STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146195	A. Building B. Wing	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical McHenry	550 Ridgeview Drive McHenry, IL 60050

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 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 interview and record review the facility failed to ensure a resident was free from physical abuse for 1 of 3 residents (R1) reviewed for abuse in the sample of 3. The findings include: The facility incident report sent to the Illinois Department of Public Health showed on 6/8/26 that V2 (CNA-Certified Nurse Aide) reported V3 (CNA) hit a resident (R1) in the head. R1's face sheet printed on 6/16/26 showed diagnoses including but not limited to left femur fracture (at admission), age-related osteoporosis, heart disease, protein-calorie malnutrition, and dementia. R1's facility assessment dated [DATE] showed severe cognitive impairment and total staff assistance needed for hygiene care, dressing, rolling, and transfers. The same assessment showed that R1 is always incontinent of urine and bowel. R1's care plan showed a focus area related to potential for alterations in psychosocial well-being, can get agitated due to dementia, mostly in the evenings. Interventions included allow resident time to answer questions and to verbalize feelings, perceptions, and fears (start dated 5/22/26). R1's care plan showed a focus area related to impaired cognition function and/or impaired thought processes. Interventions included ask yes/no questions in order to determine needs, communicate with resident, cue, reorient and supervise as needed (start dated 5/22/26). On 6/16/26 at 11:45 AM, V2 (CNA) said on a Monday (6/8/26) around 9:30 PM, he was being trained by another CNA (V3). V2 said they entered R1's room and began evening care including changing the incontinence brief. V2 said he had been told R1 can be aggressive and combative during cares. V2 said they were rolling R1 from side to side to change the brief. V3 was not using any comforting language and was being rough while turning R1. V3 was turning R1 quickly and not responding to R1. R1 repeatedly said stop, ouch, get away. V3 did not change her speed or care methods. V2 said V3's actions were clearly causing R1 to get upset. R1 began cussing and swinging her arms at V3. V2 said the resident ended up hitting V3 in the face. V3 paused a few seconds and then hit R1 on top of the head. V2 stated, I know the difference between a reflective action and using a decision to act. It was not an oh my gosh moment, I need to protect myself. It was clearly retaliatory. V2 said V3 never said anything during the exchange with R1. V2 said Oh wow, you just hit a patient. That is crazy. V3 just looked at me without response. R1 stopped swinging her arms and moved her hands toward her head. V3 covered R1 up with a blanket and they both exited the room. V2 said he was dumbfounded and walked a quick lap around unit. V2 stated then he reported the incident to the floor nurse (V4). V2 said he sent a text to the general manager (V1) after that. V2 said V3 got pulled from the floor shortly after that. V2 said V3 should have left the room and returned later as soon as R1 became aggressive. V3 should have stopped the care and reported it to the nurse. V2 said the fact that V3 continued care caused R1 to be even more combative. On 6/16/26 at 12:05 PM, V3 (CNA) stated she was terminated on 6/8/26 due to the accident involving R1. V3 said she was providing incontinence care to R1 and was training a new aide (V2). R1 became combative while being rolled side to side in bed. R1 was hitting out with her hands, swinging her arms and trying to scratch at V3. R1 was confused and yelling out for her mother to come help her. V3 said she was holding R1's hands and continued doing the care when all of the sudden R1 hit V3's cheek. V3 said she was moving herself backwards to get out of the way and (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	accidentally touched R1 on the head. V3 said R1 does scream a lot during cares. V3 said normally she tries to calm R1, give her choices, and ask what she wants to do. V3 said I know I need to be gentle and talk with R1 to keep her calm. R1 was calm at first then it just went away in the middle of things. V3 said she told the floor nurse (V4) about the exchange as soon as she left the room. V3 said she was sent home shortly after that until an investigation was done. V3 said she was never allowed to return to work after that evening. On 6/16/26 at 10:56 AM, V4 (Licensed Practical Nurse) stated he was working the evening of 6/8/26. V3 was training a new aide (V2). V4 said at some point that evening V3 asked him to look at her eye for any swelling because R1 had just hit her. V4 said he looked at V3's eye and then said he needed to report the incident. V4 said right after that V2 came to him and said he witnessed a disturbing incident. V2 told him that V3 hit a resident. V2 reported that R1 had swung at V3 and V3 swung back at her. They were doing resident care together and R1 became aggressive. V4 stated R1 normally is combative and gets aggressive if she does not want to be touched. R1 is confused with dementia. Staff need to explain what they are doing and keep a safe distance if she is in a fighting mood. She swings her arms a lot during care. Her mood varies between sweet one day then aggressive the next. V4 said he reported the incident to the chain of command. V4 said he called V7 (Assistant Director of Nurses) and she reported it to the abuse coordinator (V1). V4 said he was told to send V3 home, pending the investigation which he did. V4 said he spoke to V3 before she left the building. V3 said she was trying to defend herself while changing R1 and V3 hit her back. V4 said he definitely remembered V3 said those exact words. V3 was trying to make it sound like an accident though. V4 stated he assessed R1 immediately after the incident and did not see any injury or signs of pain. V4 continued monitoring R1 throughout the night and did not see any changes. On 6/16/26 at 12:45 PM, V5 (CNA) stated we are trained to calm down combative residents by using a calm voice and give them space. We should use a reassuring voice, don't hold them down or continue to force care. If someone is clearly distressed and yelling out that is an indication something is wrong. Aides should go tell the nurse and re-approach later. On 6/16/26 at 1:00 PM, V6 (Licensed Practical Nurse) stated R1 has known behaviors, especially during personal care with the aides. R1 slaps out, grabs arms, and yells out with confusion. Staff should stop what they are doing and let the floor nurse know. It is important for resident safety and staff safety. On 6/16/26 at 1:10 PM, V7 (ADON) said she did receive a call on 6/826 from V4. It was reported that V2 witnessed V3 hit a resident during care. V7 told V4 to remove V3 from resident care and V1 was notified. V7 said she spoke with V2 and V3 the same evening. V2 told her R1 hit V3 first and V3 smacked R1 back on the head. V7 said V3 denied hitting her, but that she just touched her face to tell her not to hit. V7 said that statement does not make sense. V3 was terminated after the incident. V7 said the definition of abuse is any willful infliction of harm of any type. Holding a resident's arms, striking, or hitting a resident are all forms of abuse. On 6/16/26 at 1:43 PM, V1 (General Manager, Abuse Coordinator) stated V7 called him the evening of 6/8/26 and reported V3 had been suspended. V1 spoke with V2 and it was reported V3 hit R1 after she became combative during care. V1 said staff should use a person centered approach during care. If a resident becomes combative staff should separate and let the resident deescalate. R1 definitely reacts better to slow motions. Staff should not hold arms down or restrain residents. That is against our abuse policy. Staff should follow personal interventions to ensure a quick way to deescalate. It is the correct and safe thing to do. V1 confirmed V3 was terminated after the investigation. V1 said it was determined V3 could have done things differently and did not follow the policies for deescalating a resident. The facilities Abuse and Neglect policy last revision dated April 2026 states: It is the policy of this facility to prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property by implementation of specific procedures listed in the required components of the policy. The policy defines abuse as: the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish. The facility provided documentation of V3's termination form dated 6/11/26. The form showed V3 was terminated due to the incident of 6/8/26 after it was determined the staff member (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	failed to follow the facility abuse policy and competency training regarding de-escalation of agitated residents.