my back pain is at a 9. I need a nurse to look at my finger, it looks worse. I didn't get all my meds yesterday. R45's MAR, dated 3/1/25 - 3/20/25, documented R45 has physician orders including acetaminophen 500 mg every 4 hours PRN (as needed) and oxycodone 7.5 - 325 mg tab four times a day PRN. This MAR does not document either of these medications were administered on 3/6/25. This MAR documented R45 rated her pain at a 9 on 3/7/25 at 12:06 AM. R45 also has orders for bupropion 150 mg daily at 8 AM for anxiety and this was not documented as administered on 3/5/25 and was documented as late administration on 3/6/25 at 10:43 AM. This MAR documented R45 has an order for duloxetine 30 mg one time a day at 8:00 AM for anxiety and depression. The duloxetine is not documented as being administered on 3/5/25 and was charted as late administration on 3/6/25 at 10:43 AM by V23. R45 has a physician order for Eliquis 5 mg BID (twice a day) for prevention of blood clots at 8:00 AM and 8:00 PM. This MAR does not document the Eliquis as administered on 3/5/25 and was charted as late administration at 10:43 AM on 3/6/25 by V23. This MAR documented an order for gabapentin 400 mg TID (three times a day) at 7:00 AM, 12:00 PM, and 8:00 PM. The gabapentin scheduled for 7 AM, for treatment of R45's pain related to diabetic neuropathy, is not documented as administered on 3/5/25. R45's MAR documented an order for lispro insulin amount to administer based on blood sugar test results (sliding scale) daily at 7:30 AM, 11:30 AM, and 4:30 PM. There are no blood sugar test results documented for 7:30 AM on 3/6/25 nor documentation that R45 received this insulin on 3/6/25 at 7:30 AM. This MAR documented R45's blood sugar was 291 and R45 required 3 units of the sliding scale lispro insulin on 3/6/25 at 11:30 AM. This MAR does not document R45's blood sugar was tested on [DATE] at 4:30 PM nor does it document any sliding scale insulin was administered at this time. This MAR documented R45 has a physician order for scheduled lispro insulin 5 units with meals at 7:30 AM, 11:30 AM, and 4:30 PM. This MAR did not document this insulin was administered on 3/5/25 at 7:30 AM nor at 11:30 AM. The 4:30 PM dose documented at 8:03 PM on 3/5/25 late administration/drug unavailable. This insulin is documented as late administration on 3/6/25 at 10:47 AM for the 7:30 AM dose. On 3/24/25 at 9:57 AM, V2, ADON, stated accuchecks should always be completed as ordered and if it is not documented then it was not done. V2 stated failure to complete accuchecks as ordered could result in a resident experiencing hypo or hyperglycemia. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	4.R21's face sheet, print date of 3/20/25, documented R21 has diagnoses including HIV (human immunodeficiency virus), hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, COPD (Chronic Obstructive Pulmonary Disease), diabetes, depression, hypertension, and heart failure. R21's MDS (Minimum Data Set), dated 2/21/25, documented R21 is cognitively intact. On 3/6/25 at 9:07 AM R21 stated to surveyor we don't have a nurse, the people who run this place are cheap and won't pay for agency. We have to suffer because V3 is cheap. Surveyor asked if he has received any medications yet and R21 replied no, and my HIV meds need to be on time. R21's MAR, dated 3/1/25 - 3/20/25, documented an order for dovato 50-300mg 1 tablet daily at 8 AM for treatment of HIV. This MAR documented R21's dovato was signed off by V23 LPN on 3/6/25 at 11:38 AM at late administration: charted late. On 3/19/25 at 9:04 AM V23 confirmed R21's medications were administered late on 3/6/25 because she was the only nurse in the building. V23 stated she should have charted administered late instead of charted late. V23 stated the time the medications were signed out on the MAR is the time they were administered on 3/6/25. 5. R25's face sheet, print date of 3/24/25, documented R25 has diagnoses including hidradenitis suppurativa, pain, cerebral infarction due to embolism of basilar artery, type 2 diabetes mellitus, depression, gastro-esophageal reflux disease, benign prostatic hyperplasia, anxiety, hypertension, and cellulitis. R25's MDS, dated [DATE], documented R25 is cognitively intact. R25's care plan, undated, documented, R25 receives psychotropic medications to treat depression. R25's care plan documented administer medication as ordered. On 3/18/25 at 7:32 AM surveyor observed V4 LPN pass medications on the [NAME] unit. R25 did not receive his scheduled duloxetine for diagnosis of depression, protonix for treatment of gastroesophageal reflux disease, and tamsulosin for treatment of prostatic hyperplasia. V4 stated these medications were not delivered to the facility last night and that R25 has been out of his tamsulosin for a couple of days. V4 stated she checked the facility's back up medication dispensing machine and it does not contain these 3 medications. R25's MAR, dated 3/1/25 - 3/20/25, documented an order for duloxetine capsule delayed release 30 mg once a day at 8 AM. On 3/18/25 V4 documented not administered: drug/item unavailable. This MAR documented an order for protonix 40 mg once a day. On 3/18/25 V4 documented not administered: drug/item unavailable. This MAR documented an order for tamsulosin .4mg once a day. On 3/18/25 V4 documented not administered: drug/item unavailable. On 3/24/25 at 3:07 PM R25 stated the facility has run out of his medications a few times since he was admitted . R25 stated his biggest issues with his medications not being available was when the facility did not have his scheduled antibiotics and pain medication available for him. On 3/24/25 at 2:47 PM V2, ADON, stated if a resident does not have medications for the med pass, then the nurse should call pharmacy for an E-Run, and the nurse should call the doctor to get an order to hold the medications. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	As of 3/24/25 R25's EMR does not document any physician notification regarding R25's missing medications on 3/18/25. The facility's Adverse Consequences and Medication Errors policy, dated 4/2014, documented the interdisciplinary team evaluates medication usage in order to prevent and detect adverse consequences and medication-related problems such as adverse drug reactions (ADRs) and side effects. Averse consequences shall be reported to the attending Physician and Pharmacist, and to federal agencies as appropriate. 1. Residents receiving any medication that has a potential for an adverse consequence will be monitored to ensure that any such consequences are promptly identified and reported. 2. An adverse consequence is defined as an unpleasant symptom or event that is due to or associated with a medication, such as an impairment or decline in an individual's mental or psychosocial status. It continues, 5. A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the progressional providing services. 6. Examples of medications errors include: a. Omission - a drug is ordered but not administered; b. Unauthorized drug c. Wrong dose d. Wrong route of administration e. Wrong dosage form f. Wrong drug g. Wrong time.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49494 Based on observation, interview, and record review the facility failed to ensure medications were stored in a locked medication cart. This failure had the potential to affect all 73 residents residing at the facility. Findings Include: On 3/10/25 at 8:44 AM surveyor observed 4 cards of medications on top of a medication cart outside of the [NAME] unit nurse's station in the hallway. The medications included a card of Seroquel (antipsychotic) 200 mg containing 29 tablets, a card of tizanidine HCL (muscle relaxer) 20 mg containing 14 tablets, Remeron (antidepressant) 15 mg containing 4 tablets, and a card of atorvastatin (statin) 10 mg containing 1 tablet. The medications documented R5's name on the cards. Surveyor observed the medications sitting on top of the medication cart unsupervised from 8:44 AM until 9:05 AM. The cart was sitting in the hallway next to the [NAME] side nurse's station and accessible to all residents. Surveyor observed R3, R4, R28, and R29 near the unsecured medications during this observation. R3's face sheet, print date of 3/10/25, documented R3 has diagnoses including developmental disorder of scholastic skills and altered mental status. R4's face sheet, undated, documented R4 has diagnoses including bipolar disorder, intellectual disability, personality disorder, suicidal ideations, and history of poisoning by unspecified drugs. R28's face sheet, print date of 3/18/25, documented R28 has diagnoses including dementia, bipolar disorder, and a history of traumatic subdural hemorrhage. R29's face sheet, print date of 3/19/25, documented R29 has diagnoses including schizophrenia, anxiety disorder, and major depressive disorder. On 3/24/25 at 2:42 PM V41 LPN (Licensed Practical Nurse) stated she did leave medication packs out on the med cart in the hallway on 3/10/25. V4 stated I got sidetracked and I did leave meds sitting out. It was an honest mistake, I'm sorry. On 3/24/25 at 2:45 PM V11, ADON (Assistant Director of Nursing), stated medications should never be sitting out where residents are able to gain access to them. They should be locked up. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Storage of Medications policy, dated 9/2003, documented the purpose of this procedure is to ensure that medications are stored in a safe, secure, and orderly manner. 1. Medications are stored in the containers in which they are received. 2. Drug containers having soiled, illegible, worn, makeshift, incomplete, damaged, or missing labels are returned to the pharmacy for proper labeling before storing. 3. No discontinued, outdated, or deteriorated medications ae available for use in this facility. All such medications are destroyed. 4. Medications for external use are clearly marked as such and are stored separately from other medications. 5. Antiseptics, disinfectants, and germicides used in resident care must have legible, distinctive labels that identify the contents and the directions for use. 6. Compartments containing medications are locked when not in use. 7. Medications are stored in an orderly manner in cabinets, drawers, or carts. 8. Medications requiring refrigeration must be stored in the refrigerator located at the nurse's station. 9. All controlled drugs ae stored under double lock and key.

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F 0770 Level of Harm - Actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49494 Based on interview, and record review the facility failed to provide laboratory services in accordance with physician orders. This deficient practice was identified for 4 of 4 residents (R3, R24, R28, R29) reviewed for laboratory services in the sample of 82. This failure to conduct labs as ordered by the physician resulted in R28 experiencing a grand mal seizure and a fall without evidence of monitoring antiseizure medication therapeutic blood levels routinely as ordered. Findings include: 1.R28's Face Sheet, print date of 3/18/25, documented R28 has diagnoses including traumatic subdural hemorrhage, epilepsy, anxiety, hypertension, asthma, dementia, cognitive communication deficit, and bipolar disorder. R28's Minimum Data Set (MDS), dated [DATE], documented R28 is severely cognitively impaired, requires moderate assistance with ADLS (activities of daily living), and substantial to maximum assistance with transfers to and from his wheelchair. R28's Care Plan, undated, documented R28 has a seizure disorder due to epilepsy. This care plan documented interventions including obtain and monitor lab/diagnostic work as ordered and report results to my physician. R28's Physician's Orders (PO), dated 2/20/25 - 3/20/25, documented an order for levetiracetam (Keppra, a medication to treat seizures) 500 milligrams (mg), 3 tabs, oral, twice a day. R28's physician orders also documented an order for a Keppra level yearly with a start date of 4/3/23. R28's EMR documented the last Keppra level was drawn in 2023. R28's Electronic Medical Record (EMR), progress notes, dated 3/7/25 at 10:02 AM, documented R28 fell face forward in dining room. The Note documented resident had grand mal seizure that lasted approximately 1 1/2 minutes until became postictal. Resident has hematoma to right forehead. Scant amount of blood noted and cleansed with NS (normal saline) and covered with bandage. 911 called by administrator. Resident had second seizure that lasted 2 minutes. Awaiting arrival of EMS. (Emergency Medical Services). R28's local hospital records, dated 3/7/25, documented patient to emergency department from this facility via EMS (emergency medical services) for c/o (complaints of) a seizure. Patient was at breakfast when he fell to the floor and had a seizure. Patient has contusions to his forehead. EMS placed patient in a c collar. Patient was alert then patient began to seize, EMS says it lasted 1 minute, EMS gave 5 MG of versed IM (intramuscular). The hospital stabilized R28 and returned him to the facility. On 3/18/25 at 2:32 PM V2, Assistant Director of Nursing (ADON), stated the facility has no record of R28's last Keppra level other than the one in the EMR (electronic medical record) dated 11/30/23. V2 stated she would call the lab and have them draw it tomorrow morning. (continued on next page)

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F 0770 Level of Harm - Actual harm Residents Affected - Few	R28's Medication Administration Record (MAR), dated 3/1/25 - 3/10/25, documents an order for levetiracetam (Keppra) 500mg for diagnosis of epilepsy; amount to administer 3 tabs (1500 mg total) twice a day, first dose between 6:30 AM - 9:30 AM and second dose between 7:00 PM - 9:00 PM. This MAR documented late administration/charted late on 3/6/25 at 10:28 AM. This MAR also documented charted date/time on 3/3/25 at 11:47 PM, 3/4/25 at 11:06 PM, 3/5/25 scheduled time 7:00 PM - 9:00 PM was not charted until 5:51 AM on 3/6/25, 3/7/25 scheduled evening dose not charted until 1:07 AM on 3/8/25, and the evening dose on 3/9/25 was not charted until 11:35 PM. On 3/19/25 at 9:02 AM V23 LPN stated she did not administer R28's Keppra until 10:28 AM on 3/6/25. On 3/19/25 at 1:27 PM V44, Pharmacist at facility pharmacy, stated the timing of levetiracetam is very important. V44 stated if one dose of this medication is given more than an hour late it can result in the patient experiencing breakthrough seizures. V44 also stated a missed dose of this medication may result in the resident developing seizures. On 3/20/25 at 11:11 AM V2 stated the lab did not draw R28's Keppra level that was supposed to be drawn yesterday. V2 stated it was ordered on 3/18/25 after you requested his last Keppra level and stated she does not know why they missed it, but they would be out today to draw a stat lab for R28's Keppra level. On 3/24/25 at 12:55 PM surveyor requested R28's Keppra lab level results and V2 stated the facility does not have the results back yet. On 3/25/25 at 11:17 AM surveyor requested R28's Keppra level from V2. V2 stated I just called the lab, and they still don't have the results. They said they outsourced it, and it could be another 5 days before we get the results. We are going to have to get a different lab service because they aren't reliable. 2. R24's Face Sheet, print date of 3/10/25, documented R24 has diagnoses including cerebral infarction due to thrombosis of bilateral vertebral arteries, type 2 diabetes mellitus, history of cardiac arrest, hyperlipidemia, essential dysfunction of bladder, history of malignant neoplasm of thyroid, and complete traumatic amputation of left foot. R24's MDS, dated [DATE], documented R24 is cognitively intact and requires partial to moderate assistance with mobility and ADLS. R24's PO, undated, documented an order for warfarin (anticoagulant medication) 2 mg daily and other test: PT (Prothrombin Time) and INR (International Normalized Ration) dated 7/1/24. R24's Care Plan, undated, documented I am at risk for bleeding/bruising due to aspirin therapy. This care plan does not address R24's order for warfarin nor anything regarding monitoring of PT and INR levels. On 3/24/25 at 2:35 PM V23, LPN, (Licensed Practical Nurse), stated, I think we check PT and INRs monthly for the residents who are on warfarin. On 3/24/25 at 2:42 PM V41, LPN, stated management keeps track of what residents are on warfarin and need PT INRs. V41 stated I think they do them monthly. (continued on next page)

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F 0770 Level of Harm - Actual harm Residents Affected - Few	On 3/24/25 at 2:47 PM V2, ADON, stated residents on warfarin should have a PT/INR drawn at least every month. On 3/24/25 at 3:02 PM R24 stated he was admitted to the facility at the end of February of 2024, and they were checking his PT/INR every week for about the first 3 months and then they just stopped. R24 stated he does not recall the last time it was checked. On 3/24/25 at 3:48 PM V2 stated R24's last PT/INR was completed on 10/8/24 and V2 handed surveyor the results. R24's PT documented prothrombin time 16.1 high and INR of 1.5 high. The paper results do not document V3, R24's physician, was notified of these results nor does his progress notes. V2 stated she cannot find any documentation about V3 being notified on his last PT/INR on record dated 10/8/24. On 3/24/25 at 4:03 PM V2 stated she cannot find where the nurses called V3 to ensure that he was aware of R24's PT/INR results of the last one drawn on 10/8/24. V2 stated they should have called and made sure it was followed up on and the failure to monitor PT & INRS for residents on warfarin can lead to serious bleeding issues. 3. R29's Face Sheet, undated, documented R29 has diagnoses including schizophrenia, anxiety disorder, major depressive disorder, and hypertension. R29's PO, dated 4/4/23, documented R29 has an order for divalproex 500 mg tablet twice a day for treatment of schizophrenia. R29's PO, dated 4/4/23, documented VPA (valproic acid level in blood) on 4/19/22, test on the 1st of every 6th month. On 3/24/25 at 4:45 PM V2 stated she cannot find when R29's last valproic acid level was drawn and stated R29's valproic acid level is to monitor for Depakote (divalproex) levels to ensure it is in therapeutic range and not too elevated which could cause different health issues. 4. R3's Face Sheet, print date of 3/10/25, documented R3 has diagnoses including type 2 diabetes mellitus with unspecified complications, morbid obesity, atherosclerotic heart disease hypertension, and Parkinson's disease. R3's Care Plan, undated, does not address his healthcare needs related to his diagnosis of type 2 diabetes. R3's PO, dated 8/30/24, documented an order for diabetic labs - HG A1C (hemoglobin blood glucose level) and FBS (fasting blood sugar) every 3 months. On 3/24/25 at 3:26 PM Surveyor requested from V2 R3's HG A1C and FBS results for R3 as they are not in R3's EMR. V2 stated she cannot find R3's lab results for these tests. V3 stated the facility has no record of R3's labs being completed as ordered. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Au Well Care Home, Inc	152 Wilma Drive Maryville, IL 62062

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F 0770 Level of Harm - Actual harm Residents Affected - Few	03/12/25 at 12:15 PM, V3, Medical Director/Owner, stated when he gives an order, he expects the nurses to follow them and enter them into the computer. V3 was questioned could possible critical lab values being missed if labs aren't being drawn? V3 stated you could assume it would but that's not correct. He said if someone is sick or presenting with some kind of urgent issue it would be different and they would send them out to the hospital to be evaluated. If there is no urgent need or the resident isn't critical, they are breathing then there is no jeopardy. V3 was asked why routine labs are ordered then if they aren't being drawn and V3 responded Routine Health that's the purpose. They may check them every 6 months, or every 3 months, or even yearly. To make sure their hemoglobin is fine, and their albumin is fine. V3 was questioned about checking levels for seizure medication and them being important V3 responded we don't just check a Keppra level for fun. If someone is having a breakthrough seizure, they would then send them out to the hospital. V3 was asked so routine labs are to determine a resident's status? V3 yes just health labs. On 3/17/25 at approximately 1:45 PM, V2 stated that lab results are faxed to the facility and critical lab results communicated to the physician by via phone. V2 stated that she recognizes there is a breakdown between lab results being received and put into the facility's electronic medical records system. V2 stated she will try to get the surveyor requested results for review by calling the company to have them faxed, as the results cannot be found in the facility. On 3/18/25 at 12:25 PM V2 stated I am unable to get lab results from the lab's computer system. My password doesn't work. Surveyor asked how long the facility has been with the current lab. V2 replied I have worked here for 8 months, and they had this lab before I started. Surveyor asked if anyone from the facility management team has been overseeing labs to ensure they are drawn as ordered and results are followed up on. V2 replied no, the nurses should be putting the orders in and filling out the requisition slips. Surveyor asked if anyone in management is monitoring to ensure the lab results are retrieved from the lab computer system and reported to the doctor. V2 stated the nurses are supposed to. V2 stated no facility staff are scanning the lab results into the facility's EMR system. 3/18/25 at 1 PM V25, Corporate Chief Executive Officer, stated the facility uses the same lab as the previous owner, and that V2 is supposed to be following up on labs to ensure they are completed as ordered and followed up on. (continued on next page)

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F 0770 Level of Harm - Actual harm Residents Affected - Few	The facility's Laboratory Services policy, undated, documented the purpose of this policy is to outline the procedures for laboratory services at the facility, ensuring tests conducted are done so safely, accurately, and in accordance with regulatory standards. This policy applies to all nursing home staff involved in the ordering, collection, processing, and interpretation of laboratory tests for residents. The facility is committed to providing high-quality care through access to laboratory services that support clinical decision-making and ensure the health and safety of our residents. Laboratory tests are utilized for diagnosis, treatment monitoring, and health assessment purposes, particularly in the psych nursing care setting. Laboratory tests available for residents may include but are not limited to: Blood Tests (Complete Blood Count (CBC), Comprehensive Metabolic Panel, etc., coagulation tests (Prothrombin Time/ International Normalized Ration - PT/INR), urine tests, electrolyte panels, thyroid function tests, toxicology screens, screening for infections. Psych-Specific Tests - psychiatric residents may require specialized testing such as: Blood levels for psychotropic medications. PT/INR testing for residents on anticoagulation therapy or when psychotropic medications interact with anticoagulants. All laboratory tests must be ordered by a licensed physician, nurse practitioner, or physician's assistant based on the resident's clinical needs. Blood draws: Performed by trained medical staff, including nurses or phlebotomists. Includes collection for PT/INR testing when ordered. Timeliness of Testing STAT testing should be prioritized, with results needed as soon as possible, typically within 1-2 hours. Routine tests should be processed and sent to the laboratory in a timely manner to ensure accurate results. Reporting of Results Laboratory results will be transmitted to the ordering physician or designated healthcare provider promptly. Results will be reviewed by the attending physician or appropriate clinical team member to interpret findings and plan further care. 2 Follow-Up on Abnormal Results Critical Results: Any abnormal or critical laboratory results, including elevated or sub-therapeutic PT/INR levels, will be flagged for immediate attention. The physician or attending provider will be notified within 30 minutes of the result being reported. Follow-up actions may include medication adjustments, further testing, or consultations with specialists. Quality Assurance Program: The facility will conduct periodic audits of laboratory procedures to ensure accuracy, compliance, and quality.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35156 Based on observation, interview, and record review the Facility failed to ensure residents were assessed and assisted with dental visits for 4 of 4 residents (R22, R23, R45 and R57) reviewed for dental services in the sample of 82. Findings include: R23's Physician Order Sheet (POS) dated March 2025 documents diagnoses of Unspecified systolic (congestive) heart failure; Essential (primary) hypertension; Depression, unspecified; Pain in left hip; Other chronic pain; Cocaine abuse, uncomplicated; Major depressive disorder, recurrent, severe with psychotic symptom. R23's Minimum Data Set (MDS) dated [DATE] documents R23 was moderately impaired for cognition for activities of daily living. The Oral/dental section was left blank and was not assessed. R23's Care Plan, current Care Plan in the Electronic Medical Record (EMR) does not address any issues with his oral health/dental. On 3/14/2025 at 10:49 AM, R23's top mouth (maxillary) only has one middle tooth (Central incisor), the tooth is angled, all the other teeth on the top were missing. On R23's bottom arch (mandible), his teeth are broken, crowded, and deformed. No abscess was visible from the outside of his face or neck. On 3/14/2025 at 10:59 AM, R23 stated he did have issues with mouth and was in a lot of pain and was having issues eating but things are better now he got medication. He is not in any pain currently and is not having issues with his teeth, but he has always had issues with his teeth, and he knows he needs to get them fixed. R23 stated his teeth have been like this for years. On 3/14/2025 at 11:04 AM, V41, Licensed Practical Nurse (LPN) stated, (R23) has not been complaining about any pain and/or having any issues with his teeth. Last month he was complaining, and I was giving him pain medications, but he seems to be doing okay now. R23's February Physician Order Sheet document he was receiving Augmentin 875 milligrams (MG), 1 tablet by mouth, twice a day for five days. On 3/6/2025 at 8:00 AM, R23's Dental Assessment was requested. On 3/14/2025 at 5:00 PM, R23's Dental Assessment was not provided. 2. R45's POS for March 2025 documents R45's diagnoses of Primary osteoarthritis, other specified site; Type 2 diabetes mellitus with diabetic neuropathy, unspecified; Hyperlipidemia, unspecified; Bipolar disorder, unspecified; Major depressive disorder, recurrent, severe with psychotic symptom; Generalized anxiety disorder; Essential (primary) hypertension; Chronic embolism and thrombosis of unspecified deep veins of unspecified lower extremity; Other seasonal allergic rhinitis; Adult failure to thrive and Personal history of suicidal behavior. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R45's MDS dated [DATE] documents R45 was cognitively impaired for decision making of activities of daily living. R45's MDS does not document any issues with oral care. R45's Care Plan in the EMR does not address any dental issues. On 3/4/2025 at 10:03 AM, R45's front tooth on top (maxillary) was discolored and her gums were moderately inflamed, and her breath smelled bad. On 3/4/2025 at 10:05 AM, R45 stated her teeth bothered her and she has asked to go to the dentist, but nobody has ever gotten her an appointment or helped her to see the dentist while she had been in the facility. On 3/6/2025 at 8:00 AM, R45's Dental Assessment was requested. On 3/18/2025 at 12:50 PM, No dental Assessment was provided for R45. 3. R22's POS for March 2025 documents diagnoses of Cerebral infarction due to unspecified occlusion or stenosis of right anterior cerebral artery; Infectious gastroenteritis and colitis, unspecified; Diabetes mellitus due to underlying condition with hyperglycemia; Major depressive disorder, recurrent, moderate; Acute kidney failure, unspecified; Retention of urine, unspecified; Cerebrovascular disease, unspecified; Unspecified injury of shoulder and upper arm, unspecified arm, sequela; Hyperlipidemia, unspecified; Low back pain, unspecified; Legal blindness, as defined in USA; Essential (primary) hypertension and constipation. R22's MDS dated [DATE] document he was severely impaired for cognition for activities of daily living. For Oral Hygiene R22 was documented as needing supervision or touching assistance for the ability to use suitable items to clean his teeth. Section L did not mark R22 having any issues with pain, discomfort or problems chewing. R22's current Care Plan in the EMR does not address his oral health/condition of his teeth. On 3/6/2025 at 8:00 AM, R45's Dental Assessment was requested. On 3/18/2025 at 12:50 PM, No dental Assessment was provided for R45. 4. R57's POS for March of 2025 documents diagnoses of Diffuse traumatic brain injury with loss of consciousness of unspecified duration, subsequent encounter; Schizophrenia, unspecified; Psychotic disorder with delusions due to known physiological condition; Vitamin D deficiency, unspecified; Moderate protein-calorie malnutrition; Dementia in other diseases classified elsewhere, mild, with psychotic disturbance. R57's MDS dated [DATE] documents, R57 was cognitively intact for decision making of activities of daily living. R57's MDS also documents she does not have any facial pain, discomfort, or difficulty with chewing. R57's current Care Plan in the EMR does not address any oral health/dental issues. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/6/2025 at 10:28 PM, V1, Administrator stated We do not have any dental assessments on any of the residents and there is nobody coming in here and doing exams and/or providing oral care services. I am not aware of anything going on in the building addressing oral health. We just don't have anything. On 3/18/2025 at 12:32 PM, V25, Chief Executive of Operations (CEO)/ marketing stated the facility does not have any residents' dental assessments and the facility does not have anyone coming into the facility and doing Oral exams. The Dental Examination/Assessment Policy with a Revision date of December 2016 documents, Each resident shall undergo a dental assessment prior to or within ninety (90) days of admission. Resident shall be offered dental services as needed.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 35156 Based on observation, interview, and record review the Facility failed to ensure staff working in the kitchen have the appropriate training and skills to carry out the functions of the kitchen while preparing food for the residents living in the Facility. This has the potential to affect all 73 residents living in the facility. Findings include: On 3/10/2025 at 6:20 AM, V47, Cook, stated, I am the only [NAME] here in the Facility. They want me to make breakfast all by myself for over 70 people. This is ridiculous! I do not have any certification for Food Safety. We were short staff all weekend. We really need more help in the kitchen. On 3/10/2025 from 7:25 AM through 8:24 AM, no hand hygiene was observed for V47 and V17 during the entire breakfast service. V47 and V17, Activity Director, both wore the same pair of gloves without dining and disinfecting during the entire meal service. All food went out of the kitchen on Styrofoam plates including hall trays and no items were covered during transport. On 3/10/2025 at 8:00 AM, V47 served the breakfast menu with only the help of V17, Activity Director. No other staff were assisting with the breakfast service. The meal consisted of biscuits & gravy, bacon, cornflakes, oatmeal, and a banana. On 3/10/25 at 8:04 AM V17 stated to (V47), You have to hurry up, I have to take a resident to a doctor's appointment. On 3/10/2025 at 8:15 AM, V17 stated, I am not certified in Food Safety, and I do not have a valid certification. I came in this past weekend to make sure the residents got fed. I called (V1, Administrator), on both Saturday and Sunday. She told me to call (V46, Dietary Manager) so I called him, and he said he was sick. I called (V1) back and told her he could not come in because he was sick. (V1) nor anyone else came in to help in the kitchen. On 3/10/25 at 8:27 AM, V49, Certified Nursing Assistant (CNA) stated the facility had a cook over the weekend but no other staff over the weekend for breakfast and lunch, no staff for supper, residents were very upset. The housekeeping staff were even helping out. On 3/10/25 at 8:40 AM V47, stated We are missing a bunch of resident meal tickets, so I am not sure what their diet is supposed to be. On 3/11/2025 at 8:03 AM, R31 stated there was not enough dietary staff over the weekend and the housekeepers were jumping in trying to help them. R31 stated We were given soup, lunch meat sandwiches, chips and I am not supposed to have deli sandwiches. We pay them money for staying here you would think they would be required to have the staff so they could feed everyone properly. On 3/11/2025 at 8:30 AM, all kitchen staff Food safety certification were requested. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/20/2025 at V45, Housekeeping stated, I know there were some issues recently on the weekend when there was not enough help in the kitchen, I am usually off on the weekends, but I jumped in to help out in the kitchen because there was not enough help. I am just a Housekeeper, and I am not certified for Food safety. They were short staffed and needed help. Me and (V10, Housekeeping). We helped served breakfast, and lunch that weekend. On 3/20/2025 at 12:25 PM, the only certification provided by the Facility was for V46. No other Food Safety certifications were provided. On 3/20/2025 at 10:32 AM, a policy on kitchen staffing credentials and requirements was requested. On 3/20/2025 at 5:00 PM, Kitchen Policies were reviewed but no kitchen policy for staffing credentials was provided by the Facility. The Facility's Long-Term Care Facility Application for Medicare and Medicaid (CMS 671) dated /16//25 documents there are 73 residents living in the Facility.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 35156 Based on observation, interview, and record review the facility failed to ensure food was stored and prepared in a manner which prevents potential contamination. This has the potential to affect all 73 residents living in the facility. Findings include: On 3/10/2025 from 7:25 AM through 8:24 AM, no hand hygiene was observed for V47, [NAME] and V17, Activity Director during the entire breakfast service. V47 and V17, both wore the same pair of gloves without changing and/or disinfecting their hands during the entire meal service, regardless of what they handled. All food went out of the kitchen on Styrofoam plates including hall trays and no items were being covered during transport. On 3/20/2025 at 8:23 AM, before entering the walk-in-refrigerator there were cases of canned goods, 4 stacked cases of industrial canned black beans sitting directly on the floor, next to it were 6 large industrial cans of mushrooms sitting directly on the floor. Both cases were stacked with 3 more cases on top of each other. There was a large box of napkins sitting directly on the floor and the box had been opened and some of the paper napkins were loose and on the floor. The napkin box had another box stacked on top of it. On 3/20/2025 at 8:25 AM, upon entering the walk-in refrigerator there was a large plastic tub of single use containers of white vitamin D milk and 2% white milk sitting in a tub of water that was full of water about two inches. The tub was sitting directly on the refrigerator floor and was not being stored six inches off the floor. At 8:31 AM, There were also two other tubs of milk on crates full of small one time use cartons of milk filled with about two inches of water. At 8:34 AM, there was a large industrial metal pan with a brown substance in it that was not dated and/or labeled. At 8:37 AM, there were four 4-pound (#) bundles of hamburger meat that were not in a pan and were thawing and being stored above the chocolate shakes. At 8:38 AM, on the shelf were round deli looking meat all opened not covered and not dated and/or labeled. At 8:39 AM, there was an orange block of an item appearing to look like some type of cheese that was not covered, dated, and/or labeled. On 3/20/2025 at 8:40 AM, the ceiling of the walk-in refrigerator has black like spots on the ceiling, and the walk-in has a musty odor or smell to it. On 3/20/2025 at 8:49 AM, V49, [NAME] stated, I do not have my food safety certification, but I am planning on getting it. I know that tub should not be on the floor. The water inside is because it was full of ice, we put ice in it when we are serving it and then put it back in the fridge after meal service. I am not sure what it is in that pan, I have no idea what it is. If it had a label, I would know what it was. We are told to put labels on but not everyone does it. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/20/2025 at 8:51 AM, in the middle of the walk-in freezer is a large block of what appears to be a block of water that was frozen then melted and then refroze. The block of ice is in the middle of the floor and from the ceiling there is water dripping. Boxes around that area were covered with ice crystals. There was a large industrial box opened with a clear plastic bag of opened French breadsticks, and next to it was an opened bag of French fries covered in small ice crystals. The boxes were both wet. On the ceiling where the area is dripping is an area that appears to be covered in some type of polyethene tape. The area is approximately 5 feet by 3 feet. The Food Storage Policy Store Guidelines and Procedure Manual 2020 documents, dry food on shelves two inches away from walls to allow ventilation, six inches off the floor to allow for proper sanitation, and 18 inches from the ceiling to ensure fire safety. Food shall be stored on shelves in a clean, dry area free from contaminants. Food shall be stored at appropriate temperatures and using appropriate methods to ensure the highest level of food safety. Leftover contents of cans and prepared food will be stored in covered, labeled, and dated containers in refrigerators and/or freezers. Store raw animal foods such as eggs, meat, poultry, and fish separately from cooked and ready-to-eat food. If they cannot be stored separately, place raw meat, poultry, and fish items on shelves beneath cooked and ready-to-eat items. If multiple shelves are available, the raw animal food with the highest final cooking temperatures should be stored on the lowest level, i.e. poultry and stuffed foods. Raw animal foods such as eggs, meat, poultry, and fish should be stored in drip proof containers. Wrap food properly. Never leave any food item uncovered and not labeled. The Facility's Long-Term Care Facility Application for Medicare and Medicaid, CMS 671 dated 3/7/25, documents there are 73 residents living in the Facility.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35156 Based on observation, interview, and record review, the administration failed as followed: Ensure systems and personnel in place to prevent abuse, protect residents from abuse, and thoroughly investigate allegations of abuse; Failed to ensure residents behavioral health needs were met and behavioral interventions were developed and implemented; Failed to provide assessment, monitoring, and treatment for residents with weight loss, and gastrostomy tubes; Failed to provide ongoing laboratory services to monitor residents medical conditions; Failed to provide water for resident use that is at safe and comfortable temperatures. These failures have the potential to affect all 73 residents residing in the facility. The Immediate Jeopardy began on 12/20/2024 when R4 began exhibiting behaviors of banging her head. On 3/13/2025 at 11:30 AM, V25, Regional/CEO Marketing and V11, Regional MDS were notified of the Immediate Jeopardy. The surveyor confirmed by observation, interview, and record review, the Immediate Jeopardy was not removed at the time of the exit. Findings include: From 3/10/2025 to 3/25/2025 the Facility failed to have a Licensed Administrator working onsite as the Administrator in the Facility. From 3/6/2025 to 3/25/2025 the Facility failed to ensure a Director of Nursing was working full time in the Facility. From 3/6/2025 to 3/25/2025 the Facility failed to ensure a Registered Nurse was working at least 8 consecutive hours a day, 7 days a week. From 3/6/2025 to 3/25/2025 the Facility failed to ensure an Infection Control Preventionist was working part time, onsite in the Facility. From 3/6/2025 to 3/21/2025 the Facility failed to ensure The Activity Director was a qualified professional and licensed and/or registered and completed a training course approved by the State. On 3/2/25 at 6:15 PM, a physical altercation occurred between V20, Certified Nursing Assistant (CNA) and R45. R45 required emergency medical treatment and antibiotics due to the injuries caused by V20 including a bite to R45 resulting in a laceration of her finger. R45 also sustained facial lacerations and a black eye during this altercation. When V1, Administrator, became aware of this allegation/encounter V1 failed to initiate an abuse investigation and remove V20 from the facility. V20 remained onsite, caring for residents the remainder of her shift. On 3/4/25 at 2:25 PM, Surveyor requested all the facility abuse investigations for the past 3 months and V1, Administrator, replied they are not done, some of them are at my home. I have not investigated anything yet about what occurred between (R45) and (V20). I was not notified about the incident until a I got to work on Monday, 3/3/25 about noon. I didn't think she had to report the altercation between (R45) and (V20) because it was self-defense by the employee. (continued on next page)

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	145858	A. Building B. Wing	03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Au Well Care Home, Inc	152 Wilma Drive Maryville, IL 62062

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 3/4/2025 at 10:28 PM, V1, Administrator at 10:00 AM, V1, Administration stated, (R45) attacked (V20, Certified Nursing Assistant), I viewed the cameras, and it was self-defense. (V20) was defending herself. I talked with (V21, Ombudsman) and she told me I could discharge (R45) to a homeless shelter. I can't believe I might get a tag because a staff member was defending herself against a resident. This is ridiculous! On 3/7/2025 at 10:03 AM, V25, Regional CEO Marking Coordinator stated, I would not expect any staff to ever touch or lay a finger on a resident. Residents are here for a reason and staff can not hit back ever. On 3/7/2025 at 10:05 AM, V11, Regional MDS Coordinator stated, Staff are never allowed to hit, bite or defend themselves against a resident. All they are allowed to do is yell for help and try and shield themselves with their hands. On 3/4/2025 3:00 PM, V1 stated she had not seen (R45) and was not aware of any injuries. I know she has a scratch on her face and a bite on her finger from the employee defending herself. I do not have an incident report for (R45's), there is no incident report for (R45) on 3/2025. This incident occurred on 3/2/25 until she got to work on 3/3/25 so it was not reported to IDPH within 2 hours. Surveyor asked V1 where the altercation occurred and V1 replied by the nurse's station. Surveyor asked V1 to review the video surveillance of the incident and V1 replied I have not reviewed it, I will see if I can pull it up. Surveyor asked V1 if she suspended the employee pending further investigation and V1 replied no I have not because I thought the CNA was defending herself. Surveyor asked V1 how she is keeping the resident's safe from abuse since the facility has residents with mental illness and V1 replied I am trying to get R45 discharged , if the facility would have called me about the incident with her and the CNA I would have given her an involuntary discharge. V1 stated I called the Ombudsman, and she said it would be okay to discharge R45 to a homeless shelter. Surveyor asked V1 if she thought a homeless shelter could meet R45's medical and mental health needs and V1 replied I don't know. Surveyor then requested R45's pre- screen for nursing home placement documents. V1 stated she will look for them. V1 stated R45 hit the CNA V20 with a pillowcase containing soda cans because R45 didn't like how the CNA picked her up with the mechanical lift. Surveyor asked V1 what her facility assessment says about meeting the needs of the residents with mental illness since the facility has so many residents with mental illness and V1 replied I haven't had time to do a facility assessment. Our Social Service consultant said our Subpart S is fine. Surveyor asked if the facility is offering the residents with serious mental illness any group therapy, one on one meetings, or activities related to Subpart S and V1 replied no, we're not doing any of that. Surveyor requested to observe the video surveillance footage of the altercation between V20 CNA and R45. On 3/4/2025 at 3:32 PM, V1 stated they were not able to pull up the footage from the video between (V20) and (R45). (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 3/4/2025 at 3:42 PM, V21, Ombudsman, stated, (V1) called me today and told me (R45) assaulted a staff member. She asked me what she should do with (R45) and I gave her advice and said if (R45) was a danger to others and/or herself then they could do an involuntary discharge and I would assist her with it. She never told me (V20) hit the resident back and/or scratched the resident in the face. She just said the resident attacked and I told her the building would ultimately be responsible for the residents. She also asked me about doing an involuntary discharge on (R30) but after discussing his case he did not seem to be aggressive and/or at harm for others and because he is not a danger then he would not qualify for an involuntary discharge. I never told (V1) she could transfer any resident to a homeless shelter and that would be unacceptable. On 3/10/25 at 11:52 AM V11, Regional MDS Consultant, stated last Wednesday (3/5/25) he heard V22 LPN raise his voice and state to R45 if she hurts another staff member again, he will beat her to death. Additionally, R45 then made an allegation of sexual abuse by V22 in the presence of V1 and V11. V1 did not immediately suspend V22. V11 stated V22 was terminated a few days later but he did work the night shift that night (3/5/25) after V22 threatened R45. V25, Regional, was present and stated this was not reported to IDPH, there is no investigation for this, nor is there any documentation in V22's employee file. On 3/12/25 at approximately 11:00 AM V11 provided a written statement authored by him that documented on 3/5/25 at approx. 11:30 AM I witnessed V22 LPN walk into the Administrator's office and V22 told V1 that he wanted to talk to R45 in her office, V1 said ok, that's fine. V1 then closed her door. I heard V22 raise his voice and state that he wasn't going to allow her to attack another female staff member and if she did, he was going to beat her to death. I got up and immediately knocked on the door to pull V22 out of that room, but I heard V1 tell V22 don't answer it, it's just V11. V22 continued to yell at R45 for approx. two minutes telling her that he won't allow her to attack anyone else and he said to her try it again and see what happens. V22 then said, I heard you are saying that I sexually assault you, are you crazy. I heard R45 say you put your balls on my head. V22 yelled loudly no I didn't, you're crazy, I would never do that. R45 said I'm leaving then V22 opened the door and left. I immediately went into V1's office and told her he needs either immediately suspended or terminated. She told me Well he is off duty, I told her it didn't matter because he will have to come to work and R45 will have to be around him. She said to me that she was the administrator and that she has been doing this many years and she knows what she is doing besides he was just standing up for a staff member that got seriously hurt and told me again to keep my mouth shut about thing I don't know what I'm talking about. V1 then told me she was going to call V25 and picked up her phone and told me to get out of her office and close the door. On 3/5/2025 at 3:31 PM, V1 stated she had received a letter from (V3, Medical Director/Owner) telling her she was going to be terminated and she was not sure how much longer she would be working. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 3/12/25 at 9:45 AM, V25, Regional CEO Marking Coordinator stated, (V1) the administrator was considered no longer employed at the facility as of 3/10/25, when she was a no call, no show. (V11) told me he had confirmed that (V1) was to have reported to work on 3/10/25 and I personally had a previous conversation with (V1) prior to her start of shift on 3/10/2025 when she indicated she would be reporting to work. Then on 3/10/2025 (V1) never showed up and she never told us what was happening. I confirmed with other people that she was not in the hospital and/or injured because I was worried. (V1) has just decided she is not going to come back here to work. Frankly, I would not want her to come back here anyway. (V1) just quit answering any messages, calls, and denied any correspondence with the facility. I would not expect any staff to ever hit back or defend themselves against a resident. The residents are here for a reason, and they should know they are never allowed to hit or strike back. On 3/12/2025 at 10:02 AM, V11, Regional Minimum Data Set (MDS) Coordinator stated, (V1) did not provide the facility any communication of things still needing to be done, abuse investigations that are in progress, abuse investigations that need finals, or initials, etc. The facility is now operating without a licensed administrator, and they are working on getting a new administrator and DON hired. (V25, Regional CEO of Marketing) is acting as the abuse coordinator at this time. I would not expect any staff to ever hit back or defend themselves against a resident. They should yell for help or try and run away. I would absolutely consider (V1's) lack of administration at the facility as well as her being a no call no show to be neglect. I find (V1's) actions appalling and will be reporting her to IDFPR (Illinois Department of Financial and Professional Regulations myself because she should not be allowed to work as an administrator. I had expressed concerns to (V1) regarding abuse and the lack of care occurring at the facility but was told, she was the administrator and would take care of it. I know for a fact (V1) has been trained in abuse, policy, and procedures. On 3/12/2025 at 11:18 AM, V25, Corporate/CEO marketing stated, I think (V1) abandoned us, and it was neglectful to the facility and the residents. R55's Initial Report dated 2/11/2025 at 12:00 PM, This is a late report. This writer was made aware of the possible altercation reading a progress note. Resident (R55) allegedly flipped another resident out of their wheelchair. The victim is not known at this time. The allegation will be investigated, and the report will be submitted upon completion. On 3/6/2025 at 10:28 PM, V1, stated, I found the initial report for (R55) but to be honest I am not sure I even did a final on it. I am not sure who the other resident was that was flipped. I did not do a final report and I don't know the name of the other resident. I have been left alone to do all of this stuff and frankly, I can't keep up with everything that needs to be done here but I am trying my best. I do not have any final reports. I know I am supposed to report everything, but I am by myself, I do not have any DON or support and I just can't do it all. I should have done it, but I am being honest I have not gotten around to it. I do not have and final reports for (R2, R3, R5, R24, R30, R38, R45, R55 and R68). R2, R3, R5, R24, R30, R38, R45, R55 and R68's Final Reports were never investigated and reported to the state agency. R55's Report also failed to document the name of the resident R55 flipped over in the wheelchair in the initial report and no final report was completed. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 3/6/2025 at 10:50 AM, V1, Administrator stated, I did recently get tagged on not having a Facility Assessment but honestly, things have been so busy, and I still do not have a Director of Nursing (DON), and I just have not had time to put anything together. I know we are supposed to have a Facility Assessment, but I have been so busy doing other things. I do not have a Facility assessment or even anything that is in place to look at what resources we already have and what we need for day-to-day operations. I inherited this mess. We do not have RN coverage, Facility Assessment, or Certified Dietary Manager. We do not have any programs that are addressing any SMI (Serious Mental Illness) and I know we have a lot of SMI residents. I have not completed all of my abuse investigations and I know I am here working my ass off and I honestly cannot keep up. During this survey V1 was unable to provide a Facility Assessment. From 3/6/2025 to 3/21/2025 the facility lacks a system to ensure facility staff are educated at least annually on the facility abuse policy. From 3/6/2025 to 3/20/2025 The facility lacks a system to ensure safety plans are implemented as recommended by local hospital's crisis management team and psychiatry. No psychiatric services were no longer being provided to any of the residents. From 3/6/2025 to 3/20/2025 The Facility lacks an effective QAPI program to identify, monitor, and make corrective actions. During this survey R2, R3, R5, R24, R30, R38, R45, R55 and R68's abuse investigation final reports were not completed and/or submitted to the State. All staff involved (V22, Licensed Practical Nurse (LPN), and V20, Certified Nursing Assistant CNA), were allowed to continue to work and were not sent home and did not clock out. V20 and V22's timecards were reviewed and document they continued to provide services. On 3/12/2025 at 11:02 AM, V25, Regional CEO/ Marketing and current abuse coordinator stated, We are not sure why there were no final reports completed for abuse but (V1) was trained on abuse and we are shocked that she did not follow up and complete the investigations. I am not sure what happened. During this survey there were 9 resident allegations (R2, R3, R5, R24, R30, R38, R45, R55 and R68) of abuse that were reviewed and 9 of the investigations were incomplete, staff were not sent home, and nothing was put in place to ensure residents were safe until the investigation was completed for R2, R3, R5, R24, R30, R38, R45, R55 and R68. On 3/7/2025 at 12:05 AM, V15, Social Service Director stated, I just started working here back in June and/or July. I do not have my certification and I am not currently enrolled in any classes. I am hoping to be the Administrator. (V1), the DON (Director of Nursing) and Administration work as a team to address any issues in the building. V11, Regional MDS is also part of that team. I am not currently doing any groups meetings and we do have several residents that are alcoholics and/or were addicted to drugs. No groups have started yet. I am not doing any behavioral interventions at this time. I do not believe I have been trained in that, but I do work with (Counseling group). We currently do not have a DON working in the facility. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 3/5/2025 at 10:00 AM, Psychosocial/Behavior programs were requested to V1 and V3 for R3, R4, R55 and R79. No proof of Psychosocial/Behavior programs for R3, R4, R55, and R79, and were not provided by the Facility. On 3/7/2025 at 3:53 PM, V1, Administrator stated the facility had no Behavior programs at all. The only thing they were currently doing in the facility was the counseling through (Counseling Services). We have nothing in place and that's tough because this facility has a lot of SMI residents. I believe that is why we have so many abuse allegations and then there are so many allegations I can't keep up because there are no programs in place for these residents. I have tried to talk to (V3, Owner/Medical Director) and he is constantly changing his vision and what he wants this building to be. Originally, he talked about making this more of a mom and pop nursing home and he talked about making a ventilator unit and/or dialysis unit, specialized units. For now, this building already has a lot of SMI residents so what do we do with them. We need programs for the residents and the staff and there are not any in place. Water temperatures in resident rooms were not being taken daily. Resident water temperatures were not safe, comfortable, and homelike on 3/6/2025, 3/7/2025 and 3/10/2025. Water temperatures were cold and hot varying in temperatures. On 3/6/2025 at 3:14 PM, Water temperatures were taken with a metal calibrated thermometer. On 3/6/2025 at 3:20 PM, There are two shower rooms on the 200 hall. The first shower room has no sink and or toilet only a shower and the water temperature after running the water for one minute registered 74.8 Fahrenheit. (F). On 3/6/2025 at 3:21 PM, V24, Certified Nursing Assistant stated, Residents use both showers on both halls it does not matter what halls they are on they use both sides. On 3/6/2024 at 3:32 PM, On the 200 halls on the opposite area next to the nurse's station was the second shower. In the shower room the sink has a sign that documents, Do No use sign there was a working toilet and the shower temperature running for two minutes was 74.2 F and the sink temperature running for two minutes was 72.4 F. On 3/6/2025 at 3:39 PM, R67, and R68 share a bathroom with R69. The sink water temperature after running for one minute was 89.7, (F) Fahrenheit. On 3/6/2025 at 3:48 PM, R60, and R61 share a Room with R63 and R64, the water temperature at the sink after running for one minute was 83.5 F. On 3/6/2025 at 3:54 PM, R58 and R59's water temperature at the sink after running for one minute was 89.9 F. On 3/6/2025 at 4:02 PM, R38, and R39 share a room with R40, and R41 the water temperature at the sink after running for one minute was 64.0 F. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 3/6/2025 at 4:04 PM, R38 stated, The water temperature is very aggravating, and this has been going on for so long. The water is cold, then it is warm, then it is hot now it is cold. I don't want to take a shower when the water is cold, would you want to take a cold shower. The water is cold today. On 3/6/2025 at 4:14 PM, R44 and R6's bathroom sink water temperature after running the water for one minute was 64.7 F. On 3/6/2025 at 4:19 PM, R49, R50, R53 and R54's bathroom water sink temperature after running for one minute was 70.4 F. On 3/6/2025 at 4:22 PM, R54 stated, The water really needs to be hotter. I personally, don't like to take cold showers. This has been going on for months and I mean months. I try and go to a friend's house at least once a week just to take a shower. I am lucky I have a friend who will let me go and take a shower at their home. Not everyone can do that. The water is too cold especially today. I am not sure anybody would want to take a shower with the water being so cold. On 3/6/2025 at 4:33 PM, R47, R48, R51 and R52's water temperature in the bathroom running for one minute sink temperature was 68.4 F. On 3/6/2025 at 4:37 PM, R47 stated, the water is cold again, the water does not stay hot. I don't want a shower in this cold water. This has been going on since December. Nobody wants a cold shower. On 3/6/2025 at 4:43 PM, R42's Water temperature in her bathroom sink running for one minute was 62.4F. On 3/6/2025 at 4:49 PM, R50 stated, the water is terrible today. Now it is cold again. When staff clean me up the water is so cold and its very uncomfortable to me. I don't like taking cold showers. On 3/6/2025 at 4:52 PM, R70 and R71, R73's water temperature at the bathroom sink running for one minute was 62.8 F. On 3/6/2025 at 4:59 PM, R73, R74, R75 and R76's Room at the bathroom sink running for one minute was 67.5 F. On 3/6/2025 at 5:00 PM, R74 stated the water was cold again this morning. It was nice on Saturday but it's cold again today. We have been having issues with cold water for too long. On 3/6/202 at 5:02 PM, R78's room at the bathroom sink running for one minute was 62.4F. On 3/6/2025 at 5:03 PM, 100 Hall Shower room running for one minute at the sink was 85.1 F, at the Shower running for one minute the water temperature was 75.4 F. On 3/6/2025 at 5:04 PM, R19, R20 and R37's water temperature at the bathroom sink running for one minute was 86.7 F. On 3/6/2025 at 5:09 AM, R15, R16, R17, and R18's water temperature a the bathroom sink running for one minute was 84.7 F. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 3/7/2025 at 3:53 PM, V1, Administrator stated, I know we have been having issues with the water temperatures being off and on again since January 2025. I am not sure what (V3) is going to do but I wish he would stop putting a temporary fix and he would just replace the whole system so we could have hot water in this building. On 3/7/2025, 3/10/2025, 3/11/2025 and 3/12/2024 the Facility was not following their menus during the lunch service. On 3/7/2025 at 8:30 AM, The Dietary Manager Certification was requested to V1. No Dietary Manager Certification was provided. On 3/7/2025 at 3:54 PM, V1 stated, I need more trained staff in the kitchen. I know our dietary manager was working on getting his certification. I am not sure if he is done with classes. I know they are not following the menus in the kitchen and now that is another thing I have to add to my plate to make sure the right foods are being ordered and served to the residents. V1's Job summary undated documents, We are seeking a dedicated and experienced Administrator to oversee operations within our senior care facility. The ideal candidate will possess strong leadership skills and a passion of providing exceptional care to our residents. This role involves managing daily operations, ensuring compliance with care standards, and fostering a supportive environment for both staff and residents. The Administrator will play a crucial role in enhancing the quality of life for seniors, particularly those requiring dementia care. Responsibilities: Lead and supervise staff members ensuring high standards of care and service deliver. Oversee medication administration processes to ensure safety and compliance with regulations. Manage daily operations of the retirement home, including staffing, scheduling, and resource allocation. Collaborate with healthcare professionals to coordinate home care services for residents. Conduct regular assessment of residents' needs and adjust care plans accordingly. Ensure adherence to all regulatory requirements related to senior care and dementia management. [NAME] a positive environment that promotes resident engagement and well-being. Provide training and support for staff in areas such as operations management and caregiving techniques. On 3/11/2025 at 5:14 PM, V2 stated, (V1, Administrator) was not here today and I am not sure if she would be returning. Last week she told me they were firing her. I heard she was not coming back. Things are crazy and I am only one person. I am late passing out medications and on top of that I had to deal with the police and (R3). I just can't do all of this stuff on my own. I am over two hours late with passing the medication but what am I supposed to do? We still do not have a Director of Nursing (DON) and now we do not even have an Administrator. I don't know what we are going to do. V1's Training on Resident Rights dated 11/18/2024 documents she had received a copy of Resident Rights and understand that I will be held responsible to report all/any violations to my immediate supervisor. V1's Abuse Acknowledgement dated 11/18/2024 documents, I (V1) have been trained and in-serviced on (Facility) abuse prevention program. I also understand it is my responsibility to report immediately to the Administrator any suspected/reported abuse. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 3/13/2025 at 10:05 AM, V39, Dietician stated, I usually send all of my recommendations for nutrition to the DON (Director of Nursing) but since they do not have a DON, I have been sending everything to (V1). (V1) requested that I send her everything. I have the same orders on three separate occasions for (R50) because the facility was not doing what I had first recommended the previous two times. (R50) did have significant weight loss. I am not sure where the breakdown was, but the facility was not following my recommendations and not implementing anything I was telling them to do. I do not know what is going in in the building, but something has got give. The Facility staff failed to do the ordered weekly skin assessment and identify and treat a wound (diabetic ulcer) for R42. This failure resulted in R42, who had a known lower extremity insufficiency, diabetic mellitus, history of dry gangrene of left foot, and amputation or left 1st toe, who was complaining of left foot pain on 2/20/2025 through 2/22/2025 without any skin assessment being completed. R42 was sent out to the emergency roiagnom on [DATE] for excruciating pain of her left foot that was unrelieved by narcotics. R42's clinical lack any ordered weekly assessment done since 2/10/202. R42 was found by the ER (emergency room) to have a wound to her left dorsal (back) of foot for 2-3 months without evaluation or treatment that was noted to have extensive necrosis of the left anterior compartment with infection spreading to the proximal calf, required antibiotics, fluids and IV pain medications which ultimately lead to the amputation of her left above the knee due to severe infection. On 3/21/2025 at 10:02 AM, V25, stated I am not sure what happened, but we do not have any current lab company in place. I am going to look into and see what happened. I would expect if there is an order for labs for the lab work to be completed. R37 experienced a significant change in condition for 2 days without interventions that ultimately required an emergency transfer and 42 day stay in the hospital that included Intensive Care Unit stay with mechanical intubation. Multiple staff failed to promptly identify a change of condition from R37's baseline and coordinate care with the medical physician that addresses the change of condition, which has the potential to prevent decline or even life-threatening consequences for the resident. This failure resulted in R37, who was known to have a history of cirrhosis with ascites and hepatic encephalopathy, had a change of condition on the morning of 12/8/24 with symptoms of slow to respond/arouse, signs and symptoms of pain and discomfort. Throughout the day on 12/9/24 R37 continued to be slow to arouse, not eating, given medication thru an oral syringe, tremors and grimacing with touch with no MD notification. At 7:34PM on 12/9/24, R37 was documented with unordered oxygen therapy @ 2L with a SPO2 of 85-89% and 911 was called and was sent out to the ER for low oxygen sat (saturations) and altered mental status. R37 was found to have highly elevated ammonia levels that required an admission to the hospital for 42 days included required mechanical ventilation. R37 was diagnosed with decompensated cirrhosis, hepatic encephalopathy, urinary tract infection, and pneumonia. The undated Facility Policy on Administration undated documents, The purpose of this policy is to establish clear guidelines for the administration of (Facility) to ensure compliance with state regulations, efficient facility operations, and the highest standard of care for residents. This policy applies to all administrative staff, including the Executive Director, Nursing Director, department heads, and all employees involved in facility management. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A Receipt filed by V11, against V1 to the Illinois Department of Professional Regulations, documents Notification Letter documenting, We have received the following information. Your complaint is against (V1). (V1) failed to report to IDPH abuse 7 of the last 8 abuse claims. (V1) allowed a night nurse to come into the facility and confront. Six abatement plans were provided by the facility to the Illinois Department of Public Health between 3/14/25-4/1/25, all being unapproved.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. 35156 Based on interview and record review the Facility failed to ensure a Resident Assessment was completed for the Facility. This has the potential to affect all 73 residents living in the facility. Findings include: On 3/4/2025 at 10:02 AM, V1, Administrator stated, I did recently get tagged on not having a Facility Assessment but honestly, things have been so busy, and I still do not have a Director of Nursing (DON), and I just have not had time to put anything together. I know we are supposed to have a Facility Assessment, but I have been so busy doing other things. I do not have a Facility assessment or even anything that is in place to look at what resources we already have and what we need for day-to-day operations. I inherited this mess. All policies provided by the Facility were reviewed but there was no Facility Assessment provided to review for the Facility. On 3/4/2025 at 3:33 PM, V1 stated she did not have a policy on requiring a Facility Assessment but knows they are supposed to have one. The Facility's Long-Term Care Facility Application for Medicare and Medicaid (CMS 671) dated 3/7/25 documents there are 73 residents living in the Facility.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 35156 Based on observation, interview and record review, the facility failed to ensure an Infection Control Preventionist (ICP) was working at least part-time onsite at the facility. This has the potential to affect all 73 residents living in the facility. Findings include: From 3/6/2025 to 3/21/2025 the Facility failed to ensure an Infection Control Specialist was working part time, onsite in the Facility. During this survey no ICP was observed working onsite in the Facility. On 3/25/2025 at 9:02 AM, A line list of the COVID testing was requested. On 3/25/2025 at 9:09 AM, V60, ICP stated via phone interview, I just started working for the facility about a month ago. I do work at another facility and try and working at both facility as the ICP. In the last month I have only been at the (Facility) for three times. I do most of my work from home. I do not work part time in the building at the facility. I do most of my work from home. I am not sure regarding the recent COVID, but I would expect them to be testing on day 1, day 3 and day 5. I am not sure where they are at with that. On 3/25/2025 at 10:50 AM, timecards were requested for both facilities where V60 worked. On 3/25/2025 at 12:30 PM, No line list had been provided. V60's timecards for the week of March 2, 2025 to March 8, 2025 documents V60 worked a total 3.5 hours total. V60's timecard for the week of March 9, 2025 to March 15, 2025 documents V60 worked a total of 1.5 hours. V60's timecard for the week of March 16, 2025 to March 22, 2025 documents V60 worked a total of 5 hours. V60's timecard for the week of March 23, 2025 to March 25,2025 does not document she was working in the facility this week. The Facility's Long-Term Care Facility Application for Medicare and Medicaid (CMS 671) dated 3/7/25 documents there are 73 residents living in the Facility.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35156 Based on observation, interview, and record review, the Facility failed to ensure the plumbing and equipment was in safe, working condition and water temperatures were not being affected in residential areas. This has the potential to affect all 73 residents living in the Facility. Findings include: On 3/4/2025 at 2:22 PM, a tour of the basement was conducted in which two large boilers were observed, but only one boiler was working. The temperature gauge on the working boiler was registering 78.0 Fahrenheit (F). On 3/4/2025 at 3:53 PM, V1, Administrator stated, The plumbers were out here on 2/28/2025 and they were replacing a mixing valve because we did not have hot water. I do not have an invoice yet. We thought that fixed the issues with not having hot water. I know we've been having issues with the hot water off and on again since January 2025. We only have one boiler that is currently working but I believe it is supposed to be replaced. On 3/7/2025 at 1:45 PM, V17, Activity Director stated, I noticed back in December we started getting complaints from residents about the water being cold. I know last week they were so happy because they said the hot water was finally working again. On 3/7/2025 at 2:36 PM, V29, Maintenance Man stated, I started working here on 1/23/2025 and from day one I have been having issues with the water temperatures here in this building. Ideally water temperature should be above 104 and below 115. The gauge should read 150 F. I know it is at 78.0 F now and the water is cold. On 3/7/2025 at 2:54 PM, V2, Assistant Director of Nursing stated, the facility has been having issues with the water temperatures since December. On 3/7/2025 at 4:14 PM, R30 stated we have been having issues with water temperatures since December. First it was cold now it is too hot. We need something in the middle you know. M The Facility's Water Temperatures were tested with a metal calibrated thermometer after running hot water for greater than one minute on the following dates/times with the following temperatures: On 3/6/2025 at 8:35 AM, the 100-hall shower room was 116.5 Fahrenheit (F) and the 200-hall shower room was 117.0 F. On 3/6/2025 at 8:30 AM, R1's Bathroom Sink Water Temperature was tested with a metal calibrated thermometer after running hot water for greater than one minute on the following dates/times with the following temperatures: On 3/6/25, at 8:38 AM, R3's Bathroom Sink Water Temperature was tested with a metal calibrated thermometer after running hot water for greater than one minute and the peak temperature was 116.4 F. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/6/2025, at 8:45 AM R4's and R55's Bathroom Sink Water Temperature was tested with a metal calibrated thermometer after running hot water for greater than one minute and the peak water temperature was 116.4 F. On 3/6/2025 at 8:48 AM, R57's Bathroom Sink Water Temperature was tested with a metal calibrated thermometer after running hot water for greater than one minute and the peak water temperature was 115.9 F. On 3/6/2025 at 8:49 AM, R5 and R6's Bathroom Sink Water Temperature was tested with a metal calibrated thermometer after running hot water for greater than one minute and the peak water temperature was 116.1 F. On 3/6/2025 at 8:52 AM, R74's Bathroom Sink Water Temperature was tested with a metal calibrated thermometer after running hot water for greater than one minute and the peak water temperature was 116.4 F. On 3/6/2026 at 8:53 AM, R15 and R16's Bathroom Sink Water Temperature was tested with a metal calibrated thermometer after running hot water for greater than one minute and the peak water temperature was 115.9 F. On 3/6/2025 at 9:02 AM, R30's Bathroom Sink Water Temperature was tested with a metal calibrated thermometer after running hot water for greater than one minute and the peak water temperature was 118.9 F. On 3/7/2025 at 8:03 AM, the 100-hall shower room was 116.4 F and the 200-hall 118.4 F. On 3/7/2025 at 8:30 AM, R1's Bathroom Sink Water Temperature was tested with a metal calibrated thermometer after running hot water for greater than one minute and the peak temperature was 116.7 F. On 3/7/25, at 8:38 AM, R3's Bathroom Sink Water Temperature was tested with a metal calibrated thermometer after running hot water for greater than one minute and the peak temperature was 116.5 F. On 3/7/2025, at 8:48 AM R4 and R55's's Bathroom Sink Water Temperature was tested with a metal calibrated thermometer after running hot water for greater than one minute and the peak water temperature was 117.4 F. On 3/7/2025 at 8:53 AM, R57's Bathroom Sink Water Temperature was tested with a metal calibrated thermometer after running hot water for greater than one minute and the peak water temperature was 116.9 F. On 3/7/2025 at 8:50 AM, R5 and R6's Bathroom Sink Water Temperature was tested with a metal calibrated thermometer after running hot water for greater than one minute and the peak water temperature was 116.4 F. On 3/7/2025 at 8:54 AM, R74's Bathroom Sink Water Temperature was tested with a metal calibrated thermometer after running hot water for greater than one minute and the peak water temperature was 116.5 F. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/7/2026 at 8:59 AM, R15 and R16's Bathroom Sink Water Temperature was tested with a metal calibrated thermometer after running hot water for greater than one minute and the peak water temperature was 116.9 F. On 3/10/2025 at 8:35 AM, the 100-hall shower room was 116.7 Fahrenheit (F) and the 200-hall shower room was 117.4 F. On 3/10/2025 at 2:19 PM, R69's Bathroom Sink Water Temperature was tested with a metal calibrated thermometer after running hot water for greater than one minute and the peak water temperature was 116.5 F. On 3/10/2025 at 2:19 PM, R55 and R4's R69's Bathroom Sink Water Temperature was tested with a metal calibrated thermometer after running hot water for greater than one minute and the peak water temperature was 120.6 F. On 3/10/2025 at 2:22 PM, R46's Bathroom Sink Water Temperature was tested with a metal calibrated thermometer after running hot water for greater than one minute and the peak water temperature was 116.1 F. On 3/10/2025 at 2:24 PM, R74's R69's Bathroom Sink Water Temperature was tested with a metal calibrated thermometer after running hot water for greater than one minute and the peak water temperature was 119.1 F. On 3/10/2025 at 2:39 PM, R23 and R69's Bathroom Sink Water Temperature was tested with a metal calibrated thermometer after running hot water for greater than one minute and the peak water temperature was 115.4 F. On 3/11/2025 at 8:39 AM, the 100-hall shower room was 115.9 F and the 200-hall shower room was 116.5 F On 3/13/25 at 10:31 AM, R4 and R55's Bathroom Sink Water Temperature was tested with a metal calibrated thermometer after running hot water for greater than one minute and the peak water temperature was 120.3 F. On 3/13/2025 at 10:33 AM room R74's Bathroom Sink Water Temperature was tested with a metal calibrated thermometer after running hot water for greater than one minute and the peak water temperature was 117.5 F. Maintenance Water Temperature Log dated 3/7/2025 documents East Shower room [ROOM NUMBER] degrees Fahrenheit, and west shower room [ROOM NUMBER].0 degrees Fahrenheit. The Maintenance Logs does not document any hot water temperatures. The Facility Plumbing Invoice date of service 1/29/2025 documents, 1-29, called out for broken hot waterline water was coming out of tunnel, found line leaking in a room at the end of hall fixed line and restored water to building. 1-30, recalled out still no hot water, went thru all tunnels could not find break, isolated different areas with valves, finally found a leak in hot waterline under kitchen floor leaking, installed valve to isolate no more leaking lines. 2-3, install new hot water line to kitchen area for 3 pan sink and prep sink. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Facility Plumbing invoice date of service 1/30/2025, requested quotes to get boilers operational and back up and running as there is not proper hot water in the building. Both boilers are in desperate need of service and repair. Unit 1 needs a new inducer motor, igniter, and control board as well as a complete tear down of the condensation line and clean out for proper operation of the boiler. (please note that parts are listed from the manufacturer. Also there will be a complete flushing of the heat exchanger. Unit 2 needs a new igniter and inducer motor as it is struggling to maintain what it is doing now. And would also need a cleaning if the condensate trap and heat exchanger as well. Parts are days out on these items as well. Please call technician if you wish to proceed. The Illinois Department on Aging Residents' Rights for People in Long-Term Care Facilities revised 11/18 documents, Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Your facility must be safe, clean, comfortable and homelike. The Undated Water Temperature Policy documents, Plumbing fixtures used by residents should provide tempered water between 105- and 120-degrees Fahrenheit (F). The Facility's Long-Term Care Facility Application for Medicare and Medicaid (CMS 671) dated 3/7/25 documents there are 73 residents living in the Facility.