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	04/15/2025

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 0600 Level of Harm - Actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45302 Based on observation, interview and record review, the facility failed to ensure residents were free of mental anguish which rose to the level of neglect for 12 of 30 residents (R11, R12, R17, R22, R29, R30, R31, R38, R39, R43, R65, R74) reviewed for neglect in the sample of 78. This failure resulted in psychosocial harm by evidence of ; R30 stating the facility closure and transfer process was very traumatic, describing himself as not even being treated like a human; R29 expressing feelings of helplessness; R31 describing trying to receive his medications after transfer as being a nightmare; R22 describing being able to take a hot shower as hearing angels singing; R17 described living in the facility as a sinking ship; R74 described being curled in the fetal position that she prayed to God that she'd have a place to live the next day; R11 described feelings of being upset, anxious, and sad. Findings include: 1- R30's Facesheet documents a diagnosis of Type 2 diabetes mellitus without complications; and essential hypertension. R30's Minimum Data Set (MDS) dated [DATE] documents he was cognitively intact for decision making of activities of daily living. R30's Care Plan with a start date of 3/26/2025 document, Problem: Abuse/Neglect: (R30) is at risk for abuse and neglect related to impaired mobility, limited range of motion, self-isolation, refusal of care, refusal of prescribed medications. R30's Progress Notes dated 4/4/2025 at 7:17 PM, CEO (V70 CEO, Marketing) notified Police and fire department d/c (discharge) paperwork was given, resident refused to leave also, resident's b/p (blood pressure) was elevated 213/109, resident was advised by MD (Medical Doctor) to go to ER (emergency room) and get medical TX (treatment) due to hypertensive emergency, resident refused to go to hospital, resident did receive discharge paperwork and medication information after deciding to leave, this nurse went over medication information, MD aware patient left via local fire services made the decision to d/c (discharge) to hotel per resident's choice. Resident is own responsible party. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Actual harm Residents Affected - Some	On 4/8/2025 at 5:12 PM, R30 stated, I know my rights and I was supposed to have thirty days from the letter to give me a chance to decide where I even wanted to go. The Facility failed to do this, and then they kicked me out the door. When I left, they said they were going to send me with my medications. When I got to the (Hotel) I did not have a glucometer to measure my blood sugar and they only sent me one pen of long-term insulin. There were three pens in the package, but the other two pens were (R23's) and (R12's) insulin so I guess they did not get all their medication either. I am also already out of my statin medications for my cholesterol. I don't know why they sent me there without my medications. I did not get a facesheet or any paper telling me what medicine I am supposed to be taking. The ADON (V68) told me she was going to send me a list but there was no list. The whole ordeal gave me a severe migraine. They violated my rights, and they did not even care how they were treating me. They treated me like I was not even a human being. You were there, you saw it was very traumatic, and it's not even over yet. 2- R29's Face sheet documents a diagnosis of Alcoholic cirrhosis of liver without ascites; Type 2 diabetes mellitus without complications; Chronic kidney disease, stage 3 unspecified; and Acute and subacute hepatic failure without coma. R29's MDS dated [DATE] document R29 was moderately impaired for cognition. R29's Care Plan with a start dated of 12/13/2024 for Abuse/neglect document (R29) is at risk for abuse and neglect related to immobility and requires assistance with all ADL's (activities of daily living). On 4/9/2025 at 9:20 AM, R29 stated, I did not get my money that they owe me from the other facility. This whole thing felt so rushed and unorganized. It's hard going to a new place and then not having things in place when you get here. I am not even sure when I will get my next $60.00 because they are missing stuff at the new (Facility) that the old (Facility) never sent with them. I do not have money for anything, no soda, no food deliver, nothing. It makes me feel helpless. This has been so hard. I miss my friends, especially (R73), and (R73) wanted to go wherever I was going but we are not together now. I am trying to adjust but it is not easy. I did not have all my medications when I got here either. I did not get my television and who knows what else they did not send. I am missing my new shoes too and my pants. I only have this pair of pants. We needed more time, but I am trying to adjust because I do not have a choice. On 4/9/2025 at 9:24 AM, V69, Director of Nursing of (V14, Facility N stated), We had to use the emergency pulled cart to get medication for (R29) because the (Facility) did not send us all of his medication. (R29) was missing several medications. (R29) was missing his hydrocodone/APAP 5/325 milligrams (mg); gabapentin 100 mg, Sodium polystyrene sulfonate vial; basaglar kwikpen, 1 syringe; amlodipine besylate 5 mg, ondansetron 4 mg; Tamsulosin and .4 mg (Zofran). We are looking into his money too but nobody at the (Facility) is answering our calls. 3-R31's Undated Face Sheet, documents he was initially admitted on [DATE] with a diagnosis of Human Immunodeficiency Virus (HIV.) R31's Care Plan, dated 9/6/2022 documents R31 is positive for HIV. R31's Physician's Order Sheet (POS) dated 4/2025 documents Tivicay (HIV medication) 50 milligrams (mg) once a day. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	R31's Treatment Administration Record (TAR) dated 4/2025 staff documented Tivicay 50 mg was not administered to R31 on 4/5/2025, 4/6/2025 or 4/7/2025. On 4/8/2025 at 10:15 AM R31 stated his medications were a nightmare because the facility didn't send his medications with him, but the new facility was able to get all medications refilled other than his HIV medication, which he hasn't had since 4/4/2025 (four days of missing medication). On 4/8/2025 at 8:27 AM V18, Administrator at (Facility V13) stated on 4/4/2025 (R31) was admitted to the facility by staff and he wasn't admitted with his medications. (Facility V13) notified the pharmacy and was finally able to get all (R31's) medications refilled from the pharmacy except his HIV medication, Tivicay, and it's an expensive medication that the pharmacy stated it is too soon to refill but she is working with the pharmacy on getting the medication filled. V18 stated she notified the facility's staff physician on Friday, April 4th at 12:41 PM that R31 arrived at the facility without his medications, and staff messaged her back stating R31's medications would be delivered to the facility shortly at 3:37 PM, On 4/8/2025 at 11:00 AM V18 stated facility staff delivered R31's HIV medication. R31 missed the HIV medication on 4/5/2025, 4/6/2025 and 4/7/2025. An article published by Northwestern Memorial Hospital, dated 8/22 and titled as Patient Education for Dolutegravir (Tivicay) states, It is important not to miss any doses of dolutegravir. Missing a dose will increase your risk of getting HIV or becoming resistant to this medication. 4-R22's Undated Face Sheet documents he was initially admitted to the facility on [DATE] with diagnosis including major depressive disorder. R22's MDS dated [DATE] documents he was cognitively intact. On 4/8/2025 at 9:00 AM R22 stated he is so much happier because (Facility V13) is a lot cleaner and they have hot water. R22 stated he took a 30 minute hot shower this morning and he heard angels. The facility didn't have water let alone hot water and it was so dirty, mice and cockroaches were his roommates. 5- R17's Undated Face Sheet documents she was initially admitted to the facility on [DATE] with diagnoses including Hemiplegia, unspecified affecting left nondominant side, Nontraumatic intracranial hemorrhage, unspecified; Type 2 diabetes mellitus without complications; Generalized anxiety disorder; Chronic pain; Chronic kidney disease, stage 3 unspecified and Acute combined systolic (congestive) and diastolic (congestive) heart failure. R17's MDS dated [DATE] documents she was cognitively intact. On 4/08/25 at 1:30 PM R17 is sitting up in her wheelchair outside of her room. She is dressed appropriately in clean clothes, hair is clean and neatly groomed, she is smiling and is happy. On 4/8/2025 at 1:33 PM, R17 stated she said this facility is so much better than the other place and she is over the moon about being here. She said the staff here are top notch. R17 said she felt like the other facility was a sinking ship and this facility was her lifeboat. She said she is gloriously happy to be here. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	6- R74's Face Sheet documents she was initially admitted to the facility on [DATE] with diagnoses including anxiety and major depressive disorder. R74's Face sheet document she was discharged on [DATE] at 8:31 PM. R74's MDS, dated [DATE] documents she was cognitively intact for decision making of activities of daily living. On 4/3/2025 at 9:33 AM, R74 stated, Everyone is telling us that everyone has to leave today. We have no choices, and they just want us out. I am so stressed! On 4/8/2025 at 10:40 AM R74 stated she stated she didn't have a choice on what facility she was being transferred to and no staff at the facility would tell her what's going on other than they were closing and she had to leave. She cried when she was told she was being kicked out of the facility because she didn't know why she was being kicked out and no staff would talk to her. She was informed she was being kicked out of the facility on 4/2/2025 and was transferred to on 4/3/2025. She stated she felt like an animal being shipped from one facility to another and she didn't have any notice on the move and it caused her anxiety. R74 stated she curled herself into the fetal position all night on 4/2/2025 crying she prayed to God that she had a place to live the next day. She is missing clothes and her friends. 7- R11's Face Sheet documents a diagnosis of Rhabdomyolysis, Irritable bowel syndrome with diarrhea, Barrett's esophagus without dysplasia, Type 2 diabetes mellitus without complications, Other specified arthritis, multiple sites, Moderate protein-calorie malnutrition, Bipolar disorder, unspecified, Essential (primary) hypertension, Other specified arthritis, multiple sites, chronic kidney disease, stage 4 (severe), and Diabetes insipidus. R11's Face Sheet documents R11 was discharged from the Facility on 4/3/25. R11's MDS dated [DATE] documents he was cognitively intact for decision making of activities of daily living. R11's Care Plan documents R11 was given a 30-day transfer/discharge notice due to Facility closure. This care plan also documented R11 is at risk for psychosocial well-being concerns. On 4/10/25 at 9:37 AM, R11 stated he and his wife, (R12), were just sent to the new (facility L). R11 stated they wanted to go to a facility in the town where their family lives, but they were not given any choices of facilities. R11 stated it would have been nice to be closer to family. R11 stated the facility did not assist he nor his wife with packing their belongings for the move and their daughter came and packed everything for them. R11 stated the abrupt closure of the facility caused both he and his wife, R12, to be upset, anxious, and sad. 8- R43's face sheet, print 4/15/25, documented R43 has diagnoses including schizophrenia, generalized anxiety disorder, depression, polyneuropathy, chronic obstructive pulmonary disease, gastroesophageal reflux disease, chronic pain syndrome, colostomy secondary to intestinal obstruction, atherosclerotic heart disease, hypothyroidism, and severe protein calorie malnutrition. This face sheet also documented R43 was discharged on [DATE] at 8:36 AM. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	R43's MDS, dated [DATE], documented R43 is cognitively intact for decision making of activities of daily living. R43's care plan, dated 4/3/25, document R43 is at risk for a psychosocial well-being concern. On 4/3/2025 at 10:42 AM, R43 was outside sitting on a bench, her hands were shaking, and she was crying. On 4/3/2025 at 10:44 AM, R43 stated they said everyone had to leave today and she wanted to go with her boyfriend, but they are both going to two different places, and she is worried she might not see him again. R43 stated they were girlfriend and boyfriend, and they were supposed to be getting an apartment together and now they are not even going to be together. 9- R38's Undated Face Sheet documents she was initially admitted to the facility on [DATE] with a diagnosis of major depressive disorder. R38's MDS dated [DATE] documents she was cognitively intact. On 4/8/2025 at 9:00 AM R38 stated she can breathe a lot easier at (Facility V13), the old facility had so much mold in it, it was hard to breathe there. 10- R65's face sheet, print date of 4/15/25, documented R65 was admitted to the facility with diagnoses including quadriplegia, neurogenic bowel, neuralgia, neuritis, neuromuscular dysfunction of bladder, anxiety disorder, and type 2 diabetes. R65's face sheet also documented R65 was discharged from the facility on 4/3/25 at 8:21 PM. R65's MDS, dated [DATE], documented R65 is cognitively intact for decision making of activities of daily living. R65's care plan, undated, documented R65 is at risk for a psychosocial well-being concern. On 4/10/25 at 8:51 AM, V66, Administrator at Facility L, stated (R65) told her I don't deserve to be here, it is so fancy. After he was transferred from the facility to his new facility. On 4/10/25 at 9:04 AM R65 stated I like this facility much better, than the other facility there's no fighting like at my previous facility. I felt rushed out of the facility, that he had to pack all his belongings without assistance from any staff, and that he had no choices of facilities offered to me prior to being discharged from the facility. 11- R39's Undated Face Sheet documents he was initially admitted to the facility on [DATE] with diagnoses including dementia, major depressive disorder, psychosis and anxiety. R39's Face Sheet document he was discharged on [DATE] at 8:56 PM. R39's MDS dated [DATE] documents he was severely cognitively impaired. On 4/8/2025 at 11:20 AM R39 was not interviewable he didn't answer the surveyor's questions. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	On 4/8/2025 at 11:40 AM 11:40 AM V67 R39's POA (Power of Attorney) stated staff (unknown name) called her on 4/2/2025 and informed her that the facility was closing and that they had to move all the residents. V67 was informed that her husband was being transferred to a facility that has a locked unit (Facility V4) which the staff stated is 2 hours from her but it is indeed 3 hours for her. She was very concerned about this move and how it would affect (R39) and she wouldn't be able to visit him often because she doesn't have a vehicle. She was very upset about this news and felt she should have had more time to find a closer locked facility for (R39.) Staff were supposed to call her on 4/3/2025 but no one called so at 9:00 PM she called (Facility V4) and they stated (R39) was not at the facility. She called the facility and no one answered the phone all night of 4/2/2025 into 4/3/2025. She was so worried about (R39) and finally got ahold of staff at 9:00 AM on 4/3/2025 and the first staff she spoke to stated (R39) was transferred to (Facility V4) so she called there again and staff stated (R39) wasn't there. Then she called the facility back and they told her he was being moved to (Facility V13) and when she found out that's not a locked facility, she was very upset because (R39) has no safety awareness, has dementia and is a wanderer and she is very worried and full of anxiety that (R39) could get out of the facility and get hurt. She can't take care of him at home, she stated at least at the facility they had a system to lock the doors but Facility V13 doesn't have that locked door system. She borrowed her family member's vehicle and came up to Facility V13 on 4/4/2025 and noted (R39) is missing a lot of clothes including shirts, jackets and pants. She spoke to V64 Social Services Director at Facility V13 and is in the process of getting a referral to other facilities that are located closer to her that have a locked unit. She stated in the process of this she prays to God that (R39) stays safe at the facility and doesn't get out of the facility due to it not being a locked facility. On 4/8/2025 at 11:15 AM V64, Social Services Director at Facility V13 stated (R39) was supposed to be transferred to (Facility V4) which is a locked facility. V64 stated she didn't know R39 was being transferred to (Facility V13) and he is not appropriate for this facility because he is a wanderer and has dementia and doesn't have safety awareness and is difficult to redirect and needs a memory care facility that can assist in redirecting him. On 4/3/25 at 1:27 PM V72, OSG Guardian stated he was notified on 4/2/25 of the closure by a message left on the after hours call service. V72 stated he was never notified to set up placement for (R13) and (R46) who he is guardian over. V72 stated he was notified by the facility that (R13) was going to (V4, Facility D). V72 stated he never agreed to this placement and doesn't find it acceptable. He also stated he will speaking with the facility about the arrangements they made. Stated he also wanted to talk with the facility about (R46) as they have lost her $20,000 electric wheel chair and nobody is answering the phone or getting back to him. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	On 4/11/25 at 7:04 AM, an excerpt from written communication with V66 (Owner/Medical Director), is documented as follows, IDPH (Illinois Department of Public Health) surveyors concluded that (town name) was not a safe place for residents. Numerous tags and IJs (Immediate Jeopardy) were issued as a proof. Facility was given maximum 30 days to move residents to safer places to cure the sufferings and miserable living conditions. I took it as an opportunity to give residents several nursing homes choices and moved them to safer places within 30 hours. I agreed with the state findings and didn't want the residents suffer any longer in an unsafe environment. I didn't trust the staff taking care of the residents. It was not only financial burden on me but also a huge liability to keep psych residents in substandard living conditions and allow incompetent staff to continue to neglect the resident care for 30 more days. That was not acceptable to me and that was not in the best interest of our residents. I apologize that you disagreed with placing residents to safer places within 30 hours instead of giving more time to the residents. I do understand and respect your point. The Facility's Prevention of Resident Abuse, Neglect, Mistreatment or Exploitation policy revised, 9/21/2017 documents neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness.

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F 0846 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have policies and procedures ensuring the administrator's responsibilities for facility closure are completed successfully. 44556 Based on interview and record review, the facility failed to implement a closure plan to ensure adequate preparation and coordinate a safe and orderly discharge and transfer of the residents from the facility. This failure has the potential to affect all 78 residents who resided at the facility prior the discharge. Findings include: 1. Notice of Move, dated 04/01/25, was given to the residents currently living at the facility. It documented the following: The nursing facility, in which you currently live, is no eligible to participate in the Medicaid program as of April 2, 2025, due to its noncompliance with certain specific resident care and quality of service requirements. As a result, it is necessary to for you to move to another setting where you care, and service needs can be met in accordance with Medicaid program requirements. To assist you in finding another place to live, the state will engage in a special process that will evaluate your needs and preferences as well as explore the options that may be available to you. Your preferences for a new livening arrangement are important to us and we will work with you and your family to offer reasonable choices about your next home, including the option to move to a community setting. The Process: Transition Coordinators employed by the State will visit you to explain why you are being required to move, the timeframes for the move and to assist you in answering questions about this process and how it will affect you. You will be evaluated by a state-designated professional who will determine your needs and preferences. After this evaluation, State staff will talk to you about other living arrangements available to you, such as another long-term care facility in your area or an alternative community setting. These staff can also assist you in making your decision and help to arrange your move. Your family or another person of your choice may participate in this discussion. After establishing your living preferences and service needs, transition coordinators from the State will assist you in transitioning to your new home. Your will receive assistance in moving your personal belongings to the new setting as well as transportation for yourself. Arrangements will be made to link you with any necessary medical services as identified by your individualized assessment, such as medication refills, physician services or other medical treatments. (continued on next page)

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F 0846 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	While the state agency team will seek information and input from the current facility staff, the current facility should not be identifying the alternative nursing facilities or non-institutional community settings or directly influencing individual resident choice of where to move. The facility staff will be responsible for ensuring that each resident receives needed services and support until transition is completed. You should not experience any disruption in your services. Every effort will be made to make your move as comfortable as possible. 2. The facility's Closure Plan, dated 04/02/2025, documented Subject: Closure Plan for the facility. Per (State Agency) and CMS (Centers for Medicare and Medicaid Services) letters, the facility got termination of Medicare and Medicaid agreement and decertification effective 4/2/2025. The facility has notified all the residents, their families / POA's (Power of Attorney) regarding state and CMS termination of agreements and decertification. Residents and their families are given 30 days' notice to find a find a place of their choice and given four nursing homes in the local areas to pick and choose from in addition to their personal preferences to pick any nursing home in the area. Residents are given the option to pick any nursing home they would like to in addition to (V63), (V13), (V8), and (V10) nursing homes. The facility will allow local nursing homes staff to come screening and talk to the residents and give options to the residents for a safe placement plan. The goal of the closure plan is the safety of our residents. Place them safely and to the facility of their choice. Goal is closure of the facility within 30 days effective immediately 4/02/2025. All the 60 plus employees have been notified and will be terminated upon closure of the facility. The facility will file bankruptcy upon the safe discharge and complete closure of the facility. 3. On 4/2/2025 at 5:38 PM, V1, Administrator stated, (V66, Medical Director/Owner) wants the residents out as soon as possible but it's going to take as long as it takes. We will be transferring residents tomorrow. We have three facilities coming tomorrow (V13, Facility M, V10, Facility J, and V9, Facility I) I will be here until everyone is transferred safely or unless (V66) becomes irrational because I know he wants the residents out as fast as possible, but I want to make sure everyone is taken care of. 4. On 4/3/25 and 4/4/25, the survey team observed all residents were transferred out of the facility. The last resident, R30, was transferred the evening of 4/4/25 to a local hotel. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0846 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/11/25 at 7:04 AM, an excerpt from written communication with V66 (Owner/Medical Director), is documented as follows, IDPH surveyors concluded that (facility) was not a safe place for residents. Numerous tags and IJs (immediate Jeopardy findings) were issued as a proof Facility was given maximum 30 adays to move resident to safer places to cure the sufferings and miserable living conditions. I took it as an opportunity to give resident several nursing homes and choices and moved them to safer places within 30 hours. I agreed with the state findings and didn't want the residents suffer any longer in an unsafe environment. I didn't trust the staff taking care of the residents. It was not only financial burden on me but also a huge liability to keep psych residents in substandard living conditions and allow incompetent staff to continue to neglect the resident care for 30 more days. That was not acceptable to me and that was not in the best interest of our residents. I apologize that you disagreed with p lacing residents to safter places within 30 hours instead of giving more time to the residents. I do understand and respect your point. On 4/10/25, at 8:46 AM V66 stated he was in a financial disaster and took this as a golden opportunity to get people out and shut it down because he was losing money. V66 stated it said 30 days so he can do it in 2 days too if he wants. On 4/4/25, Notice of Involuntary Transfer or Discharge and Opportunity for Hearing for Nursing Home Residents were reviewed for all residents discharged , with dates of 4/2 and 4/3/25 for the residents of the facility and found to be incomplete. The facility did not provide a policy regarding Closure to the survey team.