STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146033	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elms, The	1212 Madelyn Avenue Macomb, IL 61455

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. Based on Observation, Interview and Record Review, the facility failed to ensure residents were informed of how to file a grievance and ensure that written complaints can be filled anonymously. This failure has the potential to affect all 66 residents residing in the facility.Findings include:The facility's Grievance/ Complaint policy and procedure, dated 3/25/26, documents Each resident and/or resident representative may file a grievance or complaint regarding any resident right, quality of life, or quality of care concern. The party filing the grievance may present the grievance anonymously and every effort to preserve the identity of the referring source will be attempted. The Social Services Director/ Director of Nursing are the designated coordinators of this policy. The forms are located in the social services office, north and south nurses' stations and front reception desk.On 6/2/26 at 10:40 AM, during a resident group meeting. R10, R14, R64 and R66 all denied knowing how to file a written complaint or grievance. These residents also all stated the facility does not have a complaint box or a place to put anonymous suggestions or complaints.On 6/2/26 at 12:25 PM V7 (Social Service Director) confirmed that the facility does not have a grievance box or a formal complaint form that can be submitted anonymously. V7 stated We have missing item/concern forms at the receptionist desk in the main lobby and those are submitted to the receptionist. We also have those forms at the nurse's stations.On 6/2/26 at 12:30 PM V7 located the concern form at the North Hall nurse's station. This form was in a wall filing slot behind the nurse's station and above V7's head. V7 confirmed that this concern form would need to be given to a resident by facility staff since it is out of sight and reach of residents. V7 stated there is not a grievance box, sign or a way to submit the form anonymously.The facility's CMS (Centers for Medicare and Medicaid Services) Form 671 dated 6/1/26 and signed by V1 (Administrator), documents 66 residents reside within the facility.

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to label opened food items in the refrigerators. These failures have the potential to affect all 66 residents residing in the facility.Findings Include:The facility's Food Receiving and Storage policy dated 11/2022 documents, Policy statement, foods shall be received and stored in a manner that complies with safe food handling practices. Refrigerated/Frozen Storage, 1. All foods stored in the refrigerator or freezer are covered, labeled and dated (use by date). 7. Refrigerated foods are labeled, dated and monitored so they are used by their use-by date, frozen, or discarded. The facility's Refrigerators and Freezers policy dated 11/2022 documents, Policy statement, this facility will ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and will observe food expiration guidelines. Policy Interpretation and Implementation, 7. All food is appropriately dated to ensure proper rotation by expiration dates. Received dates (dates of delivery) are marked on cases and on individual items removed from cases for storage. Use by dates are completed with expiration dates on all prepared food in refrigerators. Expiration dates on unopened food are observed and use by dates are indicated once food is opened.On 6/1/2026 at 9:15 AM, during the initial kitchen tour, the refrigerator contained a bag of bacon bits that was not marked with an opening date. Additionally, several opened food containers were not properly date marked, including macaroni salad, mustard potato salad, Summer Fresh pasta salad, tuna salad, cottage cheese, pickles, two containers of sauteed vegetable base, two containers of strawberries, cheesecake, sour cream, mustard salad, western salad dressing, mayonnaise, pickle relish, Caesar dressing, and Thousand Island dressing.On 6/1/2026 at 9:25 AM, V8 (Director of Food Service) stated he does not label foods opened with a use by date and assumes the expiration date is the date to use opened foods.

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F 0600 Level of Harm - Minimal harm or potential for 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to prevent resident-to-resident verbal abuse for two of two residents (R16 and R76) reviewed for abuse in the sample of 30.Findings include:The facility's Abuse and Neglect Prevention Policy undated, documents, It is the policy of (the facility) to not tolerate abuse or neglect of its residents by an individual. (The facility) is committed to protecting our residents from abuse by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals. Verbal abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance, regardless of their age, ability to comprehend, or disability.R16's Behavior Note dated [DATE] at 6:00 AM and signed by V17 (RN/Registered Nurse) documents, (R16) up in room standing at foot of roommate's (R76's) bed, yelling, and cursing at roommate stating, You need to get the h**l out of this bed and go pay the bill, your nothing but a bi**h just lying there all day not doing anything. Pay the TV (Television) bill while you are not doing anything. This same note documents R16 left her room and went down to the south dining room and started calling other residents in the south dining room bi**hes.R16's Progress Notes dated [DATE] at 10:37 AM and signed by V17 (RN) document, (R16) moved to (another room) related to concerns with roommate.R16's Progress Notes dated [DATE] document R16 expired while in the facility.On [DATE] at 2:00 PM V17 (RN) stated, (On [DATE]) I heard (R16) yelling at (R76) and calling (R76) a bi**h.On [DATE] at 2:26 PM V1 (Administrator) stated, A resident cursing towards other residents is considered verbal abuse.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on observation, interview, and record review, the facility failed to ensure the Interdisciplinary Team (IDT) conducted and documented a comprehensive evaluation prior to the initiation and dosage increase of an antipsychotic medication to determine whether a resident was experiencing an underlying condition contributing to their symptoms, failed to document behaviors and diagnoses to support the use of an antipsychotic medication, failed to ensure a consistent and clinically documented diagnosis was used to justify the use of an anti-psychotic medication, failed to complete psychotropic assessments, and failed to follow physician's orders related to an antipsychotic medication for two of three residents (R7 and R16) reviewed for antipsychotic medication use with diagnoses of dementia in a sample of 30. Findings include: The facility's Psychotropic Medication Use policy, dated 2/2025, documents Residents do not receive psychotropic medications that are not clinically indicated and necessary to treat a specific condition documented in the medical record. Psychotropic medication is any medication that affects brain activity associated with mental processes and behavior. Medications in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: antipsychotics. Psychotropic medication management is an interdisciplinary process that involves the resident, family, and/or the representative and includes determining adequate indications for use. Residents who have not used psychotropic medications are not prescribed or given these medications unless the medication is determined to be necessary to treat a specific condition that is diagnosed and documented in the medical record. Psychotropic medications are never used to sedate or alter a resident's behavior for discipline or for the convenience of staff. When determining to initiate, modify, or discontinue medication therapy, the interdisciplinary team conducts and documents an evaluation of the resident. The evaluation includes the resident's: physical, behavioral, mental, and psychosocial status; comorbid conditions; expressions or indications of distress; changes in functional status; resident complaints, behaviors, and symptoms; and the state PASARR (Preadmission Screening and Resident Review) evaluation. Circumstances that warrant an evaluation of the residents' underlying medical condition and medications include new or worsening change in condition or status; a new medication is ordered as an emergency measure. This same policy documents Adequate indications for use refers to the identified, documented clinical rational for administering medication that is based on an assessment of the resident's condition and therapeutic goal. The clinical rational for the use of psychotropic medication, or change from one type of psychotropic to another, is documented in the medical record. Documentation must include that behavioral (non-pharmacological) interventions were attempted but not successful, and these interventions were deemed clinically contraindicated. Alternatively, documentation from a physician must describe that alternative treatments are clinically contraindicated and the rationale for the conclusion. Diagnosis alone does not necessarily warrant the use of psychotropic medication. If a psychiatric diagnosis is part of the rationale for the use psychotropic medication, there will be sufficient supporting documentation that the resident meets the criteria for diagnosis (based on the current diagnostic and statistical manual of mental disorders). 1.R16's MDS (Minimum Data Set) dated 10/15/25 documents R16 does not receive anti-psychotic medication. R16's Behavior Note dated 12/4/25 at 10:58 AM documents, (R16) is very angry and anxious this am (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(morning). (R16) states that she does not want to move to south. It is not fair that I have to leave my home. Attempted to talk with resident but she just walks away. R16's Behavior Note dated 12/4/25 at 8:23 AM documents, (R16) is yelling at roommate. (R16) states that it is not fair that (R16) has to move to south hall. (R16) is yelling at her roommate and stating, I hope no one does this to you! R16's Progress Notes dated 12/7/25 documents, (R16) has coat on. Went up front by the doors and states I am leaving. Several staff attempted re-direction. (R16) set alarms off twice. Once (R16) was back to her room became even more upset threw her cell phone when her friend called and said it wouldn't be until 10:00 AM before she came. Yelling at staff. Told the staff to get out of her room. R16's Progress Notes and Physician's Order signed by V14 (Psychiatric Nurse Practitioner) dated 12/10/25 documents, New order from (V14/Psychiatric Nurse Practitioner) to start Rexulti (anti-psychotic medication) 0.5 mg (milligrams) daily for agitation associated to (R16's) Dementia. R16's Physician's Order dated 1/9/26 given by V14 (Psychiatric Nurse Practitioner) documents, Rexulti 0.5 mg one time a day for agitation related to Alzheimer's Disease. R16's Physician's Order dated 1/9/26 given by V14 (Psychiatric Nurse Practitioner) documents, Rexulti one mg at bedtime related to Bipolar Disorder. R16's Physician's Order dated 1/13/26 and signed by V12 (Neurologist) documents, Rexulti one mg give 1.5 mg one time day related to Bipolar Disorder. R16's Physician's Order dated 3/4/26 and signed by V12 (Neurologist) documents to increase R16's Rexulti to two mg every bedtime. R16's current Physician's Orders document R16 continues to receive Rexulti two mg at bedtime for the diagnosis of Major Depression. R16's Electronic Health Record dated 12/1/25 (prior to the start of Rexulti) through 6/2/26 does not include an IDT assessment to determine if R16 had an underlying condition prior to initiating Rexulti and does not include an IDT assessment to assess R16's physical, behavioral, mental, and psychosocial status, comorbid conditions, expressions or indications of distress, changes in functional status, resident complaints, behaviors, or symptoms as directed by the facility's policy. R16's Electronic Health Record dated 12/10/25 (start of Rexulti) through 6/2/26 does not include a psychotropic drug assessment for the use of Rexulti. R16's Informed Consent Form dated 12/10/15 and signed by V20 (R16's Power of Attorney) documents R16 was prescribed Rexulti for the diagnosis of Dementia with Behaviors and Agitation. On 6/1/26 at 10:15 AM R16 was in the activity room and exhibiting no behaviors. On 6/2/26 at 12:10 PM R16 was sitting in the dining room. R16 was in the dining room. R16 was pleasant and exhibiting no behaviors. On 6/3/26 at 8:15 AM V4 (Infection Preventionist) stated the IDT team did not perform an assessment (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to determine if R16 had an underlying condition prior to the start of Rexulti and did not perform and IDT assessment to determine R16's physical, behavioral, mental, and psychosocial status, comorbid conditions, expressions or indications of distress, changes in functional status, resident complaints, behaviors, or symptoms as directed by the facility's policy. On 6/3/26 at 10:20 AM V2 (Director of Nursing) verified the facility has not performed any anti-psychotic assessments for the use of R16's Rexulti. 2. On 6/2/2026 at 10:00 AM, R7 was in the hallway in front of the nurse's station, dressed, and in her wheelchair. R7 was pleasant and polite. R7 was not interviewable. R7's Physician Medication Informed Consent form, dated 9/23/2025, documents that R7 is taking Seroquel (antipsychotic) medication. R7's MDS (Medical Data Set) dated 4/15/2026, section E (behaviors) does not document any potential indicators for psychosis. R7's Care Plan dated 6/2/2026 documents R7 is severely impaired with a BIMS (basic interview of mental status) of 4 (severely impaired) with no delirium indicators present. R7's Provider Recommendations dated 1/4/2026 documents decrease quetiapine (antipsychotic) to 12.5 mg (milligrams) PO (by mouth) at qHS (at bedtime) for Dementia with Psychosis. R7's Physician's Orders dated 6/1/2026, Seroquel (antipsychotic) 25mg at bedtime. On 06/01/2026 at 12:34 PM, V22 (R7's Family Member/Power of Attorney) stated that in the past, R7 had hit staff at times during care. V22 stated she has seen R7 saying she sees people that are not there and reaches in the air for them. V22 stated R7 has never hit another resident and has never been verbally abusive towards residents. V22 stated R7 has calmed down a lot in the last several months. On 6/2/2026 at 10:05 AM, V10 (Activities Aide) stated that R7 does not exhibit behaviors. V10 stated that R7 is always happy-go-lucky and in a pleasant mood. On 6/2/2026 at 10:10 AM, V11 (Certified Nurse Assistant) stated R7 has never had any behavior towards her. V11 stated R7 has had a morning a few times that she didn't want to get up and she was upset about it, but she has never been violent towards me and has never hit or yelled at any other resident. On 6/2/2026 at 10:15 AM, V12 (Certified Nurse Assistant) stated that R7 has never been violent toward her and that she has never seen R7 act violently toward other residents. V12 stated R7 has never exhibited any behaviors. On 6/2/2026 at 10:20 AM, V13 (Registered Nurse) stated R7 does not have any behaviors that she is aware of.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview, the facility failed to report resident-to-resident verbal abuse to the administrator and state agency for two of two residents (R16 and R76) reviewed for abuse in the sample of 30.Findings include:The facility's Abuse and Neglect Prevention Policy, undated, documents, Employees are required to report any occurrences of potential mistreatment they observe, hear about, or suspect to a Department Head or the Administrator. Initial reports will be completed immediately but no later than 24 hours after incident of alleged abuse to IDPH (Illinois Department of Public Health).R16's Behavior Note dated 1/13/26 at 6:00 AM and signed by V17 (RN/Registered Nurse) documents, (R16) up in room standing at foot of roommate's (R76's) bed, yelling, and cursing at roommate stating, You need to get the h**l out of this bed and go pay the bill, your nothing but a bi**h just lying there all day not doing anything. Pay the TV (Television) bill while you are not doing anything. This same note documents R16 left her room and went down to the south dining room and started calling other residents in the south dining room bi**hes.On 6/2/26 at 2:00 PM V17 (RN) stated, (On 1/13/26) I heard (R16) yelling at (R76) and calling (R76) a bi**h. I did not notify the administrator.On 6/2/26 at 2:26 PM V1 (Administrator) stated, I do not recall (V17) notifying me regarding (R16) cursing at her roommate. I should have been notified immediately. V1 confirmed the verbal abuse allegation of R16 cursing at her roommate (R76) on 1/13/26 has not been reported to the state agency.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and interview, the facility failed to investigate and submit a final report to the state agency regarding resident-to-resident verbal abuse for two of two residents (R16 and R76) reviewed for abuse in the sample of 30.Findings include:The facility's Abuse and Neglect Prevention Policy, undated, documents, Internal investigation of (abuse) allegations and response: An investigation will begin by obtaining a copy of any documentation relative to the incident and follow the Investigation Procedure Policy. The administrator is responsible for forwarding a final written report of the results of the investigation and of any corrective action take to the Department of Public health within five working days of the reported incident.R16's Behavior Note dated 1/13/26 at 6:00 AM and signed by V17 (RN/Registered Nurse) documents, (R16) up in room standing at foot of roommate's (R76's) bed, yelling, and cursing at roommate stating, You need to get the h**l out of this bed and go pay the bill, your nothing but a bi**h just lying there all day not doing anything. Pay the TV (Television) bill while you are not doing anything. This same note documents R16 left her room and went down to the south dining room and started calling other residents in the south dining room bi**hes.On 6/2/26 at 2:26 PM V1 (Administrator) verified the verbal abuse allegation of R16 cursing at her roommate (R76) on 1/13/26 has not been investigated and a final report has not been sent to the state agency.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on record review and interview the facility failed to perform a significant change comprehensive assessment after residents exhibited an increase in behaviors, were diagnosed with new psychiatric conditions, and were prescribed new ant-psychotics medications for two of two residents (R3 and R16) reviewed for signification change in condition in the sample of 30. The Centers for Medicare and Medicaid Services (CMS) (Resident Assessment Instrument) RAI 3.0 Manual dated 10/2025 documents a resident with MI or ID/DD must have a Resident Review conducted when there is a significant change in the resident's physical or mental condition. Therefore, when an SCSA is completed for a resident with MI/DD, the nursing home is required to notify the State mental health authority, intellectual disability or developmental disability authority (depending on which operates in their state) to notify them of the residents change in status. Section 1919 of the social Security Act requires the notification or referral for a significant change. 1.R3's medical diagnosis list documented Hallucinations added on 8/19/2023, Delusional Disorder added on 9/27/2023, and Unspecified Psychosis added on 5/16/2024. R3's physician orders documented Seroquel 25 milligrams daily was initiated on 8/21/2023 for confusion and hallucinations. On 06/02/2026 at 10:15 AM, V2 (Director of Nursing) stated the facility completed an audit of PASARR determinations in January 2026. V2 stated resident diagnoses and medications were reviewed and residents identified as requiring a Level II PASARR were referred accordingly. V2 confirmed R3 was identified through the audit as requiring a Level II PASARR and acknowledged a Significant Change in Status Assessment should have been completed but was not. On 06/02/2026 at 10:26 AM, V7 (Social Services Director) stated R3 was identified as requiring a Level II PASARR due to increased hallucinations and the initiation of a psychotropic medication. V7 stated this information was communicated to the MDS Nurse for follow-up. On 06/03/2026 at 11:00 AM, V18 (MDS Nurse) stated she was aware of the January 2026 PASARR audit findings and knew R3 had been identified as requiring Level II PASARR. V18 stated she did not complete a Significant Change in Status Assessment because she believed completion of the PASARR process alone addressed the issue. 2.R16's Behavior Note dated 12/4/25 at 10:58 AM documents, (R16) is very angry and anxious this am (morning). (R16) states that she does not want to move to south. It is not fair that I have to leave my home. Attempted to talk with resident but she just walks away. R16's Behavior Note dated 12/4/25 at 8:23 AM documents, (R16) is yelling at roommate. (R16) states that it is not fair that (R16) has to move to south hall. (R16) is yelling at her roommate and stating, I hope no one does this to you! R16's Progress Notes dated 12/7/25 documents, (R16) has coat on. Went up front by the doors and states I am leaving. Several staff attempted re-direction. (R16) set alarms off twice. Once (R16) was back to her room became even more upset threw her cell phone when her friend called and said it wouldn't be until 10:00 AM before she came. Yelling at staff. Told the staff to get out of her room. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R16's Progress Notes dated 12/10/25 documents, New order from (V14/Psychiatric Nurse Practitioner) to start Rexulti (anti-psychotic medication) 0.5 mg (milligrams) daily. R16's MDS (Minimum Data Set) Tracking dated 10/15/25 through 4/14/26 does not include evidence of a Significant Change in Status MDS being completed after R16 started to exhibit increased behaviors and was started on Rexulti on 12/10/25.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and interview the facility failed to accurately code the MDS (Minimum Data Set) Assessments for two of 17 residents (R3 and R4) reviewed for MDS Accuracy in the sample of 30. Findings include: The facility's Comprehensive Assessments policy dated 2001 documents, Comprehensive assessments are conducted in accordance with criteria and timeframes established in the Resident Assessment Instrument (RAI) User Manual. CMS's (Center's for Medicaid and Medicare) RAI Version 3.0 Manual dated 10/25 documents, Coding Instructions: Code 1, yes if PASARR (Pre-admission Screening and Resident Review) Level II screening determined that the resident has a serious mental illness and/or ID/DD (Intellectual Disability/Developmental Disability) or related condition. 1.R4's PASARR Level II Outcome dated 3/9/25 documents, You meet PASARR inclusion criteria for Serious Mental Illness with diagnoses of Major Depressive Disorder and Psychosis. Your day-to-day life has been impacted by your illness. R4's MDS (Minimum Data Set) Assessments Section A1500 Preadmission Screening and Resident Reviews dated 1/27/26 and 4/28/26 are coded as R4 is not considered by the state level II PASARR process to have a serious mental illness and/or intellectual disability or a related condition. On 6/2/26 at 10:10 AM V2 (Director of Nursing) verified R4's MDS Section A1500 Assessments dated 1/27/26 and 4/28/26 were inaccurately coded and should have been coded as R4 does have a serious mental illness according to R4's state level II PASARR dated 3/9/25. 2.R3's Physician Orders documents Seroquel 25 milligrams daily was initiated on 8/21/2023 for confusion and hallucinations. On 06/02/2026 at 10:15 AM, V2 (Director of Nursing) stated the facility completed an audit of PASARR determinations in January 2026. V2 stated resident diagnoses and medications were reviewed and residents identified as requiring a Level II PASARR were referred accordingly. V2 confirmed R3 was identified through the audit as requiring a Level II PASARR and acknowledged the residents' MDS assessment was not updated to reflect the PASARR findings. On 06/02/2026 at 10:26 AM, V7 (Social Services Director) stated R3 was identified as requiring a Level II PASARR due to increased hallucinations and the initiation of psychotropic medication and communicated this information to the MDS Nurse. On 06/03/2026 at 11:00 AM, V18 (Minimum Data Set/MDS Nurse) stated she was aware R3 had been identified as requiring a Level II PASARR but did not update the resident's MDS assessment because she believed completion of the PASARR process alone addressed the issue.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elms, The	1212 Madelyn Avenue Macomb, IL 61455

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. Based on interview and record review the facility failed to notify the state mental health authority once a resident experienced an increase in behaviors, was diagnosed with a new psychiatric condition, and was prescribed a new anti-psychotic medication for one of two residents (R16) reviewed for a significant change in condition in the sample of 30.R16's MDS (Minimum Data Set) dated 10/15/25 documents R16 does not receive anti-psychotic medication.R16's Behavior Note dated 12/4/25 at 10:58 AM documents, (R16) is very angry and anxious this am (morning). (R16) states that she does not want to move to south. It is not fair that I have to leave my home. Attempted to talk with resident but she just walks away.R16's Behavior Note dated 12/4/25 at 8:23 AM documents, (R16) is yelling at roommate. (R16) states that it is not fair that (R16) has to move to south hall. (R16) is yelling at her roommate and stating, I hope no one does this to you!R16's Progress Notes dated 12/7/25 documents, (R16) has coat on. Went up front by the doors and states I am leaving. Several staff attempted re-direction. (R16) set alarms off twice. Once (R16) was back to her room became even more upset threw her cell phone when her friend called and said it wouldn't be until 10:00 AM before she came. Yelling at staff. Told the staff to get out of her room.R16's Progress Notes dated 12/10/25 documents, New order from (V14/Psychiatric Nurse Practitioner) to start Rexulti (anti-psychotic medication) 0.5 mg (milligrams) daily. This same Order does not include the behaviors or diagnosis to warrant the use of Rexulti.R16's Electronic Health Record does not include evidence of a notification to the state mental health authority once R16 started to exhibit an increase in behaviors and was started on Rexulti on 12/10/25.On 6/3/26 at 8:15 AM, V4 (Infection Preventionist) verified that once R16 started exhibiting new behaviors and was started on an anti-psychotic medication for a mood disorder the state mental health authority was not notified.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Observation, Interview and Record Review, the facility failed to follow their policy/procedure for incontinence care, complete hand hygiene and glove changes during incontinence care for one of two residents (R41) reviewed for incontinence care in the sample of 30.Findings include: The Perineal Care policy dated 2/2018 documents The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition. Equipment and Supplies - The following equipment and supplies will be necessary when performing this procedure: 1. Wash basin; 2. Towels; 3. Washcloth; 4. Soap (or other authorized cleansing agent); and 5. Personal protective equipment (e.g. (example), gowns, gloves, mask, etc. (etcetera), as needed). Steps in the Procedure 1. Place the equipment on the bedside stand. Arrange the supplies so they can be easily reached. 2. Wash and dry your hands thoroughly. 7. Put on gloves. R41's computerized Medical Record documents that R41 is a [AGE] year-old that was admitted to the facility on [DATE] with diagnoses which included Acute Respiratory Failure with Hypoxia, Essential (Primary) Hypertension, Acute Kidney Failure, and Bacterial Infections.R41's Care Plan documents that R41 is incontinent related to activity intolerance.On 6/1/26 at 10:15 AM, V12/Certified Nursing Assistant/CNA and V16/CNA came into R41's room to provide incontinence care for R41. They were wearing gowns and gloves before they entered R41's room. They removed R41's disposable brief and V12 opened a package of disposable wipes to use to clean R41. V12 did not wash her hands or change her gloves before starting incontinence care. V12 took five wet wipes from the package and stacked them on the incontinent pad that was under R41. V12 then took all five wipes and wadded them in her hand to clean R41's vaginal area. V12 used the same wipes to clean R41's vaginal area and the area between R41's legs and torso. R41 was then turned to her left side. V12 then took another five wet wipes from the package and stacked them on R41's incontinent pad. V12 then wadded the wipes in her hand and cleaned R41's buttocks. During R41's incontinent care V12 did not change her gloves or wash her hands. V12 then applied cream to R41's buttock without washing her hands or changing her gloves.On 6/1/26 at 10:17 AM, V12/CNA was asked if she usually changes her gloves and washes her hands when providing incontinent care. V12 stated Sometimes, it depends on how much mess there is.On 6/2/26 at 1:20 PM, V4/Infection Preventionist stated that V12/CNA should not have placed the wipes on a dirty surface before cleaning R41. V4 also stated that V12 should have changed her gloves and washed her hands when providing incontinent care for R41. V4 was told by this surveyor how the incontinent care was done and V4 stated That is a problem.On 6/3/26 at 11:20 AM, V3/Assistant Director of Nursing verified that it is not in the policy to use wet wipes, and the CNAs should have used a wash basin and washcloths to do incontinent care. V3 also verified that V12/CNA should have washed her hands and changed gloves.On 6/3/26 at 11:25 AM, V1/Administrator stated the entire incontinent care process was done incorrectly for R41.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to replace oxygen tubing/nebulizer masks weekly or store/label oxygen tubing/nebulizer masks correctly for three of six residents (R8, R21, R50) reviewed for oxygen in the sample of 30.Findings include: 3. On 6/1/2026 at 10:15 AM, R8 was in her room, in her wheelchair, dressed, wearing a nasal cannula with oxygen flowing at 3L (liters). Oxygen tubing was dated 5/23. R8's Physician's Order sheet dated 5/18/2026 documents, O2 (oxygen) at 3L(liters) per NC (nasal cannula) keep stats greater than 92% as needed for respiratory distress or to maintain stats above 92%. R8's Care Plan dated 6/2/2026 documents, R8 is at risk for altered respiratory status/difficulty breathing related to COPD (Chronic obstructive pulmonary disease), COPD exacerbation, Pneumonia. Oxygen settings: O2 via NC at 3L to maintain status more than 92%. Humidified. On 6/2/2026 at 1:16 PM, V4 (Infection Preventionist) stated nursing staff are expected to change oxygen tubing every week, and it is expected to date oxygen tubing after changing the tubing. Administering Medications through a Small Volume (Handheld) Nebulizer policy dated 10/2010 documents Purpose -The purpose of this procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway. 22. Rinse and disinfect the nebulizer equipment according to facility protocol, or: a. wash pieces with warm, soapy water; b. rinse with hot water; c. allow to air dry on a paper towel. 24. When equipment is completely dry, store in a plastic bag with the resident's name and the date on it. 25. Change equipment and tubing every seven days, or according to facility protocol. 2. R21's computerized Medical Record documents that R21 is a [AGE] year-old that was admitted to the facility on [DATE] with diagnoses which included Acute Respiratory Failure and Chronic Obstructive Pulmonary Disease. R21's Order Summary Report printed 6/2/26 at 10:03 AM, documents oxygen at two to five liters as needed for respiratory distress to maintain oxygen level above 90 percent. Order date 5/20/26. The same order summary also documents to change oxygen tubing weekly on Fridays on third shift. Order date 5/27/26. On 6/1/26 at 9:50 AM, R21 was sitting in her recliner with her oxygen machine next to the recliner. The oxygen tube with nasal cannula was on the floor behind R21's chair. The tube was not dated. On 6/1/26 at 9:52 AM, R21 stated that she has needed oxygen once since she was admitted . R21 also stated that she was not sure of when she used the oxygen, but no one has changed the tubing. On 6/2/26 at 11:10 AM, V5/Registered Nurse/RN verified that R21's oxygen tube with nasal cannula was on the floor behind R21's recliner and was not dated. 3. R50's computerized Medical Record documents that R50 is a [AGE] year-old that was admitted to the facility on [DATE] with diagnoses which included Malignant Neoplasm of Unspecified Part of (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Bronchus or Lung, Chronic Obstructive Pulmonary Disease, and Acute Respiratory Failure with Hypoxia. R50's Order Summary Report printed 6/2/26 at 10:05 AM, documents oxygen at three liters per nasal canula as needed for respiratory distress or to maintain oxygen level above 90 percent. Order date 5/28/25. The same order summary also documents to change oxygen tubing weekly on Fridays on third shift. Order date 10/8/25. On 6/1/26 at 10:40 AM, R50 was sitting on the side of her bed. The oxygen tubing was dated 5/23/26. R50 had a nebulizer mask laying on the nightstand and it was dated 5/23/26. The mask was not stored in a plastic bag. On 6/1/26 at 10:41 AM, R50 stated that oxygen tubing is supposed to be changed once a week but does not always get done that often. On 6/2/26 at 11:16 AM, V5/RN verified that the oxygen tubing and nebulizer mask had both been changed that morning and were dated 6/2/26. V5 also verified that the nebulizer mask was not stored in a plastic bag. On 6/2/26 at 1:15 PM, V4/Infection Preventionist stated that oxygen tubing and nebulizer masks should be changed every week and dated. V4 also verified that the nebulizer mask should be cleaned and stored after use.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement Enhanced Barrier Precautions/EBP during direct cares for one of three residents (R41) reviewed for infection control in the sample of 30.Findings include:The Enhanced Barrier Precaution policy dated 8/2022 documents Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug-resistant organisms (MDROs) to residents. Policy Interpretation and Implementation 1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug-resistant organisms (MDROs) to residents. 3.Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: c. transferring 5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. 6. EBPs remain in place for the duration of the residents' stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk.R41's computerized Medical Record documents that R41 is a [AGE] year-old that was admitted to the facility on [DATE] with diagnoses which included Acute Respiratory Failure with Hypoxia, Essential (Primary) Hypertension, Acute Kidney Failure, and Bacterial Infections.R41's Order Summary Report printed 6/2/26 documents Enhanced Barrier Precautions: Wear gloves and gown for High-Contact Resident Care Activities. (Dressing, Bathing, Transfers, Linen changes, Hygiene, Toileting, Wound care, and/or device care such as catheter, feeding tube, trach, central line) every shift.R41's Care Plan documents the Goal for R41 is that R41 will have intact skin free of redness, blisters, or discoloration. Intervention - Enhanced Barrier Precautions: Wear gloves and gown for High- Contact Resident Care Activity. (Dressing, Bathing, Transfers, Linen changes, Hygiene, Toileting, Wound Care) R41's door had an Enhanced Barrier Precaution Sign on her door. The sign documents that all providers and staff must Wear gloves and a gown for the following High-Contact Resident Care Activities. Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, changing briefs or assisting with toileting. On 6/1/26 at 10:12 AM, This surveyor entered R41's room. R41 was lying in bed with V16/Certified Nursing Assistant/CNA, and V19/Agency CNA standing next to R41's bed checking R41 for incontinence. V16 and V19 did not have a gown on.On 6/1/26 at 10:13 AM, V16/CNA stated that R41 had just been transferred from R41's wheelchair to the bed to change R41. V16 also stated that V16 and V19 did not wear a gown during the transfer. On 6/2/26 at 11:20 AM, R41 stated that staff do not always wear gowns and gloves when they provide care for her.On 6/3/26 at 10:30 AM, V4/Infection Preventionist stated that R41 was placed on EBP because R41 had a pressure wound and a G (Gastrostomy) - tube. The pressure wound is now healed, and the G-tube was removed on 5/20/26 but R41 was left on EBP until the G-tube site is healed. V4 also stated that R41 now has a skin tear to her left lower extremity and is still on EBP for the skin tear. V4 stated that a gown and gloves should be worn when transferring or providing care for R41.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on Observation, Interview and Record Review, the facility failed to ensure the State Agency survey results were kept in a location readily accessible to residents and visitors and post a notice that survey results are available for review. This failure has the potential to affect all 66 residents residing in the facility.Findings include:The Ombudsman Resident Rights for People in Long Term Care Facilities booklet, dated 11/2018, documents You have the right to see reports of all inspections by the Illinois Department of Public health from the last five years and the most recent review of your facility along with any plan that your facility gave to the surveyors saying how your facility plans to correct the problem.On 6/2/26 at 10:40 AM, during a resident group meeting. R10, R14, R64 and R66 all denied being aware of a (state agency) survey binder or the availability to review those results. R64 confirmed she is the resident council president and stated, I wasn't aware that was even something we could look at or see those (past survey) results.On 6/2/26 at 11:15 AM, the facility (state agency) survey book observed in the lobby behind the receptionist desk in a three-ring binder, not freely accessible for residents to access. The facility's lobby area and hallways do not contain a posting about the state agency survey results being available for review.On 6/2/2026 at 12:25 PM, V7 (Social Service Director) confirmed the state survey book is located behind the receptionist desk in the front lobby and stated she is not aware of any signage about the survey results binder. V7 verified that some residents travel to the front lobby but not all of them do and that items behind the reception desk would most likely not be accessible for residents, without asking for assistance.The facility's CMS (Centers for Medicare and Medicaid Services) Form 671 dated 6/1/26 and signed by V1 (Administrator), documents 66 residents reside within the facility.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on Observation and Interview, the facility failed to ensure the daily resident census and facility staff posting was posted in an area accessible to residents and visitors. This failure has the potential to affect all 66 residents residing in the facility.Findings include:On 6/2/26 at 11:20 AM, the facility's common areas and hallways were toured and did not contain a daily staffing posting. On 6/2/26 at 11:30 AM, V2 (Director of Nursing) stated the facility daily staffing is kept at the receptionist's desk. On 6/2/26 at 11:35 AM, V2 pulled a clipboard out of an upright file slot behind the receptionist desk in the lobby entrance. V2 verified that the daily staff posting is placed on the clipboard and stored in the file slot every day. V2 confirmed this clipboard is not viewable unless you go behind the desk and remove the clipboard from the file where it's stored.The facility's CMS (Centers for Medicare and Medicaid Services) Form 671 dated 6/1/26 and signed by V1 (Administrator), documents 66 residents reside within the facility.