STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E247	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Joliet Terrace	2230 McDonough Joliet, IL 60436

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 36567 Based on observation and interview the facility failed to have window screens in resident's rooms. This applies to 5 of 5 residents (R30, R66, R74, R77 and R80) in the sample 18. The findings include: 1.R80's quarterly MDS (Minimum Data Set), dated March 21, 2025, showed R80 was cognitively intact. On May 13, 2025 at 9:11 AM, R80 stated the window in her room does not have a screen. On checking R80's window in her room, it did not have a screen. The window was partially (about 4 inches) opened on the right side. R80 stated she had slid the inner panel sideways as far as it would go. A wooden block at the left side was inside the ledge of the window that prevented sliding the panel to open the window further. R80 stated V6 (Maintenance Director) applied the wooden block to prevent residents from opening the window completely and jumping out. R80 stated when V6 applied the wooden block on April 23, 2025, she had told him about the missing screen, and he did nothing about it. R80 remarked it is warm at the facility, and therefore she opens the window to let in some fresh air. R80 remarked without a screen on the window, anything can fly in through the open window. On May 13, 2025 at 11:53 AM, V6 stated he thought that none of the windows in the facility had any screens since he started working at the facility three years ago. V6 also verified he had applied a wooden block in R80's window panel to prevent the window being opened completely, as there has been concerns regarding the same. On May 14, 2025 starting at 2:23 PM, during tour of the resident rooms in all the wings of the facility, the absence of window screens was seen in multiple rooms, including some that were warped, and others with ripped mesh, and V6 was made aware of the same. 2. R77's Annual MDS, dated [DATE], showed R77 was cognitively intact. On May 14, 2025 at 2:51 PM, R77's room window did not have a window screen, and it was partially open. R77 stated he would like a screen, as he is concerned with flies coming in all the time. 3. R74's quarterly MDS, dated [DATE], showed R74 was cognitively intact. (continued on next page)

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 - Some	On May 14, 2025 at 2:53 PM, R74's room window was also partially open and did not have a window screen. R74 stated without the screen, moths fly in all the time, and he is worried a bird might fly in. R74 stated he likes to open the window to get some fresh air. 4. R66's quarterly MDS, dated [DATE], showed R66 was cognitively intact. On May 14, 2025 at 2:57 PM, R66's room window did not have a window screen, and the screen was seen lying on the grass outside the window, with broken edges and the mesh ripped up in shreds. R66 stated the screen fell over more than two weeks ago, and was already ripped up. 5. R30's quarterly MDS, dated [DATE], showed R30 was cognitively intact. On May 14, 2025 at 3:03 PM, R30's room window had no window screen, and R30 stated he would like to have a screen, as he sometimes opens the window for fresh air. On May 13, 2025 at 11:58 AM, V1 (Administrator) stated the facility does not have a policy that shows requirements for window screens. V1 stated she is of the impression the facility did have screens on all the windows in the (unknown) past, and the residents would take them off or punch holes in them, so the facility did not re-install them.

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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** 29562 Based on interview and record review, the facility failed to prevent resident to resident abuse. This applies to 2 of 2 (R9 and R17) reviewed for abuse in the sample of 18. The findings include: R9's face sheet shows R9 is [AGE] years-old, and has multiple diagnoses including paranoid schizophrenia. R9's most recent Minimum Data Sheet (MDS) assessment indicates R9 is cognitively intact. R17's face sheet shows he is [AGE] years-old, and has multiple medical diagnoses including unspecified schizophrenia, and generalized anxiety disorder, with a MDS assessment indicating moderately impaired cognition. R17's active care plan shows R17 has history of aggressive behavior and has exhibited verbally/physically abusive behavior related/manifested by being challenged by mental illness, ineffective coping mechanisms, poor verbal skills and inability to express self in more appropriate language. Incident report, dated May 1, 2025, at approximately 3:30 PM, documents while watching a movie in the dining/day room, V4 (Psychiatric Rehab Service Director/PRSD) witnessed R17 reaching out and touching R9's arm. V4 walked over to remind R17 not to touch anyone, however, R9 immediately reacted by grabbing R17's hand and kneeing R17 in his abdomen. V4 immediately responded, however, R17 lost his balance and fell to the floor. Nurses immediately assessed R9 and R17. R17 reported he hit his head, and his ribs hurt. R9 reported his left upper arm was hurting, as R17 hit him there. R9's and R17's primary physicians and psychiatrist were notified of the incident, and both residents were sent to the hospital for further evaluation. On May 12, 2025, at 10:58 AM, R9 said he was in the dining/day room watching a movie. R9 was sitting beside R17, and for no reason, R17 became agitated while he (R17) was talking to himself. R17 started punching him lightly on his left arm repeatedly. At first R9 tried to ignore R17, until he noticed the punches were becoming harder. R9 did not say anything because that was R17's behavior. When R17 stood up suddenly, R9 grabbed R17's hand, then he turned and kneed R17 in the abdomen. R9 did not get the chance to tell staff because R17 started punching him stronger. R9 retaliated so R17 would stop what he was doing. On May 14, 2025, at 12:45 PM, R17 stated he hit R9 a little bit, then R9 hit him in the abdomen and chest. On May 12, 2025, at 10:56 AM, V9 (Certified Nursing Assistant/CNA) said, (R9) was a nice person, usually he was calm and cooperative, but he doesn't like being touched. The resident whom he attacked kept touching him. R9 informed her that R17 grabbed him, so he (R9) pushed R17. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On May 13, 2025, at 1:56 PM, V4 (Psychiatric Rehab Service Director/PRSD) stated the residents were watching a movie when the incident happened. V4 stated she saw R17 lean over R9, and R9 suddenly pushed R17. V4 stated during her interview of R9 and R17, R9 said R17 punched his arm, and then he grabbed R17 and kneed him in the abdomen. R17 fell on the floor. R17 admitted to punching R9. According to V4, R17 was socially inappropriate, (R17) likes touching people, and sometimes he would butt in to people's conversation without being invited, and is intrusive. While (R9) doesn't talk much, he keeps to himself, but he participates in all activities. During her (V4) interview of R17, the resident said he fell on his buttocks, but did not hit his head. 911 was called, both residents were sent to the hospital for further medical evaluation. On May 13, 2025, at 4:38 PM, V11 (Certified Nursing Assistant/CNA) and V12 (CNA) stated the incident happened beginning of the evening shift. V11 said she was coming out from the C-hallway, and did not witness the incident. V11 saw R17 was already on the floor, and she ran towards the day room; activity staff and V4 (PSRD) were already by R9 and R17. On May 14, 2025, at 10:46 AM, V13 (RN/Registered Nurse) stated she and the other nurses were at the nurses' station when the incident happened. V13 was charting/writing her documentation. According to V13, R17 punched R9 on the left shoulder/arm, and R9's reaction was to knee R17 in the abdominal area, which led to R17 falling on the floor. On May 14, 2025, at 3:03 PM, V17 (Psychiatric Rehab Service Assistant/PRSA) stated she was at the conference room getting ready for the smoke break, preparing the cigarettes and lighters of the residents. She did not see the incident, but heard the commotion. She went to the day area immediately, and she saw R9 being escorted to the nurses' station, while R17 was on the floor.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29562 Based on record review and interview, the facility failed to provide residents or residents' representatives their written bed hold and return policy prior to hospitalization . This applies to 4 of 4 residents (R23, R38, R72, R78) reviewed for hospitalization s in the sample of 18. The findings include: 1. R38 has multiple medical diagnoses including type 2 diabetes mellitus without complications, hypothyroidism, unspecified, constipation, unspecified, extrapyramidal and movement disorder, unspecified, hypertensive heart disease without heart failure, schizoaffective disorder, bipolar type, Ogilvie syndrome, based on the face sheet. Progress notes from November 2024 to present shows that R38 was sent to the hospital multiple times for different reasons. On November 17, 2024, he was sent to the hospital for acute left lateral fracture of the 4th, 5th, 6th, and 7th rib, with 5% pneumothorax. On December 20, 2024, he was sent for abnormal result of KUB (Kidney, Ureter, Bladder) test, and on January 2, 2025, he was admitted to the hospital for UTI (Urinary Tract Infection). Further review of R38's records showed that there was no documentation provided to R38 or R38's representatives about the bed-hold and return policy prior to hospital transfer. 41855 2. R23's EMR (Electronic Medical Record) showed R23 was admitted to the facility on [DATE], with diagnoses that included schizoaffective disorder depressive type and primary insomnia. R23 was admitted to the hospital on March 13, 2025. R23's MDS (Minimum Data Set) dated April 15, 2025, showed R23 was cognitively intact. R23's progress note written on March 12, 2025, at 1:49 PM, showed R23 was agitated and throwing things in his room. He was refusing to shower and told the staff to drop dead. R23 was making derogatory statements to staff, he was resistant to redirection, and his agitation was increasing towards staff. Progress note dated March 13, 2025, at 12:09 PM, showed R23's aggressive behavior continued to escalate towards staff. R23 was informed that due to his non-compliance with taking his medications and aggressive behavior, the physician had given an order to have R23 sent to the hospital. R23 became upset and took a swing at the nurse, other staff members had to intervene and redirected R23. At 1:17 PM, the progress note showed the ambulance arrived at 12:45 PM and took R23 to the hospital. R23's records were reviewed and there was no documentation that R23 or his representative had received in writing the facility's bed-hold policy. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. R72's EMR showed R72 was admitted to the facility on [DATE], with diagnoses that included schizoaffective disorder bipolar type, PTSD (Post Traumatic Stress Disorder), anxiety, moderate intellectual disabilities, and bipolar disorder current episode depressed severe with psychotic features. R72's MDS dated [DATE], showed R72 was cognitively intact. R72's progress note written on May 9, 2025, at 12:27 PM, showed R72 was being sent to the hospital for trying to harm herself and others. Staff attempted to get a pen away from R72, she was forcefully trying to stab staff. R72 was taken to another room, nurse called physician, and an order was given to send R72 to the local hospital for evaluation and treatment. R72's records were reviewed and there was no documentation to show that the facility had provided the resident or her representative with written notice of the bed-hold policy. 4. R78's EMR showed R78 was admitted to the facility on [DATE], with diagnoses that included anxiety, schizoaffective disorder bipolar type, and alcohol abuse uncomplicated. R78's MDS dated [DATE], showed R78 was cognitively intact. R78's progress note written on May 9, 2025, at 10:13 AM, showed R78 was making delusional statements about it being her birthday and asking residents to sing happy birthday to her. R78 was observed crying and telling stories At 8:37 PM, R78's progress note showed the nurse had asked R78 to come take her medications and R78 replied, don't tell me what to do, I'm a pharmacy tech. At 10:54 PM, R78 was being verbally aggressive towards another resident and staff intervened by separating the two residents .the nurse asked R78 if she wanted her PRN (as needed) medication and R78 said, why don't you take it? At 11:23 PM, physician was called, and an order was given to have R78 sent to the hospital. R78 was admitted to the hospital on May 10, 2025. R78's record was reviewed and there was no documentation to show R78 or her representative had been provided in writing the bed-hold policy. On May 13, 2025, at 10:17 AM, V1 (Administrator) was asked to provide the bed-hold written documentation for R23, R38, R72, and R78. At 10:58 AM, V1 brought the policy for bed hold but admitted the facility was not completing the bed-hold forms for residents being transferred to the hospital. Facility provided their Bed Hold policy that was dated effective as of April 2020. The policy showed, Guideline: Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52539 Based on observation, interview, and record review, the facility failed to provide behavioral health services to residents with SMI (severe mental illness). This applies to 2 of 3 residents (R76 and R81) reviewed for behavioral health services in the sample of 18. The findings include: 1. R76 was admitted to the facility on [DATE], with multiple diagnoses including schizoaffective disorder and attention deficient hyperactivity disorder, based on the face sheet. R76 was under [AGE] years old. R76's annual MDS (Minimum Data Set), dated February 10, 2025, showed R76 is cognitively intact. The MDS showed the resident has no functional impairments in range of motion. Further review of the MDS showed R76 requires supervision with all his ADLs (activities of daily living). The same MDS showed R76's primary SMI (Serious Mental Illness) diagnosis is schizophrenia, and the resident is on antipsychotic medication. R76's PASRR (Pre-admission Screening and Resident Review) Level II, dated September 11, 2024, showed R76 needs programs that teach the resident daily living skills needed to be independent, such as grooming, personal hygiene, mobility, nutrition, vocational skill, health, drug therapy, mental health education, money management, and maintenance of living environment. R76's PASRR summary of findings showed R76 needs to have meetings with a psychiatrist or social worker. R76's PASRR Level II, dated December 27, 2024, recommended rehabilitation supports, such as pharmacotherapy, life skills programs, and psychotherapy. The PASRR also showed R76 should have programs that teach the resident daily living skills needed to be independent, such as grooming, personal hygiene, mobility, nutrition, vocational skill, health, drug therapy, mental health education, money management, and maintenance of living environment. It was mentioned in the PASRR summary report the PASRR should be incorporated in R76's plan of care, and the staff should be aware of the services required for R76. R76's active care plan, dated June 17, 2024, showed R76 has hallucinations related to mental illness. The same care plan showed several interventions including encouraging the resident to participate in activities, coping skills, and symptom management groups. On May 12, 2025, at 11:06 AM, R76 was lying in bed and had his covers on him. He said he does not attend any in house and/or outpatient programs because he does not want to. He stated his plan was to stay in the facility long-term. He said his plan for the day was to eat and take naps. On May 13, 2025, at 9:31 AM, R76 was sleeping in bed. At this time, there was an exercise activity going on in the dining/activity area. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R76's quarterly risk of self-harm assessment, dated May 7, 2025, showed the resident has self-destructive behavior. R76's social service progress notes from December 2024 to May 14, 2025, showed the resident attended only two groups, which were money management and sexual health group. Each group lasted 30 minutes. R76 attended money management group on March 8, 2025, and attended the sexual health group on February 20, 2025. It was documented in the social service notes that R76 actively participated in the money management group and verbalized understanding of the topics discussed in the sexual health group. Based on the above information, R76 had received a total of one hour of mental health/behavioral health services from December 2024 to May 14, 2025. The facility presented a list of groups/programs with a list of participants, and R76's name was not on the list for the following groups: symptom management, home and self-care, and social skills/basic conversation. On May 13, 2025, at 11:04 AM, V4 (Psychiatric Rehabilitation Service Director/PRSD) stated R76 refused to go to one-on-one sessions, groups, or activities. On May 13, 2025, at 2:12 PM, V4 (PRSD) stated based on R76's level of functioning assessment dated [DATE], the resident can benefit from the following groups: symptom management, home and self-care, and social skills/basic conversation. V4 stated R76 refused to attend any of the above-mentioned groups. R76 also refused one-on-one sessions with the counselor, PRSD, and PRSC (Psychiatric Rehabilitation Service Coordinator). On May 14, 2025, at 10:17 AM, V4 stated there was no documentation in R76's records with regards to one-on-one sessions offered and the resident's refusal for one-on-one sessions to address his behavioral health needs. 16746 2. R81 had multiple diagnoses including schizoaffective disorder depressive type (principal diagnosis), major depressive disorder, generalized anxiety disorder and disorganized schizophrenia, based on the face sheet. R81 was under [AGE] years old. R81's quarterly MDS, dated [DATE], showed the resident is cognitively intact. The MDS showed R81 had no functional limitation in range of motion, and he required supervision to moderate assistance from the staff with his ADLs. Further review of the MDS showed R81's primary SMI diagnosis is schizoaffective disorder. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R81's PASRR summary of findings, dated March 20, 2025, showed the resident has serious mental health condition. The PASRR findings showed in-part, A nursing home will be able to provide you with the care you need and make sure your mental health needs are being met. It also showed R81 met the nursing facility level of care. The PASRR summary of findings listed multiple services and/or supports needed to be provided to R81, under rehabilitative services including, Development, maintenance, and consistent implementation across settings of those programs designed to teach individuals daily living skills necessary to become more independent and self-determining including, but not limited to, grooming, personal hygiene, mobility, nutrition, vocational skill, health, drug therapy, mental health education, money management, and maintenance of the living environment. The screening documented the above service and/or support was selected because, In the nursing facility, you could benefit from strengthening your independent living skills so you can return to the community when able. The same PASRR summary of findings showed under rehabilitative services, Individual, group and family psychotherapy. R81's PASRR service matters summary report ,dated May 1, 2025, showed multiple rehabilitative supports recommended for the resident as a routine nursing facility services including, Development, maintenance, and consistent implementation across settings of those programs designed to teach individuals daily living skills necessary to become more independent and self-determining including, but not limited to, grooming, personal hygiene, mobility, nutrition, vocational skill, health, drug therapy, mental health education, money management, and maintenance of the living environment and Individual, group and family psychotherapy. On May 12, 2025 at 10:52 AM, R81 was inside his room; he was alert and oriented. R81 stated he attends only one in-house group called money management. R81 said group is held three times per week for about 20 minutes each group session. R81 stated he also talks 1:1 to the psychosocial person once a week. According to R81, he stays inside his room most of the time, and would only come out of his room to eat at the main dining room, and to smoke during the scheduled times. R81 added he also does not attend any activities at the facility. On May 13, 2025 at 9:30 AM, R81 was inside his room, playing with his computer. At 2:40 PM, R81 was sleeping in his bed inside his room. R81's quarterly substance use assessment, dated February 26, 2025, showed the resident had history of alcohol, marijuana, and heroin use. R81's quarterly treatment motivation assessment, dated February 26, 2025, showed the resident is Somewhat willing to work on treatment plan. R81's quarterly discharge potential assessment, dated February 26, 2025, showed the resident's overall goal established during the assessment process was, Expects to be discharged to the community. Review of the facility's list of groups/programs showed that R81 was scheduled to participate/attend the money management group every Tuesdays, Wednesdays and Thursdays from 6:00 PM through 6:30 PM. R81 was not listed on any other group/program scheduled by the facility. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On May 13, 2025 at 9:30 AM, the facility was asked to provide all the group/program attendance sign-in sheet for R81 from March through May 2025. The facility presented R81's group attendance sign-in sheet for the months of April and May 2025 for the money management group. The group attendance sign-in sheet showed R81 attended the money management group only three times on April 30, May 1 and May 7, 2025. On May 13, 2025 at 2:23 PM, V4 (PRSD) stated based on R81's discharge potential assessment, the resident expects to be discharged to the community, and based on R81's latest level of functioning assessment, dated February 26, 2025, the resident would benefit from money management group, home and self-care group, and symptom management group to support his behavioral and mental health and be able to facilitate re-integration to the community. However, according to V4, R81 only attends the money management group, because he (R81) is interested in it, and refused to attend the home and self-care group and symptoms management group. V4 was asked why R81's name was not listed as a scheduled participant in the facility's list of groups/programs for home and self-care and symptom management. According to V4, R81's name was not listed because he does not attend the said groups/programs anyway. On May 13, 2025 at 2:46 PM, V7 stated she is the PRSC for R81. V7 stated for R81's mental health rehabilitative service, the main focus is to attend symptom management/coping skills group and home and self-care/life skills for ADLs (activities of daily living), but the resident refused to attend, and also had refused to have a one on one meeting to discuss his behavior and mental health. According to V7, R81 had attended money management group, but was not sure how often. V7 added R81 at times would attend activity, and the resident prefers to stay in his room and play with his computer. V7 stated she has a problem motivating R81 to attend his focus groups. V7 stated R81's goal is to eventually be discharged to the community, however, because of poor to no group attendance, it is hard to reintegrate the resident to the community. On May 13, 2025 at 3:12 PM, V4 (PRSD) stated after reviewing R81's electronic records from January through March 2025, there was no documentation to indicate the resident attended any group/program offered by the facility, except on February 20, 2025. V4 stated the February 20, 2025 group that R81 attended was the sexual health and hygiene, and the group lasted for only 30 minutes. V4 acknowledged that based on R81's attendance information from January through May 7, 2025, R81 had attended only two hours of the group/program that was provided at the facility, three times for the money management group (each lasting for 30 minutes) and once for the sexual health and hygiene group (lasting for 30 minutes). On May 14, 2025 at 9:47 AM, group exercises were going on inside the main dining room, and R81 was not present. At 9:51 AM, R81 was standing inside his room. The resident stated he does not want to attend the group exercises that were going on. R81 also stated he does not have any plans for the day, and would just be staying in his room to play with his computer. R81 was asked why he does not want to attend symptom management group and home and self-care group. R81 responded he does not like the groups, and it does not interest him. On May 14, 2025 at 10:16 AM, V4 (PRSD) stated there is no documentation from January through May 14, 2025 of any one on one meeting with the PRSD or the PRSC to discuss R81's mental health and refusals to attend the assessed groups/programs that could support his mental health service/care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E247	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Joliet Terrace	2230 McDonough Joliet, IL 60436

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 43389 Based on interview and record review, the facility failed to follow their water management program and identify areas where control measures are needed and assess how much of a risk those hazardous conditions pose. This affects all 88 residents residing in the facility. Findings include: The CMS (Centers for Medicare and Medicaid Services)-671 Long Term Care Facility application for Medicare and Medicaid, dated May 12, 2025, showed the total census of 88 residents. The facility's Water Management program stated the facility will do the following: 1. identify building water systems for which Legionella control measures are needed. 2. Assess how much risk the hazardous conditions in those water systems pose. On May 14, 2025 at 1:25 PM, it was requested from V1 (Administrator),V6 (Maintenance Director), V15 (Regional Maintenance) all information regarding their water management plan, Legionella, and other waterborne pathogens plan, their water management assessment, and any evidence of measures used to prevent Legionella. On May 14, 2025 3:32 PM, V1, V6, and V15 acknowledged and clarified information given to the surveyor, and all stated they had no other information to give surveyor for their water management program. The information that was provided included a log for room water flushing in rooms that are unoccupied for 72 hours or more, a water management program policy, and two mobile phone screen shots of the logged water flushings of unoccupied rooms. V15 stated the water flushing they are doing are considered their assessment, and that is all we have to do. V1 and V15 stated they do not have any assessment in writing or otherwise to show what the facility's risks for Legionella are, or what their control measures are based on those identified risks. V15 stated other than the logs and the water management program policy, they do not have anything more to present to the surveyor. Nowhere in the facility's water management program policy and the flushing logs was there an identification of the building's water systems for which Legionella control measures, nor an assessment of how much risk the hazardous conditions in those water systems pose. The facility's water management program policy refers one to see diagram in Figure A (attach appropriate drawing). However, there was no such Figure A drawing attached.