STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145927	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie Oasis	16000 South Wabash South Holland, IL 60473

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to respond and resolve resident grievances in a timely manner. This failure affects one of six residents (R1) reviewed for grievances. Findings include: R1's face sheet documents in part R1 is a [AGE] year-old resident with a prior medical history including: hemiplegia affecting left side, type 2 diabetes mellitus, depression, hypothyroidism, and hypertension. Record review of grievances (5/5/2025, 7/3/2025, 11/11/2025) document, in part, concerns with R1 receiving showers. The grievance dated 11/11/2025 does not indicate if the grievance was resolved or unresolved, the complainant's response to the resolution or signature from the administrator. On 12/13/2025 at 10:27 AM, R1 stated R1 has complained about showers to R1's family members and staff and stated staff do not respond timely to concerns. R1 affirmed R1's family will also complain to staff about concerns and nothing gets resolved. R1 stated, I haven't had a shower in over a month. On 12/13/2025 at 12:51 PM, V7 (R1's Family Member) affirmed V7 has complained to many staff members including V2 (Director of Nursing) about not R1 not getting care. V7 affirmed R1 does not get showers regularly and the lack of care is still an issue after filing grievances. On 12/13/2025 at 1:16 PM, V2 (Director of Nursing) affirmed the facility staff are required to document showers on shower sheets. V2 stated if shower sheets are not complete, then there is no documentation the care was provided. V2 recalled V7 had brought up concerns related to R1's care in the past, including incontinence and peri-care. On 12/13/2025 at 3:45 PM, V1 (Administrator) reviewed the grievance dated 11/11/2025. V1 stated it appeared V17 (Care Plan Coordinator) forwarded the grievance to V4 (Social Services Director) to address and R1 received a shower. V1 affirmed the grievance documentation does not indicate if the grievance was resolved or unresolved, the complainant's response to the resolution or signature from the administrator. V1 affirmed all grievances are to be sent to the administrator for review where V1 would sign off they were complete. V1 stated, They (staff) must have just put this in the grievance binder and forgot to give it to me. On 12/15/2025 at 12:15 PM, V4 (Social Services Director) reviewed the grievance (11/11/2025) and recalled the grievance was received by R1's family member during a care plan meeting. V4 explained the family was upset R1 was not receiving showers on R1's shower day. V4 told nursing staff about the incident and recalled staff showered R1 day. V4 was unsure if there was any documentation of any other follow up, auditing, investigation for the validity of the complaint, or resolution/communication to R1's family about the concern being resolved. V4 affirmed the grievance should be considered incomplete because there is no documentation the grievance was resolved, communicated to the family or the administrator was aware/signed off. V4 explained the grievance process is V4 receives the grievances, follow ups with the appropriate department, communicates and documents the resolution with the complainant and then reviews with the administrator. After, it is filed in the grievance log. Record review of R1's shower sheets for 11/2025 through 12/2025 does not document R1 had a shower between 11/30/2025 and 12/13/2025. This indicates R1 did not have a shower for 13 days. Additionally, R1 did not get showers as required until after the survey began and the concerns within the grievance related to showers were not resolved. Facility policy titled, Grievances (6/2014) documents in part, . Purpose: to establish a formal system for documentation of grievances and system of resolution . 1. The director of social services will utilize the written concern form method to document concerns . all concerns will be reviewed and signed by the administrator. 8. Concern resolutions are expected within 72 hours unless further time is needed to resolve the concern (example: ordering an item) .Facility policy titled Bath/Shower Schedule (2/2014) documents in part, A bath or shower will be given to each resident by a Certified Nursing Assistant two times per week as scheduled and (as needed) . 3. Certified Nursing Assistant will give shower as scheduled . 6. Bath/shower sheets are to be completed by the Certified Nursing Assistant upon each bath/shower scheduled whether accepted or declined. Bath/shower sheets will be maintained by the facility for the current and entire last month and then may be discarded.

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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 - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to prevent staff to resident physical abuse and neglect. These failures resulted in R1 sustaining a fractured left humerus and R3 sustaining moisture associated skin damage/skin breakdown. These failures affected two (R1 and R3) of six residents reviewed for abuse/neglect. Findings include:1) R3's face sheet documents, R3 is an [AGE] year-old resident and has diagnoses including, but not limited to: cirrhosis of the liver, unspecified supracondylar fracture of the left humerus, dementia without behavioral disturbance, unspecified protein calorie malnutrition, other disorders of bone density and structure, functional quadriplegia and metabolic encephalopathy. R3's minimum data set (MDS) dated [DATE], documents, R3 has a brief interview of mental status (BIMS) summary score of 3, indicating R3 has severe cognitive impairment. Additionally, the MDS documents indicates R3 requires assistance from staff with activities of daily living (ADLs), that R3's height is 65 inches and weighs 163 pounds. R3's care plan (6/19/2024) documents R3 is at risk of abuse/neglect and that symptoms of abuse may be manifested by verbal expressions of distress, generalized mood distress, and observable signs of distress. R1's MDS dated [DATE], documents R1 has a BIMS summary score of 13, indicating that R1 is cognitively intact. R2's MDS dated [DATE], documents R2 has a BIMS summary score of 15, indicating that R2 is cognitively intact. On 12/13/2025 at 10:27 AM, R1 stated, I have had issues with (V5, Certified Nursing Assistant) in that past. (V5) is very rude when (V5) is caring for people. She's lied on me saying I hit her, I never done anything like that. I wasn't in the room when it (the incident) happened, but I heard that (R3's) arm broke. On 12/13/2025 at 10:37 AM, R2 explained, About 4 or 5 days ago, I was sitting here in the room and V5 (Certified Nursing Assistant) was being really rough with (R3). (V5) was bossing her around, pulling on her by her clothes. (R3) doesn't talk much but (V5) was getting real smart, mouthy with her. I couldn't see exactly what happened because V5 was standing in-between me and (R3), but I heard a loud bang, and I think (R3)'s arm hit the side rail. (R3) cried out and screamed, B***h you broke my arm!. (R3) was screaming in pain after the incident. I told a nurse what happened, I can't remember exactly which one. (R3) is in a cast now. I don't recall (R3) having any recent falls. (V5) was acting real weird after the incident and kept asking me if I needed anything, which is not like her. She is normally very rude.On 12/13/2025 at 10:56 AM, R3 was observed sitting in a wheelchair with a splint/sling to R3's left arm. R3 stated, I don't know what happened, my arm, my arm broke. It hurts real bad. My arm hurts real bad. R3 was observed having difficulty answering questioning due to severe cognitive deficits. On 12/13/2025 at 11:37 AM, V5 (Certified Nursing Assistant) was unsure the cause of R3's fracture, denied witnessing any staff physically abuse any resident and denied hitting/handling R3 roughly. V5 stated, I don't yell at them (residents), but I am firm. I have boundaries, like when (R1) hit me in the head during the summer, I was real mad. I was so heated. I left the room and told social services, but I didn't hit her back. I didn't handle (R3) roughly, look at (R3's) size. I am small. Their weight versus mine. What could I do to (R3)? I couldn't hurt her. (R3) likes to put herself on the ground and is wiggly.Review of V5's healthcare worker background check form (3/16/2020) documents that V5 is 5 foot tall and weighs 134 pounds. On 12/13/2025 at 12:51 AM, V7 (R1's Family Member) recalled when visiting a few days prior, R2 had told V7 that V5 had hit R3's arm. V7 denied ever witnessing V5 hit another resident, but recalled during the summer one time, I recall (R1) telling me that (V5) got mad, raised her and raised her arm up like (V5) was going to hit (R1). (R1) said V5 called her a b***h. I am not sure if (V5) ever hit her. I have not personally seen (V5) hit any residents, but I know she refuses to care for (R1). On 12/13/2025 at 3:45 PM, V1 (Administrator) affirmed V1 is aware of R3's fracture and that the facility does not know how R3 got the fracture. V1 explained, (R3) wasn't able to say what happened, (R3) just kept saying 'woo'. (R2) had mentioned there was an issue between (R3) and (V5), but when I was asking what happened, (R2) stated that they were arguing and did not see anything else. (R2) stated she did not see her hit (R3). When I looked up the type of fracture, it said it was commonly from a fall. I was not aware of any allegation that (V5) hit (R3) or handled (R3) roughly until today but (V5) was suspended this morning pending the investigation. V1 affirmed that there was an active investigation into the fracture by V2 (Director of Nursing). On 12/15/2025 at 10:22 AM, V9 (Wound Care Nurse, Licensed Practical Nurse) denied knowing how R3 sustained the fracture. V9 stated V9 has not seen V5 ever abuse any residents but V5 is firm. V9 explained, Firm meaning like if a resident is able to do something, (V5) is not going to do that for them. Like she will tell them, no you need to wash your own private area or chest if they can On 12/15/2025 at 11:00 AM, V10 (Certified Nursing

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, interview and record review, the facility failed to implement their abuse policy; failed to suspend a staff member pending an allegation of staff to resident physical abuse; and failed to prevent retaliation of a staff member after reporting abuse. This failure affects one (R3) of six residents reviewed for abuse and has the potential to affect all 118 residents that reside within the facility. Findings include: Facility census (12/13/2025) documents in part that 118 residents reside within the facility. Review of R3's progress notes indicate that on 12/11/2025 at 10:10 AM, documents in part, CNA notified writer of resident complaint of pain at Lt arm. Upon arrival to resident's room, resident in lying in bed alert and oriented x 2. During assessment resident's Lt arm is swollen, painful to touch, and resident is yelling out in when she attempts to move Lt arm. No other apparent abnormalities noted. Writer gently placed Lt arm on pillow. T 98.1 P 65 R 20 BP 100/66 02 sat 95% RA. (V6) to be notified for pain medication orders. At 10:15 AM, R3 was seen by V13 (Nurse Practitioner) at the bedside. At 1:36 PM, R3 was sent to the hospital for evaluation and returned at 10:16 PM with a diagnosis of a closed supracondylar fracture of left humerus. There is no indication of a fall or any potential indicators of a fall or change of plane (e.g. R3 observed on the ground) within R3's progress notes reviewed since 10/1/2025-12/18/2025. On 12/15/2025 at 12:15 PM, V4 (Social Services Director) explained, Last Tuesday (12/9/2025) I was getting ready to leave around 4:15 PM. I heard noises from my office. Loud yelling, louder than normal. Loud enough for me to have concerns. I went out of my office; my office is a couple doors down from (R3's) room. V11 and V15 were also going to the room. I was in the doorway and saw (R3) lying in bed and it looked like (R3) was getting changed. (R3) was holding her left arm, the one that is broken. I asked (R3) what happened and (R3) told me (R3's) arm hurts. So, I told V16 (Licensed Practical Nurse). I don't really remember if there were other residents in the room at the time. (R2) told me on Thursday (12/11/2025) that she saw (V5) hurt (R3). I brought (R3) to (V2 Director of Nursing) and (V1 Administrator) was there. The story changed when (R2) was talking to (V1) and (V2) and (R2) stated that (R2) heard a loud bang and thought R1's arm hit the bed and that R2 couldn't see what happened because (V5) was standing in between. I would say that is an allegation of physical abuse. (R2's) cognition is intact, I would believe an interview from (R2). (R3's) cognition is in and out, some days (R3) can tell me things, other days (R3) can't. A fracture can be a sign of physical abuse.On 12/15/2025 at 1:46 PM, V12 (Licensed Practical Nurse) recalled, On Thursday Morning (12/11/2025), I was assigned to care for (R3). A staff member, I can't remember who, told me something was wrong with (R3's) arm, (R3's) screaming. I went to the room, and it was pretty bad, swollen and (R3) was guarding the arm. V13 (Nurse Practitioner) was here, assessed R3, and gave orders for an X-ray and pain medication. Around 12:30 or 1 PM, I showed (V2) (R3's) arm and (V2) instructed me to send (R3) to the hospital. When I asked (R3) what happened, (R3) stated, that woman did this to me, that woman did this to my arm. I reported this to (V2). There was no fall, (V5) never said there was any fall. I was told on Thursday (12/11/2025) by (V11 Certified Nursing Assistant) that V5 was working a double on (12/9/2025) and (V11) gave me this look. I don't remember her exact words but (V11) told me that (V11) and (V15) were talking at the nurse's station and (V11) heard (R3) scream this b***h broke my arm!. (V11) had concerns (V5) was being rough with (R3). On that same day, (R2) told me that (V5) was being rough with (R3), that (V5) snatched (R3's) arm and went bam bam bam hitting it on the rail of the bed. I told (V2) about it because I was shocked and (V2) was the closest staff that was there. I did not tell V1, I should have. I was very concerned after hearing (V11) tell me about R3's yelling and saying and then (R3) telling me a woman broke (R3's) arm, I was very concerned with physical abuse. I would think this fracture could be a sign (R3) was physically abused. I have not witnessed (V5) abuse any residents but (V5) has no patience for the residents. No fall caused this injury. V1 called me in and asked if (R3) had fell and I told (V1) not to my knowledge. They (V1 and V2) are trying to put this on me that this was caused potentially by a fall, it was not a fall. I told them it wasn't the fall. I told them my concerns, and they are going to pin this on me that I didn't chart a fall. No fall caused that fracture.On 12/15/2025 at 2:51 PM, V2 (Director of Nursing) recalled on 12/11/2025, I did go back and look at (R3's) arm. I didn't lift it because she was complaining of pain. I was more swollen more than normal. (V6) was in and had ordered pain meds and an X-ray. She was in so much pain, so we sent her out. I asked (R3) what happened she didn't say anything about a fall. (R3) stated, She turned me too hard. (R3) couldn't say who did it. Her doctor had concerns about bone density. I don't know how (the fracture) happened. Yes, I remember being in the office with (R2) and (V1). I was working on many items and was in and out of the conversation. I heard (R2) say something

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an injury of unknown origin to the state survey agency within 2 hours for one (R3) of six residents reviewed for reporting. This failure resulted in R3 experiencing left arm pain and swelling and being transferred to the hospital and diagnosed with closed supracondylar fracture of the left humerus.Findings include:Record review of initial report to the state survey agency (12/12/2025) documents in part, that on 12/11/2025 at 10:10 AM, R3's left arm was observed swollen and painful to the touch. At 22:16, R3 returned from the hospital with a diagnosis of closed supracondylar fracture of the left humerus. The facsimile transmission for the initial report documents in part, that the reportable was faxed on 12/12/2025 at 3:30 PM. On 12/13/2025 at 3:45 PM, V1 (Administrator) affirmed V1 is aware of R3's fracture and that the facility does not know how R3 got the fracture. V1 explained, (R3) wasn't able to say what happened, (R3) just kept saying [NAME]. (R2) had mentioned there was an issue between (R3) and (V5), but when I was asking what happened, (R2) stated that they were arguing and did not see anything else. (R2) stated she did not see her hit (R3). When I looked up the type of fracture, it said it was commonly from a fall . V1 affirmed the allegation was an injury of unknown origin. V1 reviewed the initial report and confirmed the facsimile was transmitted over 2 hours after the facility was made aware of the fracture. V1 stated, The facility thought it was a probably from a fall, so we treated it like reporting a fall with injury. V1 affirmed that allegations of abuse, including injuries of unknown origin, are to be reported within 2 hours of the allegation. On 12/15/2025 at 12:15 PM, V4 (Social Services Director) explained, Last Tuesday (12/9/2025) I was getting ready to leave around 4:15 PM. I heard noises from my office. Loud yelling, louder than normal. Loud enough for me to have concerns. I went out of my office; my office is a couple doors down from (R3's) room. V11 and V15 were also going to the room. I was in the doorway and saw (R3) lying in bed and it looked like (R3) was getting changed. (R3) was holding her left arm, the one that is broken. I asked (R3) what happened and (R3) told me (R3's) arm hurts. So, I told V16 (Licensed Practical Nurse). I don't really remember if there were other residents in the room at the time. (R2) told me on Thursday (12/11/2025) that she saw (V5) hurt (R3). I brought (R3) to (V2 Director of Nursing) and (V1 Administrator) was there. The story changed when (R2) was talking to (V1) and (V2) and (R2) stated that (R2) heard a loud bang and thought (R1's) arm hit the bed and that (R2) couldn't see what happened because (V5) was standing in between. I would say that is an allegation of physical abuse. (R2's) cognition is intact, I would believe an interview from (R2). (R3's) cognition is in and out, some days (R3) can tell me things, other days (R3) can't. A fracture can be a sign of physical abuse.On 12/15/2025 at 2:51 PM, V2 (Director of Nursing) recalled on 12/11/2025, I did go back and look at (R3's) arm. I didn't lift it because she was complaining of pain. It was more swollen more than normal. (V6) was in and had ordered pain meds and an Xray. She was in so much pain, so we sent her out. I asked (R3) what happened she didn't say anything about a fall. (R3) stated, She turned me too hard. (R3) couldn't say who did it. Her doctor had concerns about bone density. I don't know how (the fracture) happened. Yes, I remember being in the office with (R2) and (V1). I was working on many items and was in and out of the conversation. I heard (R2) say something about the CNA hurting (R3's) arm. (R2) said it was (V5). (R2) then said in the conversation (R2) heard a loud noise but didn't see what (V5) did. I did not report abuse to V1, V1 was there for that conversation.On 12/15/2025 at 3:41 PM, V13 (Nurse Practitioner) explained, I am (R3's) provider. I recall (on 12/11/2025) being notified by the nurse that her left upper extremity was swollen and painful. I went in and assessed her. It was swollen, it didn't look deformed though, it was tender to the touch. (R3) had very limited range of motion due to pain. (R3's) nurse at the time was unaware of any recent trauma or falls at that time. (R3) was alert times 1 (to self), (R3) could not report what happened to (R3's) arm. (R3) was sent to the hospital and diagnosed with a supracondylar left humeral fracture. I was not told that there was any suspicion of abuse. I am not ortho, but that (a supracondylar fracture) can be caused by trauma, it depends on how hard someone is hit against something. If (R3) was screaming, that isn't (R3's) baseline. It would make sense if it (the fracture) was related to trauma. It doesn't take a lot for an older adult to have a fracture. I did tell the facility they needed to investigate what happened, these fractures don't happen for no reason.Facility abuse policy (undated) documents in part, This policy affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion . VII. External Reporting of Potential Abuse. Initial reporting of Allegations. If mistreatment has occurred, the resident's representative and the department of public

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F 0677 Level of Harm - Actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (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 0677 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide incontinence care and showers for one (R1) resident that was dependent on staff for ADL (activities of daily living) care. This failure affected one (R1) of six residents reviewed for ADL care. This failure resulted in R1 experiencing pain and development of moisture associated skin damage (open areas). R1's face sheet documents in part that R1 is a [AGE] year-old resident with a prior medical history including: hemiplegia affecting left side, type 2 diabetes mellitus, depression, hypothyroidism, and hypertension. R1's MDS dated [DATE], documents R1 has a BIMS summary score of 13, indicating that R1 is cognitively intact. Additionally, the MDS indicates R1 did not have any moisture associated skin damage at the time of the assessment. On 12/13/2025 at 10:27 AM, R1 affirmed R1 is incontinent of bowel/bladder and explained, They (staff) never change me regularly. I have had open areas on my buttocks and thighs for about a week or two. I have told my daughter and the staff, I know my daughter has told the administration too about them not changing me. I am in a lot of pain on my butt, it's burning pain at like 7/10. Theres no dressing or treatment in place for my skin. R2's MDS dated [DATE], documents R2 has a BIMS summary score of 15, indicating that R2 is cognitively intact. On 12/13/2025 at 10:37 AM, R2 (R1's Roommate) affirmed R1 regularly does not get incontinence care/changed by the facility staff and that R1 waits long periods of time to be changed by staff. On 12/13/2025 at 12:51 PM, V7 (R1's Family Member) explained, (R1) has not gotten a shower in a couple weeks maybe longer. I have to constantly remind them (staff) to give (R1) a shower, and they always blame other shifts. (R1) has breakdown on (R1's) bottom from sitting in urine and feces, the staff just blame the other shifts. (R1) keeps talking about being in pain and (R1's) butt burning. I came in a few days ago in the morning and (R1) was still in bed, soaked in urine. She is gotten up from the night shift, she should already be up and have had incontinence care provided by the time I get there. V2, Director of Nursing was made aware of these issues and (V2) apologized, I think this was Wednesday (12/10/2025) morning. It's constant incontinence care issues. It's becoming overwhelming to me that (R1) isn't receiving basic care. On 12/13/2025 at 1:16 PM, V2, Director of Nursing and V12, Licensed Practical Nurse denied knowledge of R1 having any skin impairment or breakdown. V2 recalled R1's family member coming to the facility and that the family member had concerns with incontinence care. V2 stated, V2 went with the family member and did observe R1 still in bed during day shift. V2 confirmed that R1 is a 3rd shift get up and should have been up by the time the family was in the facility. V2 reviewed the last 30 days of ADL charting within R1's electronic health record and affirmed that there are multiple shifts within the last 30 days where there is no documentation that R1 received incontinence care. V2 affirmed that if there is no documentation that the service was provided, then the care was not provided. Surveyor requested any additional documentation that confirms R1 received the needed care as identified within the care plan/MDS and no further evidence was provided prior to the exit of the survey. On 12/13/2025 at 2:12 PM, V2 stated, The staff just was in here, placed (R1) in bed and performed incontinence care. Observed R1 laying in left side-lying position with no pants or brief. V2 asked R1 to rate R1's current level of pain and R1 replied, 4/10, on my left side and butt. Observed V2 and V12 perform a skin check of R1's legs, peri-area and bottom. Observed V2 displace R1's buttocks and noted a large amount of feces covering the area between R1's buttocks. V2 (Director of Nursing) stated Oop. Guess they didn't do it (peri-care) well, (the staff) left bowel movement. V12 observed and affirmed there was feces covering the area between R1's buttocks. Observed two 0.5x0.5x<0.1 cm open areas draining serosanguinous fluids on R1's left upper leg, near the buttocks with a red wound bed and intact edges. Measurements were confirmed with V2. When asked to describe the drainage coming from the open area, V2 replied, No, I think that's urine. R1 exclaimed and yelped in pain as the open areas were measured. V2 apologized. Surveyor asked V2 to continue to assess R1's skin. Observed one open area 0.2x0.5x<0.1 cm open area with a pink/red wound bed, intact edges and one open area 0.5x0.5x<0.1 cm open area with a pink/red wound bed and intact edges to R1's left buttock. Additionally, observed one 0.5x0.5x<0.1 cm open area with a pink/red wound bed with intact edges to R1's right gluteal fold. V2 educated R1 that R1 needed some cream on that (open areas). V2 placed the sheet over R1 and V2 and V12 left the room without providing R1 any peri-care after observing the feces between R1's buttocks. Record review of R1's toileting assistance provided 11/16/2025-12/15/2025 does not document that toileting assistance was provided on the following shifts: 11/17/2025 1st Shift; 11/21/2025 2nd shift; 11/22/2025 1st shift, 2nd shift; 11/29/2025 2nd