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S 000	Initial Comments Complaint Investigations 2540446/IL184839 2540498/IL184857 2540527/IL184926 Facility Reported Incident (FRI) dated 1/14/25/IL184885	S 000		
S9999	Final Observations Statement of Licensure Violaiton 1 of 2 300.610a) 300.696a) 300.696b) 300.696e) 300.696f)4) 300.697a) 300.697c) 300.1010h) 300.1060a) 300.1060b) 300.1060c) 300.1060d) 300.1210a) 300.1210b) 300.1210d)3)4)A)B) 300.3210a)2) 300.2210b)2) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the	S9999		

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facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.696 Infection Prevention and Control

a) A facility shall have an infection prevention and control program for the surveillance, investigation, prevention, and control of healthcare-associated infections and other infectious diseases. The program shall be under the management of the facility ' s infection preventionist who is qualified through education, training, experience, or certification in infection prevention and control

b) Written policies and procedures for surveillance, investigation, prevention, and control of infectious agents and healthcare-associated infections in the facility shall be established and followed, including for the appropriate use of personal protective equipment as provided in the Centers for Disease Control and Prevention ' s Guideline for Isolation Precautions, Hospital Respiratory Protection Program Toolkit, and the Occupational Safety and Health Administration ' s Respiratory Protection Guidance. The policies and procedures must be consistent with and include the requirements of the Control of Communicable Diseases Code, and the Control of Sexually Transmissible Infections Code.

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e) The facility shall establish an infection prevention and control program (IPCP) that includes, at a minimum, an antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.

f) Infectious Disease Surveillance Testing and Outbreak Response

4) Upon confirmation that a resident, staff member, volunteer, student, or student intern tests positive with an infectious disease, or displays symptoms consistent with an infectious disease, each facility shall take immediate steps to prevent the transmission by implementing practices that include but are not limited to cohorting, isolation and quarantine, environmental cleaning and disinfecting, hand hygiene, and use of appropriate personal protective equipment.

Section 300.697 Infection Preventionists

A facility shall designate a person or persons as Infection Preventionists (IP) to develop and implement policies governing control of infections and communicable diseases. The IPs shall be qualified through education, training, experience, or certification or a combination of such qualifications. The IP's qualifications shall be documented and shall be made available for inspection by the Department. (Section 2-213(d) of the Act). The facility ' s infection prevention and control program as required by Section 300.696(e) shall be under the management of an IP.

a) IPs shall complete, or provide proof of completion of, initial infection control and prevention training, provided by CDC or equivalent training, covering topics listed in

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subsection (b)(1) to the facility, within 30 days after accepting an IP position. Documentation of required initial infection control and prevention training shall be maintained in the employee file.

c) A facility shall have at least one IP on-site for a minimum of 20 hours per week to develop and implement policies governing prevention and control of infectious diseases.

Section 300.1010 Medical Care Policies

h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

Section 300.1060 Vaccinations

a) A facility shall annually administer or arrange for administration of a vaccination against influenza to each resident, in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention that are most recent to the time of vaccination, unless the vaccination is medically contraindicated or the resident has refused the vaccine. Influenza vaccinations for all residents age 65 and over shall be completed by November 30 of each year or as soon as practicable if vaccine supplies are not available before November 1. Residents admitted after November 30, during the flu

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season, and until February 1 shall, as medically appropriate, receive an influenza vaccination prior to or upon admission or as soon as practicable if vaccine supplies are not available at the time of the admission, unless the vaccine is medically contraindicated or the resident has refused the vaccine. (Section 2-213(a) of the Act)

b) A facility shall document in the resident's medical record that an annual vaccination against influenza was administered, arranged, refused or medically contraindicated. (Section 2-213(a) of the Act)

c) A facility shall administer or arrange for administration of a pneumococcal vaccination to each resident in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, who has not received this immunization prior to or upon admission to the facility unless the resident refuses the offer for vaccination or the vaccination is medically contraindicated. (Section 2-213(b) of the Act)

d) A facility shall document in each resident's medical record that a vaccination against pneumococcal pneumonia was offered and administered, refused, or medically contraindicated.

Section 300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that

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includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following:

A) Each resident shall have proper daily

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personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician.

B) Each resident shall have at least one complete bath and hair wash weekly and as many additional baths and hair washes as necessary for satisfactory personal hygiene.

Section 300.3210 General

a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by State or federal law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of the resident's status as a resident of a facility.

2) Residents shall have their basic human needs, including but not limited to water, food, medication, toileting, and personal hygiene, accommodated in a timely manner, as defined by the person and agreed upon by the interdisciplinary team.

Section 300.2210 Maintenance

b) Each facility shal

2) Maintain all electrical, signaling, mechanical, water supply, heating, fire protection, and sewage disposal systems in safe, clean and functioning condition. This shall include regular inspections of these systems

These requirements were not met as evidence by:

Based on observation, interview and record review, the facility failed to protect a resident's right to be free from neglect when they failed to: Offer immunizations for influenza, pneumonia and COVID to prevent the spread of these

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infections; Implement infection control procedures to prevent the spread of Gastrointestinal Illness and COVID-19; Administer medications as ordered to prevent potential serious outcomes; Assess, monitor and treat changes of conditions for residents with new fractures and pneumonia and COVID-19; provide a functioning plumbing system to supply hot water to residents for bathing and hygiene. This failure resulted in R40 and R43 contracting pneumonia requiring hospitalization, R1, R9, R17, R28, experiencing unnecessary anxiety, elevated blood glucose levels, tachycardia, emotional distress, pain, and suffering, R43 having ongoing symptoms of coughing and difficult breathing without treatment from 1/26 through 1/31/25 with a subsequent diagnosis of pneumonia and COVID-19 and R23 exhibiting signs and symptoms of pain including guarding of hip on 1/25 throughout the day without emergency medical treatment until 1/26/25 at 2:15 PM, where R23 was diagnosed with fracture of right hip, R3 expressing the lack of self-hygiene made him feel like he was being "borderline" abused and R41 breaking down in tears and R9, R13, R15, R17 and R19 having gastrointestinal illness when the facility neglected to identify, assess, monitor, and provide infection control procedures to address a gastrointestinal outbreak after the facility documented that R14 and R16 had symptoms of diarrhea and vomiting. This failure resulted in R40 and R43 contracting pneumonia requiring hospitalization.The Facility also failed to offer and provide influenza and pneumococcal vaccinations to 6 of 6 residents (R22, R26, R33, R40, R41, R43) reviewed of influenza and pneumococcal vaccinations. These failures affected 23 residents (R1, R3, R4, R9, R10, R11, R12, R13, R17, R18, R20, R21, R22, R24, R25, R26, R33, R36, R37, R40, R41, R43, and R44) and has the potential to affect all 71

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residents residing in the facility. Finding include:

The facility's undated Abuse Prevention Program, Procedures for Prevention Policy, documents "During orientation of new employees, the facility will cover at least the following topics: Sensitivity to resident rights and resident needs; What constitutes abuse, neglect and misappropriation of resident property; staff obligation to prevent and report abuse, neglect and misappropriation of property; and how to distinguish misappropriation from lost items and willful abuse from insensitive staff actions that should be corrected through counseling and additional training." This Policy did not document the definition of neglect.

On 1/31/25, at 9:55 AM, V1 stated that she became Administrator before Thanksgiving 2024. She stated that Director of Nursing quit shortly after. She said the facility has been without a Director of Nurses since that time. V1 stated that no one has been overseeing nursing services. V1 stated that V17, Owner/Medical Director, hired a new DON and she started on 1/27/25. She stated that she is concerned about V2's abilities and would not have hired her. She stated she is unsure if V17 fully understands running a facility. She stated that since she has started, the facility has not had an Infectious Preventionist. V1 stated that the facility has had three maintenance supervisors since she was hired. V1 stated that she is not informed as much as she should regarding nursing services such as changes in conditions, injuries of unknown origin, falls, and residents' admission to hospitals. V1 stated that the nursing department does not talk to her as much as they should. V1 stated that currently the facility is using policies that were not developed by the current ownership. V1 stated her core

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team which supports this facility is V17, V49, and V50, Administrator at sister facility.

On 2/4/25, at 9:35 AM, V17 stated that this facility is a difficult home, and he is working on it. He said the condition of the facility did not happen overnight, but he is trying. V17 stated that he is attempting to get capable staff and wants to focus on the clinical side but needs a little more time as he has been dealing with physical plant/plumbing issues. V17 stated that the residents are his responsibility.

Gastrointestinal Outbreak

On 1/23/25 at 8:58 AM, V1, Administrator, stated there was a recent "stomach bug" in the Facility. She was unsure which residents had the stomach illness. The Facility has no Infection Preventionist (IP) and no line list of residents who had the infection.

On 1/28/25 at 8:47 AM, V1, Administrator, stated no staff have been tracking and trending infections in the Facility, so she is working on her IP certification so she can do the tracking and trending herself. She stated residents who had the "stomach bug" were not isolated, and she does not think they were told to stay in their rooms.

On 1/31/25, at 9:55 AM, V1 stated that she was unaware of the extent of the gastrointestinal illness that occurred in January 2025.

On 1/23/25 at 4:15 PM, R9 stated she got the "stomach flu" about a week ago with symptoms of headache, stomachache, watery diarrhea, fever, and "puking." She stated she was sick for 36 hours and added, "I thought I was going to die."

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On 1/24/25 at 10:34 AM, V41, Licensed Practical Nurse (LPN), stated R9 was one of the residents that had the stomach virus.

R9's Physician Orders for January 2025 and Progress Notes do not document any orders for isolation, severity of symptoms or duration of R9's symptoms. There was no documentation in R9's Progress notes pertaining to gastrointestinal distress and duration of R9's symptoms.

On 1/28/25 at 9:55 AM, R13 stated she got the stomach flu a couple of weeks ago and was not isolated during that time period. She stated she did not leave her room because she did not feel well, but staff did not tell her she should stay in her room.

R13's Physician Orders for the month of January 2025 do not document any orders for isolation. There was no documentation in R13's Progress notes pertaining to gastrointestinal distress and duration of R13's symptoms.

On 1/30/25 at 10:15 AM, R14 stated he had throwing up and diarrhea a couple of weeks ago that lasted for three days. He stated he did not leave his room, but the Facility did not initiate isolation or perform any special cleaning during that time.

R14's Progress Note dated 1/8/25 at 5:41 PM documents R14 had loose stools with emesis and was given PRN (as needed) Zofran and Imodium. There was no documentation in R14's medical record regarding the severity of R14's symptoms and duration of symptoms.

R14's Physician Orders for January 2025 do not

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document any orders for isolation.

R15's Progress Notes for January 2025 do not contain documentation regarding gastrointestinal illness.

On 1/24/25 at 10:34 AM, V13, Licensed Practical Nurse, LPN, stated R15 was one of the residents who had the stomach virus.

On 1/29/25 at 12:35 PM, R15 stated he had vomiting and diarrhea for about three days a couple of weeks ago. He stayed in his room but was not told to do so by the Facility.

R15's Physician Orders for January 2025 do not document any orders for isolation. There was no documentation in R15's Progress notes pertaining to gastrointestinal distress and duration of R15's symptoms.

R16's Progress Note dated 1/8/25 at 5:58 PM documents R16 had two episodes of emesis and was treated with PRN Zofran.

R16's Physician Orders for January 2025 do not document any orders for isolation.

There was no documentation in R16's Progress notes pertaining to gastrointestinal distress and duration of R16's symptoms.

R17's Progress Note dated 1/11/25 at 5:44 PM documents R17 reported having a lot of emesis earlier in the week.

On 1/23/25 at 12:52 PM, R17 stated she started having nausea on 1/7/25, then vomited the next day and began to feel better. She was unsure what she had, but knew it was something.

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R17's January 2025 Physician Orders do not document isolation orders.

There was no documentation in R17's Progress notes pertaining to gastrointestinal distress and duration of R17's symptoms.

R19's Progress Note dated 1/11/25 at 12:34 PM documented R19 had several watery loose stools that were observed by nursing and was given PRN Imodium.

R19's Physician Orders for January 2025 do not document any orders for isolation.

There was no documentation in R19's Progress notes pertaining to gastrointestinal distress and duration of R19's symptoms.

On 1/30/25 at 11:13 AM, V6, Housekeeping Supervisor, stated he heard there was a gastrointestinal illness in the Facility, but was not told to do anything outside of normal housekeeping duties.

On 1/30/25 at 8:37 AM, V17, Medical Director, stated some residents in the Facility did complain of having abdominal pain and nausea which he suspected was Rotavirus.

On 1/23/25 at 8:58 AM, V1, Administrator, stated there was a recent "stomach bug" in the Facility. She was unsure which residents had the stomach illness. The Facility has no Infection Preventionist (IP) and no line list of residents who had the infection.

On 1/28/25 at 8:47 AM, V1, Administrator, stated no staff have been tracking and trending

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infections in the Facility, so she is working on her IP certification so she can do the tracking and trending herself. She stated residents who had the "stomach bug" were not isolated, and she does not think they were told to stay in their rooms.

On 1/31/25, at 9:55 AM, V1 stated that she was unaware of the extent of the gastrointestinal illness that occurred in January 2025.

Infection Control/COVID/Flu/Pneumonia/Vaccination

On 1/29/25 at 9:10 AM, V1, Administrator, stated R40 had pneumonia and passed away.

The Facility's Pneumococcal Vaccine Consent was signed by R40 on 2/6/24.

R40's Face Sheet documents R40 was admitted to the Facility on 12/17/23 with diagnoses including chronic obstructive pulmonary disease (COPD), alcoholic cirrhosis of liver, and femur fracture.

R40's Care Plan revised 9/25/24 documents, "I have a hx (history) of pneumonia."

R40's Minimum Data Set (MDS) dated 10/15/24 documented R40 was cognitively intact and ambulated via wheelchair.

R40's Electronic Medical Record (EMR) does not document any Immunization History for R40 and no record of vaccinations for pneumonia.

On 1/30/25 at 9:57 AM, R40's Immunization History was requested from V3, Assistant Director of Nursing (ADON).

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R40's Progress Notes dated 11/29/24 document R40 was sent to (Local Hospital) via Emergency Medical Services (EMS) after falling twice.

R40's "After Visit Summary" for 11/29/24-12/5/24 hospitalization documents a chest X-ray was performed and likely indicated a lung infection. R40 was sent home on the antibiotic Levofloxacin 750 mg (milligram) tablets once daily for 7 days from 12/6/24-12/12/24.

R40's Physician Orders document an order for Levofloxacin 750mg tablet once daily from 12/6/24-12/12/24.

R40's Physician Order dated 12/6/24 documents administer pneumonia vaccine as ordered with signed consent.

R40's Progress Notes dated 12/7/25-12/10/24 document R40 continued on antibiotics for pneumonia.

R40's Progress Notes dated 12/7/25-12/10/24 document R40 continued on antibiotics for pneumonia.

R40's Medication Administration Record (MAR) for December 2024 documents R40 received 7 doses of the antibiotic Levofloxacin

R40's Progress Note dated 12/15/25 documents R40 complained of a cold he could not get rid of and discomfort in feet and was sent to the hospital, per his request.

On 1/29/25 at 9:10 AM, V1, Administrator, stated R40 had pneumonia and passed away.

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On 2/4/25 at 4:17 PM, no documentation was provided by the Facility to show R40 received any pneumococcal vaccines in the Facility.

R40's (Local Hospital) Death Summary documents R40 opted for comfort care and passed away on 12/16/24 at 1:11 PM. The probable causes of death were acute hypoxemic respiratory failure, pulmonary edema, and COPD.

R40's Death Certificate documents R40 expired on 12/16/24. The Cause of Death was acute hypoxemic respiratory failure due to (or as a consequence of) pulmonary edema due to (or as a consequence of) COPD.

On 1/31/25 at 1:20 PM, V17, Medical Director, stated R40 had multiple organs failing, and any type of infection with that is a problem.

As of 2/4/25 at 4:17 PM, no documentation was provided by the Facility to show R40 received any pneumococcal vaccines in the Facility.

R2's Progress Note, dated 1/19/25 at 6:03 PM, documented she was sent to hospital for acute mental health concerns.

R2's Progress Note, dated 1/20/25 at 10:28 PM documented that R2 returned to the facility at 8:20 PM from the local hospital via ambulance and was COVID positive upon return.

On 1/28/25 at 12:10 PM, V34, Certified Nursing Assistant, CNA, stated that R2 was placed in isolation about a week ago. She is unaware of any other staff having COVID. V34 also states that she was unaware of any other staff or residents receiving routine COVID testing after R2 tested positive.

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On 1/28/25 at 12:00 PM, V32, CNA, stated that this was her first day back after being off for 5 days after testing positive for COVID at the facility on 1/22/25 after she began not feeling well. V32 stated that V3 tested her in the office, and she went home after testing positive. V32 was unaware if any other staff were tested for COVID.

On 1/29/25, at 9:00 AM, V22, CNA, stated that she has not received any COVID testing. V22 stated that she worked with V32, CNA on 1/22/25 when she tested positive for COVID. V22 stated that she was not offered COVID testing.

On 1/29/25 at 9:20 AM, V36, CNA, stated she has not received any offers for COVID testing after working with V32.

On 1/29/25 at 10:45 AM, V5, CNA stated she did not receive any offer to receive COVID testing. V22 who worked with V32 on 1/22/25 did not receive any offers to be tested for COVID.

R36's Progress note dated 1/25/25 at 1:59 PM documented that R36 was admitted to the medical floor due to a diagnosis of COVID.

Progress notes dated 1/29/35 at 6:20 PM documented that R36 returned to the facility. R36 will be on isolation related to positive COVID screening.

R36's hospital discharge paperwork dated 1/29/25 at 5:09 pm documented that he was positive for COVID.

On 1/30/25 at 9:20 am, V22, CNA stated that prior to going to the hospital, R36 was residing in room 221 and he did not have a roommate. V22

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had provided care to him prior to him leaving the facility to be admitted to the hospital and she did not notice any symptoms of COVID.

On 1/30/25 at 9:25 AM, R36 stated that upon arrival to the hospital he received testing for COVID and was positive. R36 stated he really doesn't even go around people.

R37's Preventative Health Care Tab in Electronic Medical Record (EMR) documented no entries for any vaccinations have been given including COVID-19.

Progress notes dated 1/28/25 at 12:57 PM documented that R37 returned to facility from the hospital. R37 was documented as COVID positive and placed on isolation.

On 1/28/25 at 1:20 PM, and 1/29/25 at 9:00 AM, there was no sign on the door alerting staff or visitors of R37's isolation status.

R17's Preventative Health Care Tab in his EMR has no vaccination entries for COVID documented.

On 1/27/2025 at 9:25 am, R17 stated that she signed up for the COVID vaccine but has not received it yet.

On 2/2/25 at 12:45 PM, R17's progress notes documented that she returned to facility via facility transport. No new orders received. R17 returned positive with COVID. R17 was being placed on isolation.

On 2/3/25 at 8:55 AM, V1 stated that R17 was sent to the hospital and tested positive for COVID. R43 who is in the hospital has also

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tested positive for COVID. V1 stated that her plan is for V2 test everybody for COVID at the facility today.

R26's Preventative health care tab in EMR documented that she received an influenza vaccine on 11/2/23 and a pneumococcal vaccine on 11/12/22. Pneumovax centers for disease control (CDC) recommends that she would have been due to receive her next pneumonia vaccine on 11/11/23.

R26's undated face sheet from the EMR documented R26 was admitted to the facility on 3/05/2021 with diagnoses of atherosclerotic heart disease, hydronephrosis, bipolar disorder, unspecified severe protein-calorie malnutrition, nonrheumatic mitral valve disorder, aural vertigo, embolism, and thrombosis of arteries of extremities, gastrostomy status, anxiety disorder, and major depressive disorder.

R26's document titled Health Care Provider Influenza vaccine consent form 2024-2025 was signed with co-signature and a printed name with the words "R26" agreed to flu shot. There was no date on the consent. The signature followed the statement "I have read (or it has been read to me) and I understand the "Influenza Vaccine Fact Sheet". I have had the opportunity to ask question and have had them answer to my satisfaction. I consent to receiving the seasonal influenza vaccine. In addition, I am aware that the personal health information collected on this form may be shared with another healthcare provider if it is required for my care." However, there was no information regarding the influenza vaccine included with the consent.

R26's document titled "Consent to Administer

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Pneumococcal Conjugate (PCV13) Vaccine" listed R26 as the Individual to receive the vaccine. Verbal consent was written in with R26's name and it was dated 2/24/23. Included in the consent is the paragraph that stated: A vaccine information statement (VIS)- "Pneumococcal Conjugate Vaccine: What you Need to know"- has been prepared by the Centers for Disease Control and Prevention and contains important information regarding pneumococcal disease and the pneumococcal conjugate vaccine. Please read the VIS before signing this consent and receiving the PCV13 shot. As the individual identified below hereby confirms that they have received, read, and understood the VIS and that they understand the risks and benefits associated with the pneumococcal conjugate vaccine and that they desire to have the pneumococcal conjugate vaccine administered, and that accordingly they give their permission for such administration.

R26's document titled "Consent to Administer Pneumococcal Conjugate (PCV13) Vaccine" listed R26 as the Individual to receive the vaccine. Verbal consent was written in with R26's name and it was dated 2/24/23.

There was no documentation in R26's medical record, R26 received the pneumococcal and flu vaccines.

On 1/27/25 at 1:06 PM, R26 stated that she does want the pneumonia and flu vaccine and has not yet received either of them.

R33's preventative health care tab in the EMR documented that she received the influenza vaccine last on 10/24/23 and the pneumonia vaccine and pneumonia vaccine with an

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approximate date of 5/9/19. R33's Preventative Health Care Tab in the EMR documented that she received the COVID vaccine last on 2/12/2023 and on 11/12/2021 prior to that.

R33's Face Sheet, undated, located in her EMR, documented she was admitted to the facility on 10/12/18 and has diagnoses of heart failure, type 2 diabetes, unspecified dementia, schizophrenia, anemia, hypertension, bipolar disorder, and major depressive disorder.

R33's MDS dated 1/5/25 documented that she is alert and oriented.

On 1/30/25 at 3:40 pm, R33 stated that if she were offered a COVID vaccination she would accept it.

R33's document titled Health Care Provider Influenza vaccine consent form 2024-2025 was signed with her signature and a printed name. There was no date on the consent.

R33's document titled Health Care Provider Influenza vaccine consent form 2024-2025 was signed with her signature and a printed name. There was no date on the consent. The signature followed the statement "I have read (or it has been read to me) and I understand the "Influenza Vaccine Fact Sheet". I have had the opportunity to ask question and have had them answer to my satisfaction. I consent to receiving the seasonal influenza vaccine. In addition, I am aware that the personal health information collected on this form may be shared with another healthcare provider if it is required for my care." However, there was no information regarding the influenza vaccine included with the consent.

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R33's document hard copy titled "Consent to Administer Pneumococcal Conjugate (PCV13) Vaccine" listed R33 as the Individual to receive the vaccine. However, there was no signature provided. Written on the pneumococcal vaccine was writing that documented "due 5/9/2024." In her EMR there was a consent for both the influenza and the pneumococcal vaccine signed and date 9/6 without a year included on the signatures.

On 1/28/25 at 8:45 AM, R33 stated that she has not received her influenza vaccine.

R33's Physician Order, dated 4/11/23 documented to administer the flu vaccine annually with a signed consent.
There was no documentation in R33's medical record, R33 received the flu, COVID and pneumococcal vaccination.

R22's Preventative Health care Tab in R22's EMR documented that he received the influenza vaccine on 9/27/22 and a pneumococcal vaccine on 2/28/23.

R22's Face Sheet, undated, located in his EMR, documented he was admitted to the facility on 8/29/21 with diagnoses including metabolic encephalopathy, alcoholic cirrhosis of liver, typer 2 diabetes, malignant neoplasm of colon, anemia, acute and subacute hepatic failure without coma, gastrointestinal hemorrhage and chronic kidney disease, stage 3.

R22's MDS dated 1/21/25 documented he is cognitively alert and oriented.

R22's preventative health care tab in the EMR documented that he received the influenza

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vaccine on 9/27/22 and a pneumococcal vaccine on 2/28/23.

R22's document titled Health Care Provider Influenza vaccine consent form 2024-2025 was signed with his signature and his printed name. There was no date on the consent. The signature followed the statement "I have read (or it has been read to me) and I understand the "Influenza Vaccine Fact Sheet". I have had the opportunity to ask question and have had them answer to my satisfaction. I consent to receiving the seasonal influenza vaccine. In addition, I am aware that the personal health information collected on this form may be shared with another healthcare provider if it is required for my care." However, there was no information regarding the influenza vaccine included with the consent.

R22's document titled "Consent to Administer Pneumococcal Conjugate (PCV13) Vaccine" listed R26 as the Individual to receive the vaccine. Verbal consent was written in with R22's name and it was dated 2/27/23. Included in the consent is the paragraph that stated: A vaccine information statement (VIS)- "Pneumococcal Conjugate Vaccine: What you Need to know"- has been prepared by the Centers for Disease Control and Prevention and contains important information regarding pneumococcal disease and the pneumococcal conjugate vaccine. Please read the VIS before signing this consent and receiving the PCV13 shot. As the individual identified below hereby confirms that they have received, read, and understood the VIS and that they understand the risks and benefits associated with the pneumococcal conjugate vaccine and that they desire to have the pneumococcal conjugate vaccine administered, and that accordingly they give their permission for such

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administration.

Pneumovax centers for disease control (CDC) recommends that R22 would have been due to receive his next pneumonia vaccine on 02/28/24. There was no documentation in R22's medical record that R22 had received the flu and pneumonia vaccinations.

R22's Physician's Orders dated 4/2/23 documented to administer the flu vaccine annually with a signed consent and to administer the pneumonia vaccine as ordered with a signed consent.

There is no verification in R22's EMR that R22 received the flu or pneumococcal vaccination.

R41's Preventative Health Tab in the EMR had no entries regarding influenza, pneumococcal or COVID vaccines.

R41's document titled Health Care Provider Influenza vaccine consent form 2024-2025 was signed with his signature and his printed name. There was no date on the consent.

R41's undated face sheet located in the EMR documented that he was admitted to the facility on 2/23/24 with diagnoses of cerebral infarction, type 2 diabetes, cardiac arrest, hypertension, hyperlipidemia, neuromuscular dysfunction of bladder, complete traumatic amputation, and benign prostatic hyperplasia.

R41's Physician's Orders dated 2/24/24 documented to administer the flu vaccine annually with a signed consent and to administer the pneumonia vaccine as ordered with a signed consent.

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R41's document titled Health Care Provider Influenza vaccine consent form 2024-2025 was signed with his signature and his printed name. There was no date on the consent. The signature followed the statement "I have read (or it has been read to me) and I understand the "Influenza Vaccine Fact Sheet". I have had the opportunity to ask question and have had them answer to my satisfaction. I consent to receiving the seasonal influenza vaccine. In addition, I am aware that the personal health information collected on this form may be shared with another healthcare provider if it is required for my care." However, there was no information regarding the influenza vaccine included with the consent.

On 1/30/25 at 3:45 PM, R41 stated that he would accept the COVID vaccine if it were to be offered to him.

There was no documentation in R41's EMR that R41 received the flu or pneumococcal vaccinations.

On 1/23/25 at 4:15 PM, R9 was sitting in dining room and called the surveyor over. She stated she was mad because they made them fill out all this paperwork for flu shots and never received them. R9 added that she never received the COVID or pneumonia vaccine.

R9's EMR documented that R9 signed a consent for the pneumococcal vaccine on 11/30/24.

On 1/27/25 at 9:56 AM, R24 reported that he did request the pneumonia and flu vaccine and he has not yet received it.

R24's EMR documented that he had signed

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consent for the influenza and pneumococcal vaccine on 9/6 with no year entered.

On 1/27/25 at 9:45 AM, R16 stated that they asked him if he wanted the flu or pneumonia vaccine, but he has still not received it.

On 1/27/25 at 9:53 AM, R10 stated that he has requested the flu and the pneumonia vaccine but has not yet received it.

On 1/28/25 at 9:55 AM, R13 stated she wanted the flu and pneumonia vaccine, but never did get it.

R13's EMR documented that R13 signed a pneumococcal consent on 8/26/24.

R4's Preventative Health Tab in the EMR documented that he received the COVID 19 vaccine on 10/21/21 and 9/25/21.

R4's COVID 19 vaccination card documented that he received his first COVID vaccination on 9/16/21 and his second on 10/21/21.

On 1/30/25 at 10:45, R4 stated he was wondering if he will receive COVID testing. He added that there are three people with COVID, and we are all around each other. He added that R36 ate near the front of the dining room and that all the residents walk past him to get to their tables. He added that would all get tested weekly until there are no more positives. R4 stated that he receives the COVID vaccine every year and that he is due for another one. He stated he just received the flu vaccine the other day by V3. He requested that we try to get them to test everyone. He stated that it makes him feel like he doesn't even want to come out of his room. R4 stated he is keeping his

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safe distance from everyone.

R43's Face Sheet documents R43 was admitted to the Facility on 5/23/24 with diagnoses including heart disease, type 2 diabetes mellitus, and hypertension.

R43's Physician's Order dated 6/6/24 documented to administer the flu vaccine annually with a signed consent and to administer the pneumonia vaccine as ordered with a signed consent.

R43's MDS dated 11/27/24 documents R43 was cognitively intact, ambulated via wheelchair and was dependent with transfer.

R43's Care Plan dated 6/17/24 documents R43 had a diagnosis of pneumonia.

R43's document titled Health Care Provider Influenza vaccine consent form 2024-2025 was signed with her signature and a printed name. There was no date on the consent.

R43's Physician Order dated 6/17/24 documents administer pneumonia vaccine unless contraindicated and chart (document).

R43's Electronic Medical Record does not document R43's Immunization History.

The Facility's Pneumococcal Vaccine consent was signed by R43 on 5/23/24.

On 1/31/25 at 8:18 AM, R43 was lying in bed in her room. She stated she has had a horrible cough for the past two weeks and thinks she has pneumonia, but they did a chest x-ray, and she has not gotten the results yet. She stated she

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wanted the pneumonia vaccine but did not receive it.

On 1/31/25 at 11:38 PM, R43's progress notes by V42, LPN documented that local hospital was phoned for update on R43. R43 was admitted to hospital with diagnosis of pneumonia.

R43's local hospital records reviewed documenting that she tested positive for COVID-19 on 1/31/2025 upon arrival to the hospital.

R43's Preventive health care tab in EMR showed no documentation or entries regarding any vaccines including COVID.

R43's COVID-19 Vaccines Global Access (Covax) record documented she received the last COVID Vaccine on 2/12/2023.

There was no documentation in R43's medical record that R43 was administered the pneumonia vaccine and COVID vaccination or offered the COVID vaccination.

On 1/28/25 at 1:15 PM, V2, Director of Nursing (DON), stated that there is only a COVID outbreak if there are 2 residents or more who have tested positive for COVID in the building. V2 stated that there was only one resident who was positive. Surveyor informed V2 that R37 returned from the hospital today and is also positive for COVID so there are two residents in the facility positive for COVID. V2 stated that now that they are in outbreak status she will have staff take vital signs every shift and perform a respiratory assessment. V2 stated if residents are positive, they will put in orders for COVID testing. V2 stated that they will test all staff in the building.

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When asked when this will begin, V2 stated it will begin tonight. When asked about staff Personal Protective Equipment (PPE), she stated that all staff will wear N95 masks and goggles.

On 1/29/25 at 2:25 PM V48, local county health service coordinator, stated that she had not received any information of residents positive with COVID occurring at the facility. She stated that the current outbreak status in the county is high. She stated that she would expect the facility to test the entire wing with the outbreak. V48 stated that if this was negative, they should test again every three, five and seven days. The testing should then be weekly.

On 1/29/25 at 9:10 AM V1 stated she was 100% certain that the local county health department was not notified for guidance because there is no one on staff who would have done that.

On 1/31/25 at 10:05 AM, V1 stated she was not notified of the COVID infection properly and nobody knew the proper guidelines. V1 stated it started with R2, then R37, and then R36 just came from the hospital with it. I think he tested positive last Saturday. V1 stated "We also had an employee test positive, but I was not notified of that. They have not been doing any testing in the facility but the guidelines I am reading say they don't have to because they are not in outbreak status." V1 is using the (State Agency) guidelines which come from Centers for Disease Control (CDC).

On 1/30/25 at 8:37 AM, V17, Medical Director/Owner, stated that there are two residents with COVID that he is aware of. He stated that they have a policy for that. He stated that he told them yesterday to follow the policy

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and keep them in isolation for ten days and use PPE. V17 stated that two residents who are COVID positive need to be isolated for at least ten days even if asymptomatic. He stated that he thought testing was optional if residents are not symptomatic. V17 stated that it is not mandatory to check everyone as far as he knows. V17 stated that he understood that if nobody had any symptoms, he did not believe that every employee and every resident needed to be tested. But we isolate residents and if someone enters room need to have precautions for ten days.

On 1/30/25 at 10:55 AM, V3, Assistant Director of Nursing (ADON) stated that any resident who has been in contact with anyone who tested positive for COVID or any resident who feels like they need a COVID test should receive it.

On 2/3/25 at 8:55 AM, V1 stated that her plan is for V2 test everybody for COVID at the facility today.

On 1/27/25 at 10:00 AM, V4, LPN stated that the residents' flu and pneumonia vaccines will be offered in a group and a designated nurse will administer these. V4 is unsure as to when this last occurred.

On 1/28/25 at 11:00 AM, V1, Administrator, stated no pneumonia vaccines were given in the Facility this year.

On 1/29/25 at 9:10 AM, V1 stated the facility as had the influenza vaccines in the facility since November and these have not yet been administered this flu season.

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On 1/30/25 at 8:37 AM, V17, Medical director, stated influenza vaccines could be given any time in the flu season. He added throughout the winter any time would be okay although normally you would expect it should be done by December but can be done any time during the season.

On 1/30/25 at 10:55 AM, V3 stated that she gave some flu vaccines on 1/28/25. V3 stated that she had been meaning to give them before this because they needed to be given. For a while she stated she was waiting for needles to be able to provide the immunizations. She added these should have been given already.

On 1/29/25 at 9:15 AM, flu vaccine storage was observed in a small refrigerator in a locked room. There were four boxes ten vials in each box) of Fluzone Lot UT8506MA. The expiration date on each box was 6/2025.

On 2/4/25 at 9:20 AM, V17 stated he was not previously aware that vaccines were not given in the Facility.

On 2/4/25 at 4:15 PM, V1 stated she expects residents who consent to flu and pneumonia vaccines to receive them in a timely fashion.

33 residents had signed consents for flu vaccine and as of 1/28/25, five residents had received the vaccine. 33 residents are overdue for receiving the pneumonia vaccine based on CDC pneumovax recommendations.

Influenza vaccine policy revised October 2019 documented that all residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits

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associated with vaccinations against influenzas. The facility shall provide pertinent information about the significant risks and benefits of vaccines to staff and residents (or residents' legal representatives); for example, risk factors that have been identified for specific age groups or individuals with risk factors such as allergies or pregnancy.

Influenza policy interpretation and implementation documented that between October 1st and March 31st each year, the influenza vaccine shall be offered to residents and employees, unless the vaccine is medically contraindicated, or the resident or employee has already been immunized. Employees hired or residents admitted between October 1st and March 31st shall be offered the vaccine within five working days of the employee's job assignment or the resident's admission to the facility. Employees will be offered the influenza vaccine at no charge, at a location onsite. Prior to the vaccination, the resident or employee will be provided information and education regarding the benefits and potential side effects of the influenza vaccine. The Infection Preventionist will maintain surveillance data on influenza vaccine coverage and reported rates of influenza among residents and staff. Surveillance data will be made available to staff as part of education efforts to improve vaccination rates among employees.

Document titled Pneumococcal Vaccine revised 3/2003 documented a policy statement which stated that all residents will be offered the pneumococcal vaccine to aid in preventing infections and pneumonia. The policy interpretation and implementation section documented that prior to or upon admission, residents will be assess for eligibility to receive

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the pneumococcal vaccine, and when indicated provided the vaccination within 30 days of admission to the facility unless medical contraindicated or the resident refuses the vaccine for personal or religious reasons. Pneumococcal vaccination assessments will be conducted within five working days of the resident's admission if not conducted prior to admission. To ensure that residents receive their pneumococcal vaccination on a timely basis, pneumococcal vaccinations will be administered to residents (unless medically contraindicated) per our facility's physician-approved pneumococcal vaccination policy. Appropriate entries will be documented in each resident's medical record indicating the date of the receipt or refusal of the pneumococcal vaccination or status of such immunization. Administration of the pneumococcal vaccine will be made in accordance with current Advisory Committee on Immunization Practices recommendations at the time of the vaccination

FAILURE TO TREAT SIGNIFICANT CHANGE IN CONDITION FOR FRACTURE AND PNEUMONIA

R43's Face Sheet documents R43 was admitted the Facility on 5/23/24 with diagnoses including heart disease, diabetes mellitus type 2, and hypertension.

R43's Minimum Data Set, MDS, dated 11/27/24 documented R43 was cognitively intact, dependent with transfer, and ambulated via wheelchair.

R43's Care Plan dated 6/17/24 documented R43 had a previous diagnosis of pneumonia.

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R43's Progress Note dated 1/24/25 at 5:50 AM documents R43 was having a non-productive cough, and lungs sounded "raspy," so the physician ordered a chest X-ray.

R43's Progress Note dated 1/26/25 at 10:50 PM documents R43's chest X-ray was obtained.

R43's Progress Note dated 1/27/25 at 6:22 AM documents still awaiting chest X-ray results.

There was no documentation in R43's Progress notes regarding R43's monitoring of symptoms from 1/27 through 1/31/25.

On 1/31/25 at 8:18 AM, R43 was lying in bed in her room. She stated she has had a horrible cough for the past two weeks and feels like she has pneumonia. She said the Facility did a chest X-ray but has not yet received any results.

On 1/31/25 at 8:20 AM, V4, Licensed Practical Nurse, LPN, stated she was unaware of R43's 1/26/25 chest X-ray results.

On 1/31/25, at 11:25 AM, R43 was coughing while lying in bed. R43 stated she had been coughing for two weeks and wishes someone would do something. She said that it was difficult for her to breath. She said that they did a chest X-ray, but they have not received any results.

On 1/31/25 at 11:40 AM, R43 stated, "I need to see a doctor really bad. I don't know how to explain it, but it hurts really bad." R43 clarified the pain was in her chest. V4, LPN, stated she would give R43 a Mucinex and contact her physician. V4 stated she had still not checked for R43's chest X-ray results.

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On 1/31/25 at 12:17 PM, V1, Administrator, stated R43 is being sent out by Emergency Medical Services (EMS) due to chest pain. V1 was not aware R43 had not been feeling well or had a chest X-ray. V1 provided the surveyors with R43's Chest X-ray results dated 1/27/25. She stated the fax machine is located in a separate office that staff may not have been checking. V1 stated "She complained of chest pain. I'm not a nurse but this is a new symptom."

R43's Radiology Report dated 1/26/25 documents the etiology (cause) was inconclusive with recommendation for CT (Computed Tomography) scan or repeat examination.

R43's Progress Note by V4 on 1/31/25 at 12:45 PM documents R43 complained of chest pain and shortness of breath. V4 then obtained the results from R43's chest X-ray, notified physician, and called 911.

R43's Progress Note dated 1/31/25 at 11:38 PM documents R43 was admitted to (Local Hospital) with diagnosis of right upper lobe pneumonia and COVID.

On 2/4/25 at 7:18 AM, received encrypted email from V47, Medical Records Privacy Analyst from (Radiology), documenting R43's chest X-ray results were faxed to the Facility on 1/26/25 at 1:36 AM.

On 2/4/25 at 9:20 AM, V17, Medical Director, stated he will be speaking with each nurse individually, because they need to do their jobs. The Facility has enough nurses, but some of them do not want to work, and that is unacceptable.

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As of 2/4/25 at 1:29 PM, the Facility did not provide documentation that any follow up imaging was completed for R43 between 1/26/25 and 1/31/25.

On 2/5/25 at 3:45 PM, V1 stated the Facility does not have a policy regarding timeliness of ancillary care but would expect X-ray results to be reviewed and physician to be notified in a timely manner.

R23's Face Sheet, print date of 1/29/25, documented R23 has diagnoses of dementia, depression, schizophrenia, generalized anxiety disorder, unspecified mood disorder, and adult failure to thrive.

R23's MDS, dated 10/29/24, documented R23 is severely cognitively impaired and requires partial/moderate assistance with mobility.

R23's Progress Note, dated 1/24/25 at 8:52 PM, documented Certified Nurse's Aide (CNA) came to this nurse and stated that resident was hit by another resident, resulting with resident having a nosebleed. Residents already separated when this nurse was made aware of situation. Pressure applied and bleeding controlled. 911 called for transport to hospital for further evaluation. ADON and administrator notified. When police arrived, resident's emergency contact notified of situation. Resident's emergency contact stated, "if resident's nosebleed stopped, do not send him to hospital. Grimacing observed by this nurse. PRN (as needed) Tylenol given with HS medication. Neuro and frequent checks initiated for safety.

R23's Progress Note, dated 1/25/25 at 5:00 PM, documented resident incident f/u (follow-up) day 2. Resident left eye bruised. Resident neuro

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checks WNL (within normal limits). Resident stayed in bed this shift. Resident winced in pain with movement.

R23's Progress Note, dated 1/26/25 at 11:57 AM, documented resident incident f/u (follow up) day 3. Resident up in wheelchair and awake. General malaise noted. Resident wincing with movements. There was no documentation that V17, R23's physician, was notified.

R23's Progress Note, dated 1/26/25 at 2:03 PM, documented resident wincing, guarding, and screaming out with touch and unable to state location of pain. Resident normally transfers and ambulates with minimal assistance. Resident is now unable to stand without difficulty and assistance of two. Resident unable to stand or ambulate without assistance. Resident drowsy and not easily aroused. Resident eyes flutter open and closing when name called. Resident confused more confused than normal mentation and sitting in wheelchair and in a slumping posture. This writer assessed resident and mental status changes and pain noted. ROM (range of motion) not able to be completed due to resident resisting and pushing away. Called 911 to have resident evaluated. Management notified and brother notified. Awaiting EMS (Emergency Medical Services) arrival.

R23's Progress Note, dated 1/26/25 at 2:15 PM, documented local fire department arrived, and resident was transported at this time to local hospital on stretcher. Resident lifted cradle style to stretcher by EMS staff due to immobility. Anderson hospital notified of resident enroute.

R23's local hospital progress note, dated 1/26/25 at 5:02 PM, documented R23 has a fracture of

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his right greater trochanter. This is typically non operative. Please treat with Motrin and Tylenol as needed. He needs follow-up with orthopedic surgery in 1 week.

R23's Progress Note, dated 1/26/25 at 5:45 PM, documented received call from local hospital stating resident has a trochanter fracture. States resident to return today.

R23's Progress Note, dated 1/26/25 at 10:09 PM, documented resident returned to facility at 7:50 PM via ambulance. New orders, ibuprofen 800 mg tab TID (3 times per day) PRN (as needed) and acetaminophen 1000 mg TID PRN, both orders for 7 days.

R23's Progress Note, dated 1/27/25 at 4:28 PM, documented resident had s/s (signs and symptoms) of increased pain this shift. PRN pain meds were given. Resident's appetite was poor for all 3 meals.

On 1/27/25 at 9:33 AM V1 stated there was a resident-to-resident altercation Friday night (1/24/25) between R22 and R23. V1 stated R23 is confused and wandered into R22's room. R22 punched R23. When surveyor questions how R23 sustained a hip fracture, ked V1 replied she was not aware of the fracture. V1 then looked at R23's progress notes and stated, "He does have a fracture; it is probably from the incident on Friday night between the two residents."

On 1/27/25 at 11:30 AM V13 LPN stated she did not know how R23 developed the hip fracture. V13 stated R23's last fall was on 1/10/25 but he did not show any signs of pain until after the incident between R22 and R23 that happened on Friday night. V13 stated she did not get anything

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in report about R23 having a fall, but she did get in report that R23 was punched by R22 and developed a bloody nose and black eye.

On 1/27/25 at 11:33 AM V1 stated she did not know about R23's hip fracture until surveyor told her. V1 stated she is still investigating. V1 stated she did not know if R23 fell or not during the incident on Friday night.

On 1/27/25 at 1:26 PM surveyor questioned V17, R23's Physician/Medical Director, regarding R23's hip fracture and V17 responded "I was not aware of that, I will investigate it."

On 1/29/25 at 8:50 AM V1 stated she has not had time to complete the unknown injury investigation on R23's hip fracture. Stated she spoke to R23, and he was not able to say how he injured his hip. V1 stated R23 had a fall on 1/10/25 but did not complain of pain until after the resident-to-resident incident on Friday night (1/24/25). Surveyor requested R23's fall incident report and investigation. V1 stated no one has been investigating resident's falls nor putting interventions into place. Survey asked V1 how she is notified of resident injuries of unknown origin and V1 stated the staff are supposed to call her, but no one notified her of R23's hip fracture. V1 stated she was not aware of R23's hip fracture until surveyor informed her. V1 sated she just gained access to the facility's EMR (electronic medical records) last week and she has not been able to determine if the facility's EMR has a risk management system to investigate resident incidents and unknown injuries.

On 1/29/25 at 9:07 AM V35 CNA and V36 CNA transferred R23 from reclining wheelchair to bed. V36 placed a gait belt around R23 and started to

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assist R23 to a standing position. R23 moaned and winced in pain, surveyor then intervened and advised V35 and V36 to stop the transfer. Surveyor asked V35 and V36 if they had been informed about R23's hip fracture and both replied no. Surveyor then went and informed V1. V1 stated I don't know what his precautions are. I will have to look but he should be a mechanical lift until he sees the orthopedic doctor.

On 1/29/25 at 11:30 AM V33, LPN, stated the CNAs attempted to get R23 up on Saturday (1/25/25), but he was hurting too bad, and he couldn't pinpoint where the pain was. V33 stated she did not call the doctor on Saturday to update on R23's condition. V33 stated R23 was very uncomfortable on Sunday (1/26/25) so she called the doctor on Sunday and had R23 sent out to the ER.

On 1/29/25 at 2:17 PM V40, Physical Therapist, stated R23 should not be weight bearing including toe touch until he sees the orthopedic doctor.

On 1/30/25 at 8:37 AM V17, Medical Director and owner, stated he would expect R23 to be non-weight bearing and staff should transfer R23 with a mechanical lift.

On 2/3/25 at 11:37 AM V1 stated R23's appointment with the orthopedic doctor has not been scheduled yet and the Social Service Director has attempted to contact them but has not heard back yet regarding an appointment date.

On 2/3/25 at 12:50 PM R23's progress notes and R23's EMR does not document any attempts to schedule R23's orthopedic follow up appointment as ordered by the local hospital emergency

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AU WELL CARE HOME, INC	152 WILMA DRIVE MARYVILLE, IL 62062

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department.

MEDICATIONS NOT ADMINISTERED AS ORDERED

On 1/28/25 at 10:30 AM surveyor was walking by the 200-hall wing nurse's station when surveyor was stopped by R1 and R9. Both residents stated they had not received any medications today. R1 was tearful and stated she needs her nerve medicine. R9 stated she needs her blood pressure and anxiety medications.

On 1/28/25 at 10:34 AM surveyor asked V2, Director of Nursing (DON), if she was aware that the 200-hall wing did not have a nurse and that residents were upset because they had not received any of their morning medication. V2 stated she was aware and that she was trying to get access to the facility's EMR (electronic medical record) so she could pass the medications.

On 1/28/25 at 11:05 AM V1, Administrator, stated "I am aware we don't have a nurse for the 200-hall wing and no medications have been passed this am. The DON started yesterday, and she doesn't have access to the EMR yet." V1 stated a day shift nurse called off and the ADON (Assistant Director of Nursing) worked last night. V1 stated there are about 40 residents on the 200-hall wing who have not received any medications today and most of them are diabetic.

On 1/28/25 at 3:30 PM surveyor was on site and the 200-wing still did not have a nurse resulting in the residents to go without medication from approximately 7 AM to 4 PM on this date.

R1's Face Sheet, print date of 2/3/25,

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documented R1 has diagnoses including anxiety disorder, schizophrenia, depression, chronic pain syndrome, polyneuropathy, gastro-esophageal reflux disease, atherosclerotic heart disease, and COPD (chronic obstructive pulmonary disease) and seizures.

R1's Physician's Orders, dated 2/1/25, documented R1 is supposed to receive medications every morning including atorvastatin 40 milligrams (mg) for atherosclerotic heart disease, buspirone 10 mg for anxiety, duloxetine 60 mg for treatment of anxiety, depression, and neuropathy, and lamotrigine 100 mg for prevention of seizures.

R1's Minimum Data Set, (MDS), dated 12/31/24, documented R1 is cognitively intact.

R1's Care Plan, revision date of 1/20/25, documented R1 has a history of suicidal ideations with an approach of I will talk with staff when I have thoughts of self-harm and take medication as prescribed. R1's care plan also documented R1 is currently prescribed anti-anxiety medication hydroxyzine for the treatment of generalized anxiety disorder with approaches including give anti-anxiety medications ordered by physician.

R1's EMR documented a recent hospitalization for suicidal ideations. R1's progress note, dated 1/17/25 at 9:25 PM, documented resident stated to this nurse that she will commit suicide with scissors that she has. Scissors removed from resident and aide told to stay with residents.

R1's Progress Note, dated 1/17/25 at 9:39 PM, documented EMS (emergency medical services) in facility to transport resident. Resident will be transported to regional hospital.

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R1's Progress Note, dated 1/22/25 at 11:40 AM, documented R1 returned to facility from regional hospital.

R1's Physician's Order (PO), dated 2/1/25, documented R1 is supposed to receive medications every morning including atorvastatin 40 milligram (mg) for atherosclerotic heart disease, buspirone 10 mg for anxiety, duloxetine 60 mg for treatment of anxiety, depression, and neuropathy, and lamotrigine 100 mg for prevention of seizures.

R1's January 2025 Medication Administration Record (MAR), did not document that R1 received any medication from 7 AM to 6 PM on 1/28/25.

R1'S EMR did not document any physician notification regarding medications not being administered as ordered on 1/28/25 nor does it document an order for R1's medications to be held on 1/28/25.

On 1/29/25 at 9:02 AM R1 stated she did not receive any medications yesterday, including morning, noon, nor evening medication and that it caused her to be very anxious last night.

R9's Face Sheet, print date of 2/3/25, documented R9 has diagnoses including diabetes, COPD (chronic obstructive pulmonary disease), osteoarthritis, hypertension, bipolar disorder, heart failure, and depression.

R9's MDS, dated 12/12/24, documented R9 is mildly cognitively impaired although on 1/30/25 at 12:22 PM V41 LPN (Licensed Practical Nurse) stated R9 is not confused and is able to make her

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needs known.

R9's Care Plan, revision date of 10/10/24, documented R9 has a diagnosis of CHF (congestive heart failure) with the potential for medical complications related to the diagnosis. This care plan has approaches including administer medications as ordered observing their effectiveness. R9's care plan also documented R9 has a diagnosis of diabetes mellitus which places R9 for risk of medical complications with approaches of blood glucose monitoring as ordered by physician and administer medications as ordered by MD (medical doctor).

On 1/28/25 at 3:28 PM R9 stated she still had not received any of her morning nor noon medications. R9 stated she was feeling very nervous because she had not received any of her psych medications. R9 stated she was also worried about her blood pressure being high due to not receiving her medications for it. R9 then stated, "I don't see why state doesn't shut this place down, this is bull s***."

R9's January 2025 MAR, documented R9 has physician orders for amlodipine 5mg daily for hypertension, atenolol 50 mg TID (three times a day) for hypertension, buspirone 15 mg BID (twice a day) for anxiety, fluoxetine 20 mg BID for depression, furosemide 20 mg daily for CHF, lisinopril 10 mg daily for hypertension, potassium chloride 20 milliequivalents (meq) daily, and incruse ellipta 1 puff daily for COPD. This MAR documented not administered: other comment: done by previous nurse, dated 1/28/25 at 6:59 PM, by the night shift nurse.

On 2/4/25 at 8:51 AM R9 stated she did not

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receive any of her daily medications on 1/28/25 and that the DON, V2, only gave her evening medications. R9 stated she was very anxious and stressed on 1/28/25 because of not receiving her daily medications.

On 2/4/25 at 8:57 AM, V2 stated she did administer all R9's daily medications to her, cannot recall what time it was but it was after 3 PM on 1/28/25.

R9's EMR does not document any vital signs for 1/28/25 including blood pressure and oxygen saturation level.

R9's EMR does not document any notification nor physician orders for R9's medications to be held nor administered late for 1/28/25.

R17's Face Sheet, undated, documented R17 has diagnoses including tachycardia, acute and chronic respiratory failure, and hypothyroidism.

R17's MDS, dated 1/15/25, documented R17 is cognitively intact.

R17's PO and MAR for January 2025, documented R17 is ordered to receive medications including aspirin 81 mg daily, and metoprolol succinate 50 mg daily for tachycardia.

On 1/28/25 at 3:25 PM R17 stated she has not received any of her scheduled medications today. R17 stated she takes metoprolol every day for tachycardia, she was concerned because she had not received the medication, and that her current heart rate was 107. Surveyor observed R17 sitting in bed with her pulse oximeter placed on her finger and the monitoring device did read a heart rate of 107 while R17 was at rest.

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R17's MAR, print date of 1/30/25, did not document R17 received her 8 AM scheduled metoprolol nor aspirin on 1/28/25. R17's EMR does not document any vital sign results for 1/28/25.

R17's EMR does not document any notification nor physician orders for R17's medications to be held nor administered late for 1/28/25.

R28's Face Sheet, print date of 2/3/25, documented R28 has diagnoses including bipolar disorder, osteoarthritis, type 2 diabetes, hyperlipidemia, major depressive disorder - recurrent, severe with psychotic symptoms, generalized anxiety disorder, hypertension, chronic embolism, and thrombosis of unspecified deep veins of lower extremity, and history of suicidal behavior.

R28's MDS, dated 1/16/25, documented R28 is cognitively intact.

R28's Care Plan, dated 1/22/25, documented R28 requires healthcare monitoring related to diagnosis of hypertension and R28 requires healthcare monitoring related to diagnosis of diabetes. This care plan documented R28 is receiving oral glycemic, insulin, and/or blood glucose monitoring daily. R28 is at risk for episodes of hyperglycemia or hypoglycemia. Approaches for this care plan include blood glucose monitoring as ordered, administer medication as ordered, monitor vital signs during routine care and notify MD of abnormal findings. R28's care plan documented R28 is at risk for pain related to some impaired mobility and diagnoses of osteoarthritis, diabetes, and neuropathy with interventions including administer

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pain medications as ordered. This care plan also documented R28 is on an anticoagulant for a diagnosis of chronic DVTS (deep vein thrombosis) with an approach to administer medication as ordered.

On 1/28/25 at 3:15 PM R28 stated she is a brittle diabetic, on insulin, gets her blood sugar checked all the time normally but hasn't had her blood sugar checked since last night, no insulin nor any meds today, pain is at a 10 right now in neck, legs, and back. R9 stated she was about to start using her wheelchair again instead of walking with her walker because her legs hurt so bad. R28 stated she takes oxycontin for pain, but she has not received any medication all day.

R28's January 2025 MAR, documented R28 has physician orders including amlodipine 10 mg daily for hypertension, atorvastatin 40 mg daily for hyperlipidemia, buspirone 15 mg BID for anxiety, Eliquis 5mg BID for prevention of blood clots, gabapentin 400 mg TID for neuropathy, blood glucose monitoring QID (4 times per day), insulin lispro 100 unit/5ml administer 5 units QID with meals, Lantus insulin 20 units once a morning, insulin 100 unit/ml amount to administer per sliding scale based on blood glucose monitoring results TID, losartan 50 mg daily for hypertension, and lurasidone 40 mg daily for diagnosis of depression with psychotic symptoms. This MAR documented on 1/28/25 by the night nurse these meds were not administered: other comment: done by previous nurse. R28's EMR including MAR does not document any blood glucose monitoring was completed as ordered on 1/28/25 at 7:30 AM, 11:30 AM nor at 4:30 PM. R28's MAR documented R28's blood glucose level was 293 and 386 on the following day, 1/29/25, after R28 did not receive her insulin as ordered on 1/28/25.

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R28's EMR does not document any physician notification regarding R28's medications being held nor late. R28's orders do not document an order for R28's medications to be held nor to be administered late for 1/28/25.

On 2/4/25 at 11:50 AM R28 stated she did not receive any medications on 1/28/25 until after 4 PM. R28 stated she did not feel like herself, had anxiety, a headache from not receiving her blood pressure medications, and experienced a lot of pain due to not receiving her medications on 1/28/25. R28 also stated her blood sugar ran high that next day on 1/29/25.

On 2/4/25 at 9:18 AM V17, Physician/Medical Director/Owner, stated the facility did not notify him until 1 PM on 1/28/25 about the 200-wing not having a nurse and residents not receiving medications. V17 stated V2 could have passed the medications on 1/28/25 before 4 PM, that she did have access to paper MARS. V17 stated if the DON is not capable of doing the job, and I am going to replace her as soon as I find someone else to do the job. V17 stated there could have been negative outcomes related to the residents not receiving diabetic and blood pressure medications such as hyperglycemia and elevated blood pressure. V17 stated he would have expected V2 to be monitoring the diabetic residents' blood sugar and should have been checking blood pressures for residents that didn't receive medications for hypertension.

On 2/4/25 at 3:27 PM V1, Administrator, was asked by surveyor if the facility considers the issue with 200-hall not having a nurse on 1/28/25 and medications not being administered or administered 8 hours late a medication error and

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V1 replied "oh gosh yes, 100%."

The facility's Administering Oral Medications policy, dated 9/2003, documented the purpose of this procedure is to provide guidelines for the safe administration of oral medications. General Guidelines: 1. Always verify the "5 Rights" before administering medications - the right medication; the right dose; the right resident; the right route; and the right time. 2. Be familiar with the resident's medical diagnosis and reason for administering the drug, as well as contraindications, unusual dosages, side effects, and intended outcome of the drug. 3. Double check the Medication Administration Record (MAR) against physician orders before administering medications. It continues, 6. Administer medications within one (1) hour before or after their scheduled time.

The facility's Medication Errors and Drug Reactions policy, dated 9/2003, documented the purpose of this procedure is to establish uniform guidelines in the reporting and recording of medication errors and drug reactions. 1. All medication errors and drug reactions must be promptly reported to the director of nursing services, attending physician, and the pharmacist. 2. A detailed account of the incident must be recorded in the resident's medical record. 3. Residents receiving incorrect medication or having a drug reaction must be closely monitored. Any change in the resident's condition must be immediately reported to the director of nursing services and attending physician. 4. The nurse supervisor will be responsible for completing an incident report and submitting a copy to the director of nursing services and a copy to the administrator. 5. All incident reports relating to medication errors and

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drug reactions will be reviewed by the Pharmaceutical Services Committee at their next regularly scheduled meeting.

On 1/28/25 at 10:30 AM surveyor was walking by the 200-hall wing nurse's station when surveyor was stopped by R1 and R9. Both residents stated they had not received any medications today. R1 was tearful and stated she needs her nerve medicine. R9 stated she needs her blood pressure and anxiety medications.

On 1/28/25 at 10:34 AM surveyor asked V2, DON (Director of Nursing), if she was aware that the 200-hall wing did not have a nurse and that residents were upset because they had not received any of their morning medication. V2 stated she was aware and that she was trying to get access to the facility's EMR (electronic medical record) so she could pass the medications.

On 1/28/25 at 11:05 AM V1, Administrator, stated "I am aware we don't have a nurse for the 200-hall wing and no medications have been passed this am. The DON started yesterday, and she doesn't have access to the EMR yet." V1 stated a day shift nurse called off and the ADON (Assistant Director of Nursing) worked last night. V1 stated there are about 40 residents on the 200-hall wing who have not received any medications today and most of them are diabetic. V1 stated V27, facility owner and Medical Director, will not allow the facility to have agency nurses.

R1's face sheet, print date of 2/3/25, documented R1 has diagnoses including anxiety disorder, schizophrenia, depression, chronic pain syndrome, polyneuropathy, gastro-esophageal

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reflux disease, atherosclerotic heart disease, and COPD (chronic obstructive pulmonary disease) and seizures.

R1's MDS (Minimum Data Set), dated 12/31/24, documented R1 is cognitively intact.

R1's care plan, revision date of 1/20/25, documented R1 has a history of suicidal ideations with an approach of I will talk with staff when I have thoughts of self-harm and take medication as prescribed. R1's care plan also documented R1 is currently prescribed anti-anxiety medication hydroxyzine for the treatment of generalized anxiety disorder with approaches including give anti-anxiety medications ordered by physician.

R1's EMR documented a recent psychiatric hospitalization for suicidal ideations. R1's progress note, dated 1/17/25 at 9:25 PM, documented resident stated to this nurse that she will commit suicide with scissors that she has. Scissors removed from resident and aide told to stay with residents.

R1's progress note, dated 1/17/25 at 9:39 PM, documented EMS (emergency medical services) in facility to transport resident. Resident will be transported to regional hospital.

R1's progress note, dated 1/22/25 at 11:40 AM, documented R1 returned to facility from regional hospital.

R1's physician orders, dated 2/1/25, documented R1 is supposed to receive medications every morning including atorvastatin 40 mg for atherosclerotic heart disease, buspirone 10 mg for anxiety, duloxetine 60 mg for treatment of anxiety, depression, and neuropathy, and

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lamotrigine 100 mg for prevention of seizures.

R1's MAR (medication administration record), dated 1/1/25 - 1/31/25, did not document that R1 received any medication from 7 AM to 6 PM on 1/28/25.

R1'S EMR did not document any physician notification regarding medications not being administered as ordered on 1/28/25 nor does it document an order for R1's medications to be held on 1/28/25.

On 1/29/25 at 9:02 AM R1 stated she did not receive any medications yesterday, including morning, noon, nor evening medication and that it caused her to be very anxious last night.

R9's face sheet, print date of 2/3/25, documented R9 has diagnoses including diabetes, COPD (chronic obstructive pulmonary disease), osteoarthritis, hypertension, bipolar disorder, heart failure, and depression.

R9's MDS, dated 12/12/24, documented R9 is mildly cognitively impaired although on 1/30/25 at 12:22 PM V41 LPN (Licensed Practical Nurse) stated R9 is not confused and is able to make her needs known.

R9's care plan, revision date of 10/10/24, documented R9 has a diagnosis of CHF (congestive heart failure) with the potential for medical complications related to the diagnosis. This care plan has approaches including administer medications as ordered observing their effectiveness. R9's care plan also documented R9 has a diagnosis of diabetes mellitus which places R9 for risk of medical complications with approaches of blood glucose

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monitoring as ordered by physician and administer medications as ordered by MD (medical doctor).

On 1/28/25 at 3:28 PM R9 stated she still had not received any of her morning nor noon medications. R9 stated she was feeling very nervous because she had not received any of her psych medications. R9 stated she was also worried about her blood pressure being high due to not receiving her medications for it. R9 then stated "I don't see why state doesn't shut this place down, this is bull s***.

R9's MAR, dated 1/1/25-1/30/25, documented R9 has physician orders for amlodipine 5mg daily for hypertension, atenolol 50 mg TID (three times a day) for hypertension, buspirone 15 mg BID (twice a day) for anxiety, fluoxetine 20 mg BID for depression, furosemide 20 mg daily for CHF, lisinopril 10 mg daily for hypertension, potassium chloride 20 meq daily, and incruse ellipta 1 puff daily for COPD. This MAR documented not administered: other comment: done by previous nurse, dated 1/28/25 at 6:59 PM, by the night shift nurse.

On 2/4/25 at 8:51 AM R9 stated she did not receive any of her daily medications on 1/28/25 and that the DON, V2, only gave her evening medications. R9 stated she was very anxious and stressed on 1/28/25 because of not receiving her daily medications.

On 2/4/25 at 8:57 AM, V2 DON, stated she did administer all R9's daily medications to her, cannot recall what time it was but it was after 3 PM on 1/28/25.

R9's EMR does not document any vital signs for

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1/28/25 including blood pressure and oxygen saturation level.

R9's EMR does not document any notification nor physician orders for R9's medications to be held nor administered late for 1/28/25.

R17's face sheet, undated, documented R17 has diagnoses including tachycardia, acute and chronic respiratory failure, and hypothyroidism.

R17's MDS, dated 1/15/25, documented R17 is cognitively intact.

R17's physician orders and MAR, dated 1/1/25 - 1/30/25, documented R17 is ordered to receive medications including aspirin 81 mg daily, and metoprolol succinate 50 mg daily for tachycardia.

On 1/28/25 at 3:25 PM R17 stated she has not received any of her scheduled medications today. R17 stated she takes metoprolol every day for tachycardia, she was concerned because she had not received the medication, and that her current heart rate was 107. Surveyor observed R17 sitting in bed with her pulse oximeter placed on her finger and the monitoring device did read a heart rate of 107 while R17 was at rest.

R17's MAR, print date of 1/30/25, did not document R17 received her 8 AM scheduled metoprolol nor aspirin on 1/28/25. R17's EMR does not document any vital sign results for 1/28/25.

R17's EMR does not document any notification nor physician orders for R17's medications to be held nor administered late for 1/28/25.

R28's face sheet, print date of 2/3/25,

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documented R28 has diagnoses including bipolar disorder, osteoarthritis, type 2 diabetes, hyperlipidemia, major depressive disorder - recurrent, severe with psychotic symptoms, generalized anxiety disorder, hypertension, chronic embolism, and thrombosis of unspecified deep veins of lower extremity, and history of suicidal behavior.

R28's MDS, dated 1/16/25, documented R28 is cognitively intact.

R28's care plan, dated 1/22/25, documented R28 requires healthcare monitoring related to diagnosis of hypertension and R28 requires healthcare monitoring related to diagnosis of diabetes. This care plan documented R28 is receiving oral glycemic, insulin, and/or blood glucose monitoring daily. R28 is at risk for episodes of hyperglycemia or hypoglycemia. Approaches for this care plan include blood glucose monitoring as ordered, administer medication as ordered, monitor vital signs during routine care and notify MD of abnormal findings. R28's care plan documented R28 is at risk for pain related to some impaired mobility and diagnoses of osteoarthritis, diabetes, and neuropathy with interventions including administer pain medications as ordered. This care plan also documented R28 is on an anticoagulant for a diagnosis of chronic DVTS (deep vein thrombosis) with an approach to administer medication as ordered.

On 1/28/25 at 3:15 PM R28 stated she is a brittle diabetic, on insulin, gets her blood sugar checked all the time normally but hasn't had her blood sugar checked since last night, no insulin nor any meds today, pain is at a 10 right now in neck, legs, and back. R9 stated she was about to start

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using her wheelchair again instead of walking with her walker because her legs hurt so bad. R28 stated she takes oxycontin for pain, but she has not received any medication all day.

R28's MAR, dated 1/1/25 - 1/30/25, documented R28 has physician orders including amlodipine 10 mg daily for hypertension, atorvastatin 40 mg daily for hyperlipidemia, buspirone 15 mg BID for anxiety, Eliquis 5mg BID for prevention of blood clots, gabapentin 400 mg TID for neuropathy, blood glucose monitoring QID (4 times per day), insulin lispro 100 unit/5ml administer 5 units QID with meals, Lantus insulin 20 units once a morning, insulin 100 unit/ml amount to administer per sliding scale based on blood glucose monitoring results TID, losartan 50 mg daily for hypertension, and lurasidone 40 mg daily for diagnosis of depression with psychotic symptoms. This MAR documented on 1/28/25 by the night nurse these meds were not administered: other comment: done by previous nurse. R28's EMR including MAR does not document any blood glucose monitoring was completed as ordered on 1/28/25 at 7:30 AM, 11:30 AM nor at 4:30 PM. R28's MAR documented R28's blood glucose level was 293 and 386 on the following day, 1/29/25, after R28 did not receive her insulin as ordered on 1/28/25. R28's EMR does not document any physician notification regarding R28's medications being held nor late. R28's orders do not document an order for R28's medications to be held nor to be administered late for 1/28/25.

On 2/4/25 at 11:50 AM R28 stated she did not receive any medications on 1/28/25 until after 4 PM. R28 stated she did not feel like herself, had anxiety, a headache from not receiving her blood pressure medications, and experienced a lot of

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pain due to not receiving her medications on 1/28/25. R28 also stated her blood sugar ran high that next day on 1/29/25.

On 2/4/25 at 9:18 AM V17, Physician/Medical Director/Owner, stated the facility did not notify him until 1 PM on 1/28/25 about the 200 wing not having a nurse and residents not receiving medications. V17 stated V2, DON, could have passed the medications on 1/28/25 before 4 PM, that she did have access to paper MARs, DON is not capable of doing the job, and I am going to replace her as soon as I find someone else to do the job. V2 sits in her office and doesn't do her job. V17 stated there could have been negative outcomes related to the residents not receiving diabetic and blood pressure medications such as hyperglycemia and elevated blood pressure. V17 stated he would have expected V2 to be monitoring the diabetic residents' blood sugar and should have been checking blood pressures for residents that didn't receive medications for hypertension.

On 2/4/25 at 3:27 PM V1, Administrator, was asked by surveyor if the facility considers the issue with 200 hall not having a nurse on 1/28/25 and medications not being administered or administered 8 hours late a medication error and V1 replied "oh gosh yes, 100%."

The facility's Administering Oral Medications policy, dated 9/2003, documented the purpose of this procedure is to provide guidelines for the safe administration of oral medications. General Guidelines: 1. Always verify the "5 Rights" before administering medications - the right medication; the right dose; the right resident; the right route; and the right time. 2. Be familiar with the resident's medical diagnosis and reason for

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administering the drug, as well as contraindications, unusual dosages, side effects, and intended outcome of the drug. 3. Double check the Medication Administration Record (MAR) against physician orders before administering medications. It continues, 6. Administer medications within one (1) hour before or after their scheduled time.

The facility's Medication Errors and Drug Reactions policy, dated 9/2003, documented the purpose of this procedure is to establish uniform guidelines in the reporting and recording of medication errors and drug reactions. 1. All medication errors and drug reactions must be promptly reported to the director of nursing services, attending physician, and the pharmacist. 2. A detailed account of the incident must be recorded in the resident's medical record. 3. Residents receiving incorrect medication or having a drug reaction must be closely monitored. Any change in the resident's condition must be immediately reported to the director of nursing services and attending physician. 4. The nurse supervisor will be responsible for completing an incident report and submitting a copy to the director of nursing services and a copy to the administrator. 5. All incident reports relating to medication errors and drug reactions will be reviewed by the Pharmaceutical Services Committee at their next regularly scheduled meeting.

Lack of HOT WATER.

On 1/22/25 at 12:43 PM, V1, Administrator, stated there was a massive water leak in the Facility. She was unsure of the exact reason, but the water has been cold for a couple of days now. She stated V12, Maintenance Supervisor, just

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started on 1/20/25, was unsure if he would be able to fix it and was unsure when the problem would be resolved.

The Facility's water temperatures in the 112-115 Hall Shower Room were tested with a metal calibrated thermometer after running hot water for greater than one minute on the follow dates/times with the following temperatures: On 1/22/25 at 12:33 PM, the peak temperature was 85 degrees (°) Fahrenheit (F); on 1/23/25 at 9:40 AM, the peak temperature was 83° F; and on 1/24/25 at 7:37 AM, the peak temperature was 82° F.

The Facility's Water Temperatures in the 200-211 Hall Shower Room were tested with a metal calibrated thermometer after running hot water for greater than one minute on the following dates/times with the following temperatures: on 1/22/25 at 12:22 PM, the peak temperature was 75° F; on 1/23/25 at 9:32 AM, the peak temperature was 75° F; and on 1/24/25 at 7:25 AM, the peak temperature was 58° F.

The Facility's Water Temperatures on the 212-221 Hall Shower Room were tested with a metal calibrated thermometer after running hot water for greater than one minute on the following dates/times with the following temperatures: On 1/22/25 at 12:26 PM, the peak temperature was 85° F; on 1/23/25 at 9:35 AM, the peak temperature was 83° F; on 1/24/25 at 7:27 AM, the peak temperature was 80° F.

R1's Bathroom Sink Water Temperature was tested with a metal calibrated thermometer after running hot water for greater than one minute on the following dates/times with the following temperatures: On 1/22/25 at 3:10 PM, the peak temperature was 86° F; on 1/24/25 at 9:47 PM,

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the peak temperature was 80° F; and on 1/24/25 at 12:46 PM, the peak temperature was 83° F.

R3's Bathroom Sink Water Temperature was tested with a metal calibrated thermometer after running hot water for greater than one minute on the following dates/times with the following temperatures: On 1/22/25 at 4:05 PM, the peak temperature was 73° F.

R4's Bathroom Sink Water Temperature was tested with a metal calibrated thermometer after running hot water for greater than one minute on 1/22/25 at 4:10 PM, the peak temperature was 83° F.

R12's Bathroom Sink Water Temperature was tested with a metal calibrated thermometer after running hot water for greater than one minute on the following date/times with the following temperatures: On 1/24/25 at 9:55 AM, the peak temperature was 79° F; on 1/24/25 at 12:52 PM, the peak temperature was 72° F.

On 1/29/25 at 7:20 AM, the shower in the 212-221 Hall Shower Room was turned on, and no water came out of the faucet. No water was available for showers.

On 1/29/25 at 7:23 AM, the shower the 201-212 Hall Shower Room was turned on, but only a trickle of water came out of the faucet. No water was available for showers.

On 1/29/25 at 7:27 AM, the shower in the 100 Hall Shower room was turned on, but only a trickle of water came out of the faucet. No water was available for showers.

On 1/29/25 at 7:29 AM, the hot water in R3's

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bathroom faucet came out at a slight trickle. R3 stated there was no announcement that water was going to be turned off in the Facility.

On 1/30/25 at 7:25 AM, the water temperature of the 201-211 Hall Shower Room was tested with a metal calibrated thermometer after running hot water for greater than one minute. The water measured 61°F.

On 1/30/25 at 7:27 AM, V21, CNA, stated there is still no hot water in the Facility.

On 1/30/25 at 7:35 AM, R44 stated there is still no hot water in the Facility. R44's bathroom sink water was tested with a metal calibrated thermometer after running hot water for greater than one minute. The water measured 70°F.

On 1/30/25 at 7:45 AM, R18's bathroom sink water was tested with a metal calibrated thermometer after running hot water for greater than one minute. The water measured 61°F.

On 1/31/25 at 7:27 AM, the water temperature in the 201-211 Hall Shower Room was tested with a metal calibrated thermometer after running hot water for one minute. The water measured 71°F.

On 1/22/25 at 12:30 PM, R1 stated, "The water in the shower is always too cold. There is a problem with the sewer, and it just won't get warm."

R1's Minimum Data Set (MDS) dated 12/31/24 documented R1 was cognitively intact, used wheelchair and required partial assistance with bathing.

On 1/22/25 at 1:35 PM, R3 stated, "There has been no hot water in the Facility for a week. If

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they can't fix it, they can't complain about me stinking. I would do a sponge bath if we could microwave a bucket of water." R3 stated "The hot water has been an absolute mess in the past and has gone on before for one and a half weeks (at a time). They fix the plumbing in bits and pieces, but it has been a periodic problem." R3 stated "I know the Facility is falling apart, but that's borderline abuse having you shower in the cold water."

R3's MDS dated 12/4/24 documented R3 was cognitively intact, ambulated via wheelchair, and required supervision with bathing.

On 1/22/25 at 1:44 PM, R4 stated the shower water is not hot at all. He added, "The Facility has lots of busted pipes and a major leak. I have been taking a sink bath for weeks. I'm getting tired of it too. I'd really like to go wash off in there. I'm almost to the point where I'm thinking about having them microwave a bed pan of water. I haven't had a hot sink bath in a while."

R4's MDS dated 11/14/24 documents R4 was cognitively intact, ambulated via wheelchair and required partial assistance with bathing.

On 1/23/25 at 11:35 AM, R9 stated the Facility has not had hot water in a week, and nobody in the building has taken a shower because of it.

R9's MDS dated 12/12/24 documented R9 was moderately cognitively impaired, used walker and required substantial assistance with bathing.

On 1/24/25 at 7:30 AM, R10 stated showers have been cold for the past week, and he has just been doing "wash ups." He stated he would prefer to take a shower.

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R10's Face Sheet documents R10 was admitted to the Facility on 3/20/23.

R10's MDS dated 12/7/24 documented R10 was cognitively intact, ambulated with cane, and was independent with bathing.

On 1/24/25 at 7:46 AM, R11 was standing at the 100 Hall Nurse's station with a towel wrapped around her head, shivering. She stated she just took a shower, and even after giving the water time to warm up, stated, "It was freezing. I'm not gonna do that again."

R11's MDS dated 12/9/24 documented R11 was independent with cognitive skills for daily decision making. R11's bathing and mobility needs were not assessed.

On 1/24/25, at 10:20 AM, R9 and R13 were in their room. Entered room. R9 stated they have no hot water, and she hasn't taken a shower in a week. When asked if the water is warm, she said "no". R13 stated they have had to use wipes. R13 stated "I don't like them." R9 stated several weeks ago the sewer backed up into the room. R9 stated "The owner is an a****** and doesn't care about the residents at all and it's all about the money to him so he doesn't care."

On 1/24/25, at 10:28 AM, R20 and R21 were in their room. R20 stated that they have not hot water. R20 stated they were not able to bathe. R21 stated that they have had no showers. R21 stated "I just use a washcloth and pointed to the bathroom." Surveyor asked if water was warm and R20 got up and said, "Let's go look." R20 walked in the bathroom with him, he turned on hot water and water was lukewarm too touch.

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R20 stated "It's not warm, it's still cold." R21 stated it has been that way for a while.

On 1/28/25, at 9:25 AM R25 stated that he has been here for 4 months and doesn't want to stir up trouble. R25 said that the facility has been without hot water for a long time. R25 said that he had to call family and discuss if he could go out to get a shower. He said that it has taken too long to fix. He said no one should have to live like this. He stated that he was concerned because without hot water they can't bathe or wash their hands. He said that some of the residents are concerned about infection control. He said that this morning, he went to the kitchen and got hot water out of the coffee machine. He said it was too hot, so he had to mix cold with it to wash up. He said, "We shouldn't have to do this." He again said they everyone tell them that they are working on it, but nothing is done.

On 1/29/25 at 7:50 AM, R41 stated the water is cold all of the time, so he does not want to shower. He stated, "I'm sorry, but I am type 1 diabetic and ...." R41 trailed off and began to cry. R41's MDS dated 11/30/25 documented R41 was cognitively intact and required supervision with showering.

The Facility's Resident Council Meeting Minutes dated 12/3/25 document, "Pipes frozen" as an "Issue/Concern."

On 1/22/25 at 12:29 PM, V5, CNA, stated the water in the shower only got lukewarm the other day.

On 1/23/25 at 8:00 AM, V12, Maintenance Director, stated he just started working here on 1/20/25, and there are leaks in the tunnels. He

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stated V17, Medical Director, plans to get all new plumbing.

On 1/24/25 at 10:20 AM, V22, Certified Nursing Assistant (CNA), stated for the past week or two they have been having trouble getting warm water to perform perineal care. She stated it has not been getting not warm enough, and the residents do not care for it.

On 1/24/25 at 12:50 PM, V25, CNA, stated Facility water has been intermittently cold, and it is difficult to get the water warm enough for care. She stated the residents do not like it.

On 1/29/25 at 7:25 AM, V12 stated he was not aware the hot water was turned off, but was focusing on repairing the washing machine, because they had no functioning washing machine at that time.

On 1/29/25 at 7:27 AM, the shower in the 100 Hall Shower room was turned on, but only a trickle of water came out of the faucet. No water was available for showers.

On 1/29/25 at 7:29 AM, the hot water R3's bathroom sink was turned on, but only a trickle of water came out of the faucet.

On 1/29/25 at 7:30 AM, V25, Certified Nursing Assistant (CNA), stated the hot water is turned off today. She was told by night shift that the water had been turned off, and the plumber would be out today to fix it.

On 1/29/25 at 7:45 AM, V25, CNA, stated she was assigned to do showers today, but since there is not hot water she will catch up on other things. She stated they have been trying to get

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the water as warm as possible for peri care or just using wipes. She said the residents have been getting really on edge from not having hot water for so long.

On 1/30/25 at 7:51 AM, V12 stated the plumber was still working at the Facility when he left last night. The plumber told V12 he fixed one leak, but there is still one more leak to repair. V12 stated he went down to the basement, and the water is still running out of the pipes, so that means there is still a leak somewhere. The washing machine is working now. The issue was low water pressure when the plumber turned off the hot water.

On 1/30/25 at 8:37 AM, V17 stated the plumbers were here yesterday and are coming back today for a mixing valve that is very old and needs to be replaced. They are hoping the issue will be resolved today.

On 1/22/25 at 12:43 PM, V1 stated there was a massive water leak in the Facility. She was unsure of the exact reason, but the water has been cold for a couple of days now. She stated V12, Maintenance Supervisor, just started on 1/20/25, was unsure if he would be ableto fix it and was unsure when the problem would be resolved.

On 1/23/25, at 10:52 AM, V1 stated that the plumbing company provided a bid to the facility and V17 said it was okay. V1 stated she has sent the information to accounts payable. She noted that the plumbing company needed a deposit so they can work on the pipes in the basement and gain access to the service tunnels which contains the plumbing so they can "diagnose" the problem.

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S9999	Continued From page 66 On 1/27/25 at 1:26 PM, V17, Owner/Medical Director stated the Facility has been without hot water since last week. On 2/4/25 at 2:35 PM, V1 stated she would have expected the issue to be fixed sooner but did not think V17 understood the severity of the situation. She stated the Facility does not have a policy regarding functioning equipment. The Illinois Department on Aging "Residents' Rights for People in Long-Term Care Facilities" revised 11/18 documents, "Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life." The Policy documents "Your facility must be safe, clean, comfortable and homelike." The Facility's "Pneumonia Vaccine" Policy revised 2003 documents, "All residents will be offered the pneumococcal vaccine to aid in preventing infections and pneumonia." Document titled COVID Policy and Procedure dated 11/14/2022 stated that the COVID 19 policy is designed to outline the rules and regulations set forth by the Centers of Disease Control and the Illinois Department of Public Health in reference to testing requirements. The purpose: to facilitate a safe environment while meeting the needs of each resident, staff member and visitor. Testing requirements are as follows. This facility reserves the right to test residents twice weekly unless the resident does not prefer to be tested. Asymptomatic residents and health care personnel (HCP) with a close contact or higher-risk exposure with someone with severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection should have a series of three viral tests unless they are recovered from	S9999		

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COVID in the prior 30 days. Testing residents HCP for COVID-19 will be at least 24 hours after exposure and if negative, again in 48 hours after the first negative test and if negative, and if negative, again 48 hours after the second negative test. When the facility has a high transmission rate, a new admission will be tested on the date of admission, and if negative again 48 hours after the second negative test. Residents will be advised to wear source control for 10 days following their admission, day 0 is the date of the admission. Residents who leave the facility for 24 hours or longer, regardless of vaccination status, should generally be managed as an admission and managed as above. Testing is not required for residents who leave the facility for fewer than 24 hours. The facility will use a broad-based approach which will include the unit where the positive COVID-19 case was identified. This includes any HCP who becomes positive for COVID-19. The residents and HCP working the unit will be tested every 3-7 days until there are no more positive cases identified for 14 days. The facility will test every 3-7 days until there are no more positive cases identified for 14 days. If additional cases are identified after testing a unit, the facility will expand testing to facility-wide testing if testing and implementation of infection control measures have failed to halt transmission.

The facility's Administering Oral Medications policy, dated 9/2003, documented the purpose of this procedure is to provide guidelines for the safe administration of oral medications. General Guidelines: 1. Always verify the "5 Rights" before administering medications - the right medication; the right dose; the right resident; the right route; and the right time. 2. Be familiar with the resident's medical diagnosis and reason for administering the drug, as well as

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contraindications, unusual dosages, side effects, and intended outcome of the drug. 3. Double check the Medication Administration Record (MAR) against physician orders before administering medications. It continues, 6. Administer medications within one (1) hour before or after their scheduled time.

The Facility's Daily Census Report dated 1/23/25 documents there are 71 residents living in the Facility.

(A)

Statement of Licensure Violation 2 of 2

300.610a)
300.1210a)
300.1210b)
300.3210t)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1210 General Requirements for Nursing and Personal Care

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S9999	Continued From page 69 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These requirements were not met as evidence by: Based on observation, interview and record	S9999		

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review, the facility failed to conduct a thorough investigation of resident neglect and implement corrective actions to prevent further resident-to-resident abuse for 3 of 7 residents (R2, R22, R23) reviewed for correction of alleged violations of abuse in the sample of 48. This failure resulted in the facility's failure to implement corrective action after an initial resident-to-resident abuse incident which resulted in R22 and R23 again having an altercation resulting in R22 hitting R23 and R23 sustaining a black eye and nosebleed.

Findings include:

1.On 1/27/25 at 9:28 AM R23 was lying in bed. R23's right eye had a dark bruise covering the eyelid and under his eye. Resident was unable to answer questions. R22's resides in the room across the hall from R23.

R23's Progress Note, dated 12/3/24 at 1:12 AM documented R23 had an altercation with another resident incident occurred in hallway and was witnessed by writer both residents exchanged words and were observed hitting one another resident was bleeding from his nose no other injury noted resident unable to verbalize pain resident had no S/S distress both residents separated and moved off same hall.

On 1/28/25 at 10:26 AM surveyor requested the incident investigation for the resident-to-resident altercation that was documented in R23's Electronic Medical Record (EMR) on 12/3/24. V1, Administrator, stated the other resident was R22 and she would look for the investigation.

The facility's serious injury incident final investigation report, dated 12/9/24, documented

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R22 stated he was hit in the back of the head by R23 and that he hit R23 back. R23 did not answer when he was asked, which is not unusual for him. Based on the witness statements and the resident statement, the facility does believe that this incident did occur. The two residents do not reside on the same hall and all efforts will be taken to prevent this from occurring again.

R23's Care Plan, dated 11/14/24, documented R23 was at risk for abuse and/or neglect related to impaired mobility, history of psychiatric illness, use of psychotropic medications, wandering behavior and diagnoses of dementia and schizophrenia. The Care plan interventions, dated 11/14/24, documented "Assure resident that he/she is in a safe and secure environment with caring professionals" and "identify areas that put resident at risk." No interventions were put into on 12/3/24 after the resident-to-resident incident with R22.

R23's Progress Note, dated 1/24/25 at 8:52 PM, documented Certified Nurse's Aide (CNA) came to this nurse and stated that resident was hit by another resident, resulting with resident having a nosebleed. Residents already separated when this nurse was made aware of situation. Pressure applied and bleeding controlled.

On 1/27/25 at 9:33 AM V1 stated there was a resident-to-resident altercation Friday night (1/24/25) between R22 and R23. V1 stated R23 is confused and wandered into R22's room. R22 punched R23. V1 stated she has not put any interventions in place to prevent any further incidents between R22 and R23 because she is still investigating.

On 1/27/25 at 11:25 AM R22 stated "I did swing at

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R23, he came in my room and was messing with my clothes, he swung at me, so I hit him."

R22's Face Sheet, print date of 1/29/25, documented R22 has diagnoses of alcoholic cirrhosis, type 2 diabetes, metabolic encephalopathy, colon cancer, and chronic kidney disease.

R22's Minimum Data Set, MDS, dated 10/29/24, documented R22 is cognitively intact and requires partial/moderate assistance with transfers to and from wheelchair.

R22's Care Plan, revision date of 7/29/24, documented R22 has been accused of suspected actual abuse related to a physical incident that occurred between R22 and another resident of the facility. Interventions include ensure the safety of those in contact with me by providing close observation and intervention for behavioral outbursts, remind me when my actions are inappropriate and provide me re-direction as needed, observe me closely Q (every) shift for behaviors and ensure treatment and reporting to provider as indicated. R22's Care Plan was not revised with interventions on 12/3/24 and 1/24/25 when he had a resident-to-resident altercation with R23.

R22's Progress Note, dated 1/24/25, documented CNA came to this nurse and stated that resident hit another resident, causing the other resident to have a nosebleed. Residents already separated from each other when this nurse was made aware of situation. This nurse asked resident why he hit another resident. Resident replied, "because he came in my room." This nurse informed resident that he should not be hitting people. Resident became aggressive yelling "he

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tired of staff taking up for other residents and if somebody hits him, he's gonna hit them back." 911 called. ADON (Assistant Director of Nursing) and Administrator notified. When police arrived, resident refused to go to hospital for evaluation. ADON and Administrator aware of refusal. Resident in room laying in bed at this time.

On 1/27/25 at 11:30 AM V13, Licensed Practical Nurse, LPN stated she did get in report that R23 was punched by R22 and developed a bloody nose and black eye.

On 1/28/25 at 8:44 AM V1 stated R22 gets easily angered and can go from 0 to 100 pretty quickly. R23 does pester others. R22 does have a history of verbal abuse against other residents. I will have to check and see if he has a history of physical abuse towards others.

On 1/28/25 at 9:25 AM V33 LPN stated R22 does have a history of verbal aggression towards other residents and that R22 does tell other residents he will beat them up. V33 stated R23 has a history of putting his fists up at residents and giving them the finger. V33 also stated R23 has a history of wandering into other resident's rooms.

On 1/28/25 at 11:35 AM V1 stated R22 or R23 should have been moved to another hall after the resident-to-resident altercation on 12/2/24. V1 stated 100% one of them should have been moved at that time. R23 did get a bloody nose from R22 on 12/2/24.

On 1/28/25 at 11:45 AM R22 and R23 continued to reside in rooms on the same hall and across from one another.

On 2/3/25 at 8:52 AM V1 stated R22 and R23 are

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still residing on the same hall and across from one another.

2. R2'sMinimum Data Set, MDS, dated 1/9/25, documented R2 is cognitively intact.

The facility's Serious Injury Incident Report that was sent to, (State Agency), dated 1/21/25, documented on 1/15/25 at 7:00 PM It was reported that R2 was in her room yelling and hitting her head on the wall and that the nurse, V18, did not address R2 but instead closed the double doors on her hall so that the noise could be stifled. R2 called 911 for transport to ED (Emergency Department) for suicidal ideations. EMS (Emergency Medical Services) came to the facility to pick R2 up and the nurse V18 was not aware. When EMS arrived to the facility, it was reported by the EMS that V18 refused to give them the necessary paperwork to contact R2's guardian and that they would have to take it up with management as she "was not dealing with it." When these allegations were reported to the administrator, V18 was suspended pending an investigation. Interviews were not able to determine with certainty that V18 closed the doors in an effort to ignore R2's crying, the EMS was able to corroborate the interaction with V18. A statement from V18 denied both allegations. The facility is not able to substantiate that neglect did occur, however this does not represent the best practices that the facility expects from it nurses and did terminate V18. It cannot be determined with absolute certainty that this did occur, so it is considered unsubstantiated.

On 1/23/25 at 8:59 AM V1, Administrator, stated she submitted the final investigation into the nurse V18. Stated she received a phone call from the EMT (Emergency Medical Technician) that

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was transporting R2 to the hospital and the EMT stated V18 LPN (Licensed Practical Nurse) refused to hand over R2's paperwork for the hospital transfer. Her investigation revealed that the nurse V18 did close the double doors that night, so she didn't have to listen to R2. V1 stated she did fire V18 for neglect.

On 1/23/25 at 10:22 AM V1 stated she does not have any written statements from the EMTS who transported R2 to the hospital. V1 stated she does not know the names of the EMTS who transported R2 to the hospital that night. V1 stated she was at home when she received a phone call from one of the EMTS and she did not document the conversation nor get the EMTS names. V1 stated the EMT did substantiate that V18 refused to provide the EMTS R2's paperwork for transfer to the hospital and that V18 stated to the EMTS, 'I am not dealing with this'.

On 1/23/25 at 10:43 AM, V1 stated "I'm not having any luck finding out who the EMTS were that transported R2 on the 15th. Surveyor asked V1 if the facility has surveillance cameras. V1 stated yes but I haven't checked the footage yet to see if the hallway doors were closed. Surveyor asked V1 if she would consider it neglect if the nurse did shut the fire doors and V1 stated absolutely 100%. Surveyor asked V1 how her abuse investigation concluded no abuse nor neglect occurred without her interviewing the EMTS and reviewing the video footage and V1 replied "I thought I did conclude neglect; I will have to look at the investigation again and may have to update the final investigation."

On 1/28/25 at 9:40 AM Surveyor requested resident interviews for the investigation into the allegation with R2 and V18 LPN from V1. V1 was

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unable to provide any resident interviews.

The facility's Abuse Prevention Program policy, undated, documented IV. resident assessment: as part of the resident social history and evaluation and MDS assessments, or who have needs and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals, and approaches, which would reduce the chances of abuse, neglect, or mistreatment for these residents. It continues, V. internal reporting requirements and identification of allegations: Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, or misappropriation of property immediately to the administrator or in the absence of the administrator the person in charge of the facility. VII. Protection of residents, the facility will take steps to prevent mistreatment while the investigation is underway. Residents who allegedly mistreated another resident will be removed from unsupervised contact with other residents during the course of the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement, considering his or her safety, as well as the safety of other residents and employees of the facility. It continues, VII. Internal investigation of Abuse, Neglect, or Misappropriation Allegations and Response: 1. All incidents of alleged abuse will be documented. 2. Any incident or allegation involving abuse, neglect, or misappropriation will result in an investigation. 3. For any other incident or pattern involving "reasonable cause to suspect abuse, neglect, or misappropriation", the administrator will appoint a person to gather further facts prior to making a determination to conduct an abuse investigation. An injury should

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be classified as an "injury of unknown source" when both of the following conditions are met: The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. 4. Following the Resident Protection Abuse Investigation Procedures the appointed investigator will investigate as required; interview relevant staff, resident(s), or any other person that can provide information; and be sensitive to resident confidentiality concerns. It continues, 6. Final Abuse Investigation Report. The final investigation report shall contain the following: Name, age, diagnosis and mental status of the resident allegedly abused or neglected; The note day, time, location, the specific allegation, by whom, witnesses to the occurrence, circumstances surrounding the occurrence and any noted injuries made; Facts determined during the investigation; Conclusion of the investigation based on known facts; Police notification; If the allegation is determined to be valid and the perpetrator is an employee, include the employee's name, address, phone number, title and current status (still working, suspended or terminated). The administrator or designee will review the report. The administrator or designee is then responsible for forwarding the final written report of the results of the investigation and of any corrective action taken to the (State Agency) within five working days of the reported incident. The administrator or designee is also responsible for informing the resident or their representative of the results of the investigation and of any corrective action taken. 7. Quality Management

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005961	A. BUILDING: _____ B. WING _____	R-C 03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AU WELL CARE HOME, INC	152 WILMA DRIVE MARYVILLE, IL 62062

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 78 Review. Any investigation that concluded that abuse occurred shall be reviewed by the facility Quality Assurance Committee. VIII. External Reporting of Allegation. If mistreatment has occurred, the resident's representative and the Department of Public Health shall be informed as soon as possible within 24 hours. A written report shall be sent to the (State Agency) regional office. The written report should contain the following information, if known at the time of the report: Name, age, diagnosis, and mental status of the resident allegedly abused or neglected. Date, time, location, and circumstances of the alleged incident. Any obvious injuries or complaints of injury. Steps the facility has taken to protect the resident. The administrator or designee will also inform the resident or resident's representative of the report of an occurrence of potential mistreatment and that an investigation is being conducted. 2. Five-day Final Abuse Investigation Report. Within five working days after the initial report of the occurrence the final report will be sent to the (State Agency). (B)	S9999		