STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145969	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Forest Park	8200 West Roosevelt Road Forest Park, IL 60130

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide a comfortable and homelike environment, failed to have a readily available and adequate supply of clean bed and bath linens for residents to perform daily hygiene, bathing, or showers, failed to provide adequate lighting in resident rooms, and failed to ensure a mattress was provided on the bed frame and the bed was made with linen and a pillow for a resident that transferred into a room. This failure affected four residents (R38, R43, R94, and R158) out of a sample of 67 residents and has the potential to affect all 199 residents residing at the facility reviewed for a clean and comfortable homelike environment. Findings include: Facility census, dated 2/23/26, documents 199 residents residing at the facility. R38's face sheet documents diagnoses that include but are not limited to paraplegia, chronic pain, urinary tract infection, and bacterial infections R38's BIMS (brief interview for [NAME] status) score, dated 12/04/25, is 14 which indicates R38 is cognitively intact. R38's physician order, dated 1/07/26, documents, in part, Coccyx: Cleanse with wound cleanser, pat dry with gauze, apply Medi honey and dry dressing, every day shift for wound care and as needed for wound care. On 2/23/26 at 11:00am, R38 said, I don't know what's going on, but there's no rags or towels anymore here (facility). I have to wait to get my dressings changed because the nurses say that they (facility nurses) have to wait for more clean towels and rags to clean me up first before they (facility nurses) can change my dressings. Sometime they (facility staff) bring in stained rags or cut up rags. I'm like you (facility staff) ain't cleaning me with that (stained or cut up rags). Those (stained or cut up rags) look like they're (stained or cut up rags) used to clean toilets or furniture. I want to get out of bed but have to wait because they (facility) don't have rags and towels to clean me up. Man, I'm sorry, it (not having clean washcloths and towels) just makes me mad. On 2/24/26 at 11:31am, a review of the entire facility's washcloths and bath towel was done with V19 (Housekeeping Supervisor/Laundry Supervisor). During observation of the facility's laundry department with V19 (Housekeeping Supervisor/Laundry Supervisor), 15 clean towels and 6 clean washcloths, as well as 4 sheared/cut towels (in pile with clean washcloths) were observed. V19 said, These (4 sheared/cut towels) aren't supposed to be with the clean rags. We (facility) cut the old towels and use them for dust rags. Surveyor inquired where the rest of the clean washcloths and bath towels are located in the laundry department. V19 replied, That's it down here (laundry department). There are (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	carts on the floor with clean washcloths and bath towels. Surveyor inquired again where the rest of the clean washcloths and bath towels are located in the laundry department. V19 replied, There's (clean wash cloths and bath towels) more on the floors, but not down here (laundry department). We (facility) started doing our own laundry in January (1/2026), before the laundry was outsourced. I think we have enough (clean bath towels and wash cloths) for the residents but we're (staff) just not getting washcloths and towels fast enough up to the floors. On 2/24/26 at 11:36am, surveyor requested to see all linen carts and/or storage rooms that would have clean washcloths and bath towels for resident use for the entire facility. Upon observation of the second floor linen carts, with V19 (Housekeeping Supervisor/Laundry Supervisor), the following was observed: Two linen carts on the second floor A-side were observed. The first linen carts had no clean washcloths and no clean bath towels. The second linen cart had 8 clean bath towels and 11 clean washcloths. Two linen carts on the second floor B-side were observed. The first linen cart had 9 clean washcloths and 9 clean bath towels. The second linen cart had 7 clean bath towels and 8 clean washcloths. Surveyor asked V19 if there were any more linen carts or storage rooms on the second floor with clean washcloths and bath towels, and V19 replied, No. That's it. On 2/24/26 at 11:49am, upon observation of the third floor linen carts, with V19 (Housekeeping Supervisor/Laundry Supervisor), the following was observed: Two linen carts on the third floor A-side were observed. The first linen cart had no clean washcloths and no clean bath towels. The second linen cart also had no clean washcloths and no clean bath towels. V19 said, Oh boy. This isn't good. Three linen carts on the third floor B-side were observed. The first linen cart had 7 clean bath towels and 4 clean washcloths. The second linen cart had 7 clean bath towels and 6 clean washcloths. The third linen cart had 5 clean bath towels and 5 clean washcloths. Surveyor asked V19 if there were any more linen carts or storage rooms on the third floor with clean washcloths and bath towels, and V19 replied, No. On 2/24/26 at 11:56am, upon observation of the fourth floor linen carts, with V19 (Housekeeping Supervisor/Laundry Supervisor), the following was observed: Two linen carts on the fourth floor A-side were observed. The first linen cart had no clean washcloths and no clean bath towels. The second linen cart also had no clean washcloths and no clean bath towels. Two linen carts on the fourth floor B-side were observed. The first linen cart had no clean washcloths and no clean bath towels. The second linen cart also had no clean washcloths and no clean bath towels. Surveyor asked V19 if there were any more linen carts or storage rooms on the fourth floor with clean washcloths and bath towels, and V19 replied, No. We (facility) do not have a total inventory of (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	how many washcloths and bath towels are here (facility). Like I said before, we (facility) just started this past January (1/2026) doing the laundry here (facility). It's a work in progress. R43's face sheet documents diagnoses that include but are not limited to psoriasis, psoriatic arthritis mutilans, and morbid obesity. R43's BIMS (brief interview for [NAME] status) score, dated 1/21/26, is 15 which indicates R43 is cognitively intact. R43's physician order, dated 1/19/26, documents, in part, Desitin External Paste 40 % (Zinc Oxide (Topical): Apply to underarms, and groin topically one time a day for dry skin/rash. R43's physician order, dated 1/19/26, documents, in part, Clotrimazole External Cream 1 % (Clotrimazole (Topical): Apply to underarms, and groin topically one time a day for dry skin/rash. R43's physician order, dated 12/15/21, documents, in part, Calcipotriene Cream 0.005 %: Apply to affected areas topically every 12 hours as needed for psoriasis. On 02/24/2026 at 1:21pm, R43 stated his concern was the facility did not have enough washcloths since facility changed laundry services. R43 stated he needed washcloths to clean his armpit, abdominal folds and groin so he could apply his medication 3 times daily at 6:00am, 2:00pm, and 10:00pm and to clean his armpit, abdominal folds and groin area so he could apply his Desitin cream at 11:00pm. R43 stated 2 to 3 weeks ago during the night shift, he observed (V44 - CNA) cut a diaper into pieces so she could use it to clean the residents. When asked how R43 felt about not having enough wash cloths, R43 replied, I gotta do what I gotta do. Record review of facility's Grievance Binder, shows R43's Concern/Compliment Form, dated 12/15/25, that documents, in part, Resident (R43) had no face cloth this morning. On 2/24/26 at 1:30pm, V33 (Director of Purchasing/Corporate) said, I was told you have a concern with the PAR (Periodic Automatic Replenishment) with the towels and washcloths. I think we (facility) have enough for the residents. On 2/24/26 at 3:12pm, V2 (Director of Nursing/DON) said, I think there's enough washcloths and bath towel for the residents. I just think that the staff are throwing them out. There should be, at minimum, three wash cloths and 3 towels for each resident. Record review of facility documents titled, Purchase Order, documents the following purchases: 12/4/25: 83 washcloths and 50 bath towels; 1/20/26: 15 bath towels; 1/28/26: 30 bath towels and 50 washcloths; and 2/12/26: 50 washcloths. Total purchased: 183 washcloths and 95 bath towels. Record review of facility document titled, (Name of Facility) Morning Meeting Minutes, dated 2/12/2026, documents in part, Getting low on washcloth. Record review of facility document titled, (Name of Facility) Morning Meeting Minutes, dated 2/24/2026, documents in part, Other issues: Need more linen. R158 is [AGE] years of age. Current diagnoses include but are not limited to Pleural Condition (Left Pleural Effusion), History of Falling, Chronic Respiratory Failure, Type 2 Diabetes Mellitus, (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Hypertension, End Stage Renal Disease with Dependence on Renal Dialysis, Congestive Heart Failure, Dependence on Supplemental Oxygen. R158 was admitted to the facility on [DATE] per the census report from the hospital. R158's comprehensive assessment section C Cognitive Patterns dated 02/05/2026 documents a brief interview for mental status score of 10 which indicates R158 has moderate issues with thinking and memory. On 02/24/2026 at 10:30 AM, Resident #158 said, They moved me up here from downstairs after breakfast. They told me they didn't have to tell me anything. I've been up since 4AM and I want to lay down. They didn't have a mattress on the bed. A lady had to bring a mattress for the bed. They still haven't made my bed yet. They said they were going to get sheets but never came back. I'm tired and I want to go to sleep! R158's bed has a fitted sheet that appears to have brown stains. There is no flat sheet, blanket, or pillows on the bed. There is a covered linen cart in the hall but there are no bed linens on the cart at this time. On 02/24/2026 10:33 AM, V20, Registered Nurse (RN) was inquired of R158. V20 RN said, I didn't even know she was in the room. My CNA came and told me she was in the room. I had to go find some oxygen for her. I didn't even get any report. On 02/24/2026 10:35 AM, V25, Nurse Manager was inquired of R158's move from second floor. V25 said, I wasn't aware of it, I'm the manager for the third floor but I can try to help. R158 told V25 she was moved to the current room after breakfast and there wasn't a mattress on the bed. A lady brought in a mattress. They still haven't made my bed. On 2/24/26 at 11:16 AM, V3, Assistant Director of Nursing (ADON) said, I didn't know about her being transferred or anything with her roommate, but I can go find out what happened. V3 went to R158's room with this surveyor and observed R158'S bed with only a fitted sheet. R158 told V3 what happened when she was transferred to the room. On 02/24/2026 at 12:00 PM, V5, Social Service Director's (SSD) progress note documents R158's transfer was effective at 9:17 AM but was created at 11:41 AM after this surveyor questioned V3 ADON regarding R158's room transfer in which V3 was unaware of. On 2/24/26 at 12:31 PM, V3 came to the conference room to speak with this surveyor. V3 said, V5 told me she told her (R158) about moving and she was ok with it. V3 was asked if she spoke with R158. V3 said, No, I haven't but I know she has some dementia. Review of R158's admission contract indicates she signed her own contract on 01/26/2026. R158's comprehensive assessment documents she only has moderate issues with thinking and memory. On 02/24/2026 at 1:31 PM, V5 was inquired of R158's transfer. V5 SSD said, The CNAs made me aware (R158) wasn't appropriate for the floor. I was made aware she (R158) was being resistant to being moved. The CNA asked me to come tell her why she was being moved. I assisted her upstairs to the room. There wasn't a mattress on the bed, so I went back down and brought the mattress off her bed upstairs. It was two CNAs that helped me. I can't remember their names. Normally I work with guest services (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	to make sure the move was smooth, but I don't normally work with moves, they needed my assistance. I'm not sure who her nurse was. I didn't speak to her nurse. My plan was to document it sometime today. On 02/24/2026 at 1:44 PM, V31, Certified Nurse Assistant (CNA) was inquired of R158's transfer. V31 said, R158 is a one person assist to transfer. She has a wheelchair. She is a check and change (incontinent). I was told to transfer her by V5 SSD to 4th floor after breakfast. Two other CNAs helped me. We packed all her stuff and took it upstairs. I transferred her in the wheelchair. I didn't tell V5 that she (R158) didn't want to move upstairs because I didn't know anything. She (R158) just asked why she was being moved out the room. I went to get V5 because she (R158) had a question, but she didn't refuse to go. V5 was at the nurse's station, I told her and V5 said she'd go talk to her (R158). When I took her (R158) up to the room there wasn't a mattress on the bed, so I told V5. When I went back to my floor, I told V25 LPN (Licensed Practical Nurse). On 02/24/2026 at 1:55 PM, V25, Licensed Practical Nurse (LPN) was inquired of R158's transfer. V25 LPN said, R158 is alert with some confusion, and she has dementia. She can transfer but needs assistance. She has a wheelchair. When the CNA's moved her, they just told me she was moving. I don't know who told me she was moving. I'm prn (as needed), but I've been here a year. I took the meds up there. I gave her morning meds before I took them. I don't know the nurse's name, but it was around 10 or 10:30 I went up there and gave report. I don't know who's responsible for making sure the room was ready. I didn't go into her (R158) room upstairs. On 02/24/2026 at 2PM, V32, Nurse Supervisor 2nd Floor was inquired of R158's transfer. V32 said, I was just coming in when it was happening, so I don't know about it. On 02/24/2026 at 2:38 PM, V20, RN was inquired of R158's transfer. V20 said, Why was R158 moved up here? After she was up here V25 LPN just came and brought her meds and said she was alert, oriented and cooperative. He never said why she was being moved or anything else. I wasn't even told she has dialysis. On 02/24/2026 at 2:51 PM, R158's bed is made up with a flat sheet, a pillow and blanket. R158 is sitting in her wheelchair next to the bed sorting through her belongings. R158's belongings are on the bed in a bag. There is a rolling walker at the foot of her bed. R158 said, They finally made my bed. My husband's here, he's in the washroom and he's gonna help me put my things away. That's his walker. It took the facility from 10AM to 2PM after R158 was transferred into her new room to have her bed fully made with complete bed linen. On 02/25/2026 at 2:45 PM, V2, Director of Nursing (DON) was inquired of R158. V2 said, I believe the social worker said she was moving. It was more based on her diagnosis due to dementia. I can't remember if she ever tried to leave or had any behaviors. The room was supposed to be set up with the bed made. V25 LPN (Licensed Practical Nurse) should have given report with all the resident's information. He (V25) has been here over a year, and he works full time. On 2/23/2026 at 11:01 AM, observed R94 resting in bed with V28 (R94's Family Member) at the bedside. R94's section room did not have a overbed or reading light. V28 explained, the facility has no linen here, I have been trying to get (R94) a blanket for hours now. He deserves and wants a blanket when sleeping. V28 also stated, I don't understand why (R49)'s roommate has an overbed light and (R49) (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	doesn't. We had to bring on from home. (R49's) roommate has cabinetry, overbed lights, etc. I don't understand why we can't have that too. On 2/23/2026 at 11:09 AM, observed the 2nd floor linen room. There was no linen on any of the shelves. Surveyor requested if there were any blankets in the linen closet or on the unit. V27, Housekeeper and V26, Certified Nursing Assistant (CNA) checked the linen room and affirmed there were no blankets available for the residents on the second floor. V26 stated, this happens often, not having enough linen. On 2/23/2026 at 11:11 AM, V21, LPN stated, We are frequently run out of linen for the residents, it's like three times a week. We call down to laundry to get more, and hopefully it comes up. On 2/23/2026 at 11:18 AM, V8, Maintenance Director observed R94's room and confirmed that there was not an overbed light for R94. V8 explained, These rooms used to all be single occupancy rooms, but when COVID hit, they were remade back into 2 person rooms. They are licensed for 2 beds; we just never remodeled the second side. Record review of Illinois Long-Term Care Ombudsman Program Resident's rights booklet, dated 11/18, states in part that the facility must be safe, clean, comfortable, and homelike. The residents should receive the services and/or items included in the plan of care. Record review of facility policy titled, Resident Rights, dated 1/04/19, documents, in part, Purpose: To promote the exercise of rights for each resident, including any who face barriers (such as communication problems, hearing problems and cognition limits) in the exercise of these rights. Exercising rights means that residents have autonomy and choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care, subject to the facility's rules, as long as those rules do not violate a regulatory requirement. Record review of facility job description titled, Certified Nursing Assistant, dated 5/02/17, documents, in part, The Certified Nursing Assistant (CNA) is responsible for providing resident care and support in all activities of daily living and ensures the health, welfare and safety of all residents. Provide assistance in personal hygiene by giving bedpans, urinals, baths, backrubs, shampoos, and shaves; assisting with travel to the bathroom; helping with showers and baths. Provide for resident comfort by utilizing resources and materials; answering call lights and requests; reporting observations of the residents to the nursing supervisor. Record review of facility job description titled, Laundry Aide, dated 3/23/17, documents, in part, The primary purpose of your job position is to perform the day-to-day Laundry Department functions, to assure that quality laundry services are provided on a daily basis, to safeguard d the health, safety and welfare of all residents of the facility, and to assure the facility laundry is maintained in a clean, safe and sanitary manner, in accordance with the facility's established policies and procedures, applicable laws and regulations and the directions of your supervisors, who include the Laundry Supervisor, Administrator, Assistant Administrator, and other members of the facility's management to whom such persons report, in order to assure that the highest level of laundry services for the facility's residents is maintained at all times. As a Laundry Aide, you are delegated the authority, responsibility, and accountability necessary for carrying out your assigned duties. Record review of facility job description titled, Administrator, dated 5/02/17, documents, in part, The Administrator directs the day to day functions of the facility in accordance with current (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	federal and local standards, guidelines, and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided to our residents at all times.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its abuse policy by failing to report an alleged violation involving a resident-to-resident verbal/mental abuse. This failure affected one (R7) of two residents reviewed for abuse in a total sample of 67.Findings include:R7 reported that she was being harassed by another resident as documented in a progress note dated 2/16/2026 at 23:36:35 by V47 (LPN), Patient complained of being harassed by another patient. Patient asked to be pushed by wheelchair to her room. Patient informed me that she heard that the other patients might attack her if she is seen in the dayroom tomorrow. Patient was in her room when R16 came to her room and started to bother her. I asked R16 to leave and he continued to harass her. Patient was crying and called for her family members to come. Called nursing supervisor of the current situation. Family members came and it was intense for several moments. Eventually, the patient family members dispersed and left. It was further reported for the police to come if there was any further involvement.R7 is [AGE] years old, and the face sheet listed the following past medical history: blindness to left eye, essential primary hypertension, diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema bilateral, hyperlipidemia, history of falling, type 2 diabetes with other circulatory complications, etc.On 2/23/2026 at 11:32AM, R7 said that R16 has been messing with her, she reported to staff, and nothing is being done. R16 will come to her room, harassing her and telling her that he will get some people to come and beat her up. R7 said that R16 messes with her wig when she puts it on.On 02/24/2026 at 9:16AM, R16 said he recalls an altercation with R7, R16 said he told R7 to stop messing with people and leave them alone. R16 said to the surveyor, I know what R7 told you, she said that I threated her, but I did not threaten her. R16 added that he made it clear to R7 and her sister that if R7 put her hands on him first, he will do the same.On 2/24/2026 at 2:28PM V48 (Family member) said that her sister (R7) keeps getting into an altercation with R16, R7 had an issue with another resident, R16 went to R7's room to confront her. V48 said that R7 called her crying, V48 came to the facility with other family members and spoke to management. R7's other sister called the facility and spoke to a CNA (V45) and spoke to a nurse. R16 went to R7's room and pushed her door open, told R7 that she better not come to the dining room, or he will f her up.On 2/24/2026 at 11:13AM, surveyor requested for the investigation and reportable for R7 and R16 from V1 (Administrator) who said that he is the abuse coordinator, V1 said that he did not have any investigation or reportable for R7 and R16 because it was not abuse. V1 was asked if he conducted any investigation to determine if abuse occurred or did not occur and he said, no, the staff statements is my investigation.On 2/24/2026 at 3:07PM, V18 (RN) said that she was called to the third floor that a resident's family member was on the floor. V18 was informed that R7 called her family and said that R16 came to her room and threatened her. V18 told the family members the facility is going to investigate due to R7 stating that R16 threatened her. V18 called the DON and the administrator, not sure if anyone reported the incident, the administrator is the abuse coordinator, V18 did not witness what happened.On 2/25/2026 at 2:56PM V45 (CNA) said that she was present on the day R7 and R16 had an altercation, but she did not witness what happened. V45 was at the nursing station, she answered the phone, and it was R7's family member who was very upset, stating that R16 said something to R7. Several attempts were made by the surveyor to speak to V47 (LPN) but was unsuccessful.Abuse prevention and reporting revised 10/24/2022 states in part under guidelines: the facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	----------In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to, ---------- and mistreatment of residents.Definitions: Mental and verbal abuse. Mental abuse is the use of verbal or non-verbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation.Verbal abuse may be considered a type of mental abuse. Verbal abuse includes the use of oral, written. Or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend or disability.Examples of mental and verbal abuse include, but are not limited to harassing a resident, mocking, insulting, ridiculing, yelling or hovering over a resident with the intent to intimidate, threatening residents, etc.Resident-resident abuse (any type).A resident -to-resident altercation should be reviewed as a potential of abuse. Not all resident-resident altercations result in abuse, for example infrequent arguments or disagreements that occur during the course of normal social interactions (e.g. dinner table discussions) would not necessarily constitute abuse but should be investigated to make this determination.Internal reporting requirements and identification of allegation.Any allegation of abuse or any incident that results in bodily injury will be reported to the department of public health immediately, but not more than two hours after the allegation of abuse. Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145969	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Forest Park	8200 West Roosevelt Road Forest Park, IL 60130

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its abuse policy by failing to initiate and thoroughly investigate an allegation of resident-to-resident verbal/mental abuse. This failure affected one (R7) of two residents reviewed for abuse in a total sample of 67. Findings include:R7 is [AGE] years old, and the face sheet listed the following past medical history: blindness to left eye, essential primary hypertension, diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema bilateral, hyperlipidemia, history of falling, type 2 diabetes with other circulatory complications, etc.On 2/23/2026 at 11:32AM, R7 was observed in the dining room, awake and alert and stated that R16 has been messing with her, she reported to staff, and nothing is being done. R16 will come to her room, harassing her and telling her that he will get some people to come and beat her up. R7 said that R16 messes with her wig when she puts it on.Progress noted dated 2/16/2026 at 23:36:35 by V47 (LPN) documented the following: Patient complained of being harassed by another patient. Patient asked to be pushed by wheelchair to her room. Patient informed me that she heard that the other patients might attack her if she is seen in the dayroom tomorrow. Patient was in her room when R16 came to her room and started to bother her. I asked R16 to leave and he continued to harass her. Patient was crying and called for her family members to come. Called nursing supervisor of the current situation. Family members came and it was intense for several moments. Eventually, the patient family members dispersed and left. It was further reported for the police to come if there was any further involvement. On 02/24/2026 at 9:16AM, R16 said he recalls an altercation with R7, R16 said he told R7 to stop messing with people and leave them alone, she got mad and started cursing R16 out. R16 cursed R7 back, he never went into her room but was in the doorway, a CNA was present and told both to stop. R16 said to the surveyor, I know what R7 told you, she said that I threated her, but I did not threaten her. R16 added that he made it clear to R7 and her sister that if R7 put her hands on him first, he will do the same. R16 said that the altercation started with other residents on the floor, he expected someone to put them side by side and get the truth of what happened. On 2/24/2026 at 2:28PM V48 (Family member) said that her sister (R7) keeps getting into an altercation with R16, R7 had an issue with another resident, R16 went to R7's room to confront her. V48 said that R7 called her crying, V48 came to the facility with other family members and spoke to management. R7's other sister called the facility and spoke to a CNA (V45) and spoke to a nurse. R16 went to R7's room and pushed her door open, told R7 that she better not come to the dining room, or he will f her up.On 2/24/2026 at 3:07PM, V18 (RN) said that she was called to the third floor that a resident's family member was on the floor. V18 was informed that R7 called her family. said that R16 came to her room and threatened her. V18 told the family members the facility is going to investigate due to R7 stating that R16 threatened her. V18 called the DON and the administrator, not sure if anyone investigated the incident, the administrator is the abuse coordinator, V18 did not witness what happened.On 2/25/2026 at 2:56PM V45 (CNA) said that she was present on the day R7 and R16 had an altercation, but she did not witness what happened. V45 was at the nursing station, she answered the phone, and it was R7's family member who was very upset, stating that R16 said something to R7.Several attempts were made by surveyor to speak to V47 (LPN) but was unsuccessful.On 2/24/2026 at 11:13AM, surveyor requested for the investigation for R7 and R16 from V1 (Administrator) who said that he is the abuse coordinator, he did not do any investigation for R7 and R16 because it was not an abuse. V1 said that R16 told him that R7 was being rude to a staff, R16 intervened and told R7 to stop, she became rude to R16. V1 said that the supervisor on duty (V18) spoke to both residents, V1 also spoke to the CNA (V45) and no one reported any abuse. V1 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	added that not every disagreement is an abuse, verbal abuse is if someone says something like watch out, I am going to get you. V1 said to the surveyor, from what you are saying, I am going to initiate an investigation.There is no documentation that anyone spoke to R7 or R16 regarding the incident, V1 only documented speaking to R7 about moving her to another floor.Abuse prevention and reporting revised 10/24/2022 states in part under guidelines: the facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, ----------In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to, ---------- and mistreatment of residents.Definitions: Mental and verbal abuse. Mental abuse is the use of verbal or non-verbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation.Verbal abuse may be considered a type of mental abuse. Verbal abuse includes the use of oral, written. Or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend or disability.Examples of mental and verbal abuse include, but are not limited to harassing a resident, mocking, insulting, ridiculing, yelling or hovering over a resident with the intent to intimidate, threatening residents, etc.Resident-resident abuse (any type).A resident -to-resident altercation should be reviewed as a potential of abuse. Not all resident-resident altercations result in abuse, for example infrequent arguments or disagreements that occur during the course of normal social interactions (e.g. dinner table discussions) would not necessarily constitute abuse but should be investigated to make this determination.Internal investigation: all incidents will be documented, whether or not abuse neglect, exploitation, mistreatment misappropriation of resident property occurred, was alleged or suspected. Any incident or allegation involving abuse, neglect, exploitation, mistreatment, or misappropriation of resident property will result in an investigation.

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on interview and record review, the facility failed to obtain from an outside resource routine and emergency dental services. This failure affected one (R210) resident reviewed for dental services in the total sample of 67 residents. Findings include:R210's census list documented that R210 was admitted at the facility on 10/26/2020 and was discharged on 1/28/2026. R210's (01/05/2026 - 02/28/2026) order Recap Report documented that R1's diagnoses include but are not limited to hemiplegia (paralysis) and hemiparesis (muscle weakness), cerebral infarction, and COPD (Chronic Obstructive Pulmonary Disease). R210's (01/16/2026) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 14. Indicating R210's mental status as cognitively intact. The (02/24/2026) email correspondence with V5 (Social Services Director) documented, in part Subject: (R210) Notes. Kindly include any dental notes. The (02/24/2026) email correspondence between National Preventive solutions and V36 (Social Services Assistant) documented, in part The most recent notes we have for (R210) are from 2024. (V49 - Dentist National Preventive Solutions) saw (R210) for an exam and wrote a referral for her to have extractions. (R210) is not enrolled in our dental program so she may not be added to the list to be seen regularly unless we receive a request from the facility or family. I would be happy to send you the forms from 2024 or add her to be seen during the next visit, if needed. R210's (04/01/2024) Dental Consult National Preventive Solutions documented, in part Treatment Type: Exam. Referral extract 14, 3, 8, 9.R210's (04/01/2024) Patient Referral Form documented, in part Reason For Referral: Extract #8, 9, 3, 14. Of note, no additional dental services note received from facility including extraction of teeth # 8, 9, 3, and 14.On 02/26/2026 at 12:42pm, V50 (Clinical Support National Preventive Solutions) stated she (R210) was never enrolled in the dental program. (V49) saw her on 04/01/2024 and they never heard anything after April 01, 2024. V50 stated he (V49) did the exam and made a recommendation for teeth extraction of #3, 8, 9 and 14. The facility should take the referral to an outside dental office. It is the facility's responsibility to schedule. V50 stated for Medicaid residents they were usually seen by their dentist 3-4 x a year and by their dental hygienist 8 times a year. The program is paid for by Medicaid. On 02/24/2026 at 10:09am, V5 (Social Services Director) stated she (R210) was on medicaid and she should be scheduled to see a dentist and an ophthalmologist at least once every year. She can get a pair of glasses and can have dental cleaning once a year and as needed if she needed more attention. Nursing would let the Social Services know if she needed to be seen and she would put her on the list and she would send an email out for eye and dental appointment. On 02/25/2026 at 9:44am, V2 (Director Of Nursing) stated dental services should be provided to the resident at least yearly. If the dental service was last provided in 2024, it means she (R210) was not provided dental service the whole year of 2025. On 02/25/2026 at 1:38pm, V43 (Assistant Administrator) stated the facility did not have Dental services policy and procedure as it relates to frequency of providing the services. Requested V43 to send an email as to the facility expectation. The (undated) Dental Visits documented, in part Based on Centers for Medicare and Medicaid Services (CMS) regulations, nursing home facilities are required to ensure residents have access to dental services, but there is no rigid, universally mandated, specific timeframe (such as every 6mnths) for a dentist to physically see a resident. Residents will be seen on an as needed basis. Authored by V1 (Administrator). The (undated) Residents' Rights for People in Long-Term Care Facilities documented, in part As a long-term care resident in the State, you are guaranteed certain rights, protections and privileges according to State and Federal laws. Your rights to safety. Your facility must provide services to keep your physical and mental health at their highest practicable levels.