STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055095	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ROLLING MEADOWS,THE	4225 KIRCHOFF ROAD , ROLLING MEADOWS, Illinois, 60008

(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) COMPLETION DATE
S0000	Initial Comments Annual Licensure Survey	S0000		
S9999	Final Observations Statement of Licensure Violations 1 of 5 300.615e) 300.615f) Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act) f) The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and record reviews, the facility failed to follow its policy in conducting background checks within 24 hours of admission and fingerprints	S9999		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055095	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2025

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S9999	Continued from page 1 within 72 hours of background check results. These failures apply to 4 (R4, R11, R12, R13) of 10 residents reviewed for admission screening. These deficiencies also have the potential to affect the 123 residents currently residing in the facility. Per census report, there are 123 residents currently residing in the facility. On 07/08/2025 at 1:38 PM during review of documentation pertaining to background checks, the following were presented by facility: R4 is a 45-year-old-male admitted to the facility on 07/01/2025 with diagnosis including but not limited to Multiple Sclerosis; Leukocytosis; Neurogenic Bladder; Spasticity; Weakness; Colostomy Care; Ileus; Urinary Tract Infection; Pneumonitis; Anxiety; Diarrhea; Central Pain Syndrome; Gastrointestinal hemorrhage; Rectal Bleeding; and Dysuria. There were no records on file that his Illinois sex offender registry was checked upon admission. R4's Criminal History Information Response Process (CHIRP), the department of corrections were checked within required time frame. R4 has no criminal history; therefore, no fingerprints were required during his background check process. R11 is a 73-year-old male admitted to the facility on 03/26/2019 with diagnosis including but not limited to Senile Degeneration of Brain; Type 2 Diabetes Mellitus with Diabetic Neuropathy; Osteomyelitis of Vertebra, Lumbar Region; Malignant Neoplasm of Prostate; Neuromuscular Dysfunction of Bladder; Major Depressive Disorder; Unspecified Dementia; And Wernicke's Encephalopathy. There were no records on file that his state sex offender registry, and department of corrections were checked upon admission. R11's Criminal History Information Response Process (CHIRP) was checked on 07/06/2023. R11 has confirmed criminal background history; R11's fingerprints were checked 02/13/2024. R12 is a 55-year-old male admitted to the facility on 07/25/2023 with diagnosis including but not limited to Aphasia; Asthma; Dementia in Other Diseases Classified Elsewhere; Restlessness and Agitation; Alzheimer's	S9999		

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S9999	Continued from page 2 Disease; Anxiety Disorder; Depression; Personal History of Other Diseases of The Nervous System and Sense Organs; And Bell's Palsy. R12's Criminal History Information Response Process (CHIRP) was checked on 08/30/2023. R12's state sex offender registry and department of corrections were checked within required time frame. R12 has confirmed criminal background history; R12's fingerprints were checked 02/13/2024. R13 is a 43-year-old male admitted to the facility on 02/12/2025 with diagnosis including but not limited to Spondylolisthesis; Traumatic Subdural Hemorrhage with Loss of Consciousness of Unspecified Duration; Orthostatic Hypotension; Traumatic Subdural Hemorrhage with Loss of Consciousness of Unspecified Duration; Schizophrenia; Bipolar Disorder; Anxiety Disorder; Depression; And Post-Traumatic Stress Disorder. R13's Criminal History Information Response Process (CHIRP) was checked on 04/23/2025. R13's state and national sex offender registry and department of corrections were checked within required time frame. R13 has confirmed criminal background history; R13's fingerprints were checked 05/27/2025. On 07/08/2025 at 1:38 PM V26 (Admissions Director) said, "I've been working in the facility for three weeks now. R11's CHIRP (Criminal History Information Response Process) was not verified until former admission's director ran it in July of 2023. R11's state sex offender registry and state department of corrections checks were never done. R11 has a confirmed criminal background check. R12 is missing state sex offender registry. R4, R11, and R12 should have had these checks done upon admission. I will make sure it is done immediately, especially that they have confirmed criminal background checks. It is important to know residents' criminal background checks to make sure everyone around is safe." On 07/09/2025 at 1:58 PM V1 (Administrator) said, "Once we find out we are getting a new resident into the facility, we try to check their background checks as soon as possible, preferably before the resident arrives to the facility as soon as possible. It is important to check residents' background checks for safety of other residents and staff, and to make sure	S9999		

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S9999	Continued from page 3 they are a right fit for us, and we are a right fit for them." The facility "Resident Background Checks/Sex Offender" policy last reviewed 01/18/2025 reads in part, "When a resident is admitted to a facility, an electronic name based UCIA background check must be ordered within 24 hours, unless the resident was admitted from a hospital and the hospital notified the facility that the UCIA name check was ordered. Once the facility determines the resident is an Identified Offender, the facility must arrange for the resident to undergo a live scan State and FBI (national) fingerprint-based Fee Applicant criminal history check within 72 hours." (C) 2 of 5 Section 300.2100 Food Handling Sanitation Every facility shall comply with the Department's rules entitled "Food Code." (Source: Amended at 49 Ill. Reg. 760, effective December 31, 2024) These requirements were NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to follow proper food storage and kitchen practices, failure to monitor and record dishwasher temperatures, and failed to ensure all staff wore hair nets to prevent the spread of food-borne illness and contamination. These failures have the potential to affect all 121 residents receiving meals from the kitchen. Findings include: On 07/08/25, V7 (Dietary Manager) provided facility census 121 residents currently receiving prepared food from the kitchen. On 7/07/25, at 10:20am the following were observed in the kitchen during initial tour: Kitchen floors are wet with water and food debris; oven visible with layers of grease and baked-on food remnants. Industrial stove was on with low flame and	S9999		

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S9999	Continued from page 4 empty pot overheating. In the reach-in refrigerator, the following food items were not labeled with no open or expiration dates: unidentified red sauce in a plastic container, unidentified mayonnaise-based salad, brown gravy in a plastic container, cut up melon, beans, unidentified dark brown liquids in a small plastic cup, unidentified and uncovered yellow liquid in a square container, red colored liquid in a pitcher, and orange colored liquid in a pitcher. In the walk-in refrigerator, the following food items were observed: 12 opened containers of cups of apple sauce with plastic wrap without open dates, 24 opened small container cups of white pudding with plastic wrap with no dates; red colored chopped food items in small container cups with no dates. In the walk-in freezer, an opened bottle of tequila was sitting on top shelf reserved for frozen food items. In the dry storage area, more than a dozen of individually plastic wrapped sandwich bread were in a metal container with no label, and no date. Under the metal food prep table, were two empty red sanitizing buckets without any sanitizing solution. It was observed that V8 (dietary tech) was not wearing a hair net. Last recorded dish wash machine temperature was 7/02/2025. On 7/07/25 at 1:30pm in the reach-in refrigerator, a plate of shredded lettuce and metal container of scrambled eggs without open and expiration dates. In the walk-in freezer, opened bottle of tequila (liquor) on the top shelf. Surveyor asked V7, if bottle of alcohol belonged in the freezer. V7 said, "No" and removed the bottle.	S9999		

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S9999	Continued from page 5 Facility's Policy titled "Sanitation" dated/reviewed 8/01/23 stated in part: Policy: The food service area shall be maintained in a clean and sanitary manner. Procedure: All kitchen, kitchen areas, and dining areas shall be kept clean, free from litter and rubbish, and protected from rodents, roaches, flies and insects. All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks, and chipped areas. Facility's policy titled "Food Storage (Dry, Refrigerated and Frozen)" stated in part: Policy - Food storage areas will be clean, dry and maintained at temperatures as required to ensure food safety. Procedure: All open products (as able) will be sealed (rolled closed, wrapped closed, with lid closed, etc) to ensure quality and prevent contamination against pests or rodents. Goods that have been opened with no date, left on the floor, or not properly sealed will be discarded. All outdated goods will be discarded the day after expiration. Food stored in bins are removed from original packaging. Bins are labeled and dated. Scoops stored outside of bin in clean, designated space. Foods stored in these containers are used until bin is completely empty then sanitized. New package can then be opened and emptied into bins with updated date of open. All open products are sealed, labeled and dated. Refrigerated Foods: Open products are sealed, labeled, and dated. Frozen Foods: Frozen foods are placed in the freezer upon receipt. If taken out of original packaging, product is labeled and dated. (C) 3 of 5 300.2210a) 300.2210b)1)2)3) Section 300.2210 Maintenance a) Every facility shall have an effective written plan for maintenance, including sufficient staff, appropriate equipment, and adequate supplies. b) Each facility shall: 1) Maintain the building in good repair, safe and free	S9999		

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S9999	Continued from page 6 of the following: cracks in floors, walls, or ceilings; peeling wallpaper or paint; warped or loose boards; warped, broken, loose, or cracked floor covering, such as tile or linoleum; loose handrails or railings; loose or broken windowpanes; and any other similar hazards. 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. 3) Maintain all electrical cords and appliances in a safe and functioning condition. Based on observation, interview and record review, the facility failed to maintain a metal electrical junction light box with an exposed live wiring lightbulb socket, and with protruding rusty metal edges within easy reach of cognitively impaired residents. Findings include: R6 is a cognitively impaired 76-year-old resident with medical diagnosis including but not limited to bipolar disorder; amyloidosis; congestive heart failure; stage 4 chronic kidney disease; and nephrogenic diabetes insipidus. R7 is a cognitively impaired 68-year-old resident with medical diagnosis including but not limited to cord compression; spinal stenosis; morbid (severe) obesity; chronic embolism and thrombosis of deep veins; and lymphedema. R18 is a cognitively impaired 83-year-old resident with medical diagnosis including but not limited to senile degeneration of the brain; Parkinson's disease; dementia; combined systolic and diastolic heart failure; and chronic obstructive pulmonary disease. On 07/07/2025 at 12:22 PM, two Surveyors entered a resident room with three cognitively impaired residents R6, R7, and R18. In the center of the room, on the right wall at the foot of the center bed, next to the bathroom entrance, was an exposed rectangular-shaped	S9999		

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S9999	Continued from page 7 metal electrical junction box housing a lightbulb socket, without a lightbulb, and had sharp rusted metal edges on the top right-hand corner of the electrical box. V18 (CNA) stated to both surveyors that she saw the uncovered metal box with the exposed lightbulb socket, that it used to be covered, and that she noticed it several days ago but did not report the issue to anyone. V17 (CNA) indicated he did not know what the open metal box with the exposed lightbulb socket in the room was, but did affirm that it appeared to be electrical in nature. V2 (Director of Nursing) said she did not notice the exposed electrical junction box in the resident room and was unaware of the issue, but would contact V19 (Maintenance Director) about it; however, V19 was on medical leave for several weeks now. Surveyors asked whether any staff covered for V19 in his absence, and V2 indicated that she contacted V16 (Housekeeper Director) to come up to the floor. V16 said he was in charge of the facility's maintenance in V19's absence. V16 was shown the electrical box with the exposed lightbulb socket in the residents' room by the Surveyors, indicating he was not aware of it, and adding that it appeared to be a night light box. Surveyors asked if the lightbulb socket wire was live, and V16 said he would put a light bulb in it to check, whereupon V16 installed a light bulb and the bulb lit up. Surveyor asked if he were to put his finger in the open socket if it would be safe or if he could get electrocuted; V16 said at first he was not sure, then added that he would not put his finger in the socket because it would definitely electrocute him. Surveyors also asked about the edges of the metal box itself, and V16 affirmed that the edges of the box were sharp and rusty, and could be a hazard that could injure a resident, visitor, family member, or staff. On 07/09/2025 at 10:15 AM, V19 said managers rounded the facility to see what was wrong with resident rooms, from Monday to Friday; any staff member could report room maintenance issues; and he was not aware of the exposed light socket in the resident room because no one reported the issue to him. (B)	S9999		

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S9999	Continued from page 8 4 of 5 300.510e) Section 300.510 Administrator e) The licensee and the administrator shall be familiar with this Part. They shall be responsible for seeing that the applicable regulations are met in the facility and that employees are familiar with those regulations according to the level of their responsibilities. This requirement is NOT MET as evidenced by Based on interview and record review, the facility failed to ensure that the Administrator enforced and implemented key abuse prevention policies by: failing to verify staff background checks before hire; and failing to ensure staff were trained on the abuse prevention policy , failed to ensure completed background checks including waivers and past disciplinary reprimands were investigated prior to hire, and failed to ensure abuse prevention training was provided to staff on a regular and continuing basis. These systemic failures have the potential to affect all 123 residents in the facility. Findings include: On 7/7/25 during an annual licensure survey, an allegation of inappropriate touching was made against V30 (LPN) night shift nurse who entered the room at approximately 12:30 after midnight of R6's room and did not knock and startled the resident by tapping on the resident's shoulder or feet (unknown), did not identify self, nor explain his purpose for waking the resident. R6 reported this to V1 administrator who telephoned V30 to interview this nurse but not request the staff person to come in person for face-to-face interview for her investigation. On 7/8/25 at 10:30 AM, V1 said to the survey team that she did not interview V29 (LPN) because the nurse worked at night and was not present during her work	S9999		

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S9999	Continued from page 9 hours. Surveyors asked if this was the normal procedure for investigating allegations of abuse or any sort of reported mistreatment voiced by residents, V1 indicated that she didn't hear anything from V29 that stood out as abusing or inappropriate to warrant the staff person to come in for in-person interview of the allegations made against him. Surveyor asked whether a person's mannerisms or body language can be observed over a phone interview, V1 said that she decided to just telephone V29 because again, the staff person worked at night and that she herself had no problems with V29 . Surveyors asked how she knew this as her hours did not coincide with V29 to come to this conclusion, V1 indicated that there were a few occasions when she'd come in at 6 in the morning and V29 was ending his shift at 7 AM. Surveyor asked if V29 was provided abuse training, V1 said that all staff were trained on abuse and would obtain abuse training regularly. R7 is a 68-year-old female with a diagnoses history of Spinal Stenosis (Spinal Cord Compression), Peripheral Neuropathy, Chronic Embolism and Deep Vein Thrombosis, and Generalized Muscle Weakness who was admitted to the facility 12/21/2021. 07/07/2025 12:45 PM R6 and R19 reported that V29 (Licensed Practical Nurse) woke them up out of their sleep by tapping them to attempt to "pass medications". R6 stated V29 nudged her awake and she told him don't touch me but continues on nudging her and touching her against her will. R19 confirmed that V29 has also done this to her, but he tapped her on the leg while she slept. R6 and R19 stated they reported this to V3 (Assistant Director of Nursing) and V1 (Administrator) a few days ago and V3 said she would take care of it because V29 he's not nice, doesn't talk to anyone or smile and just a general unease with the nurse. R6 and R19 reported being woken up by being tapped by V29 startled and scared them when it happened, and they are not comfortable with him as a nurse. R19 stated V3 (ADON) told her if they receive one more complaint about V29 "he is gone". R6 is a 76-year-old alert and oriented female with a diagnoses history of Heart Disease, Stage 4 Chronic Kidney Disease, Aphasia (Communication Disorder), who was admitted to the facility 04/02/2025. R19 is a 76-year-old female with a diagnoses history of Generalized Anxiety Disorder, Major Depressive	S9999		

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S9999	Continued from page 10 Disorder, Adjustment Disorder, COPD, Heart Failure, and Mild Cognitive Impairment who was admitted to the facility 05/19/2023. 07/08/2025 11:53 AM V23 (Human Resources) stated she wasn't aware of any disciplines in V30 (Licensed Practical Nurse) background check records, she won't hire a staff if there are any red flags in their background, for example she didn't hire a nurse that had disciplinary action in her background reports due to narcotics. V23 stated because she didn't notice the waivers or disciplinary action in V29's background reports she didn't look into or inquire about what the discipline is for and agreed the disciplinary action could have been a red flag that prevented her from hiring V29. 07/08/2025 12:29 PM V2 (Director of Nursing) stated she couldn't find any abuse or customer service training for V29 (Licensed Practical Nurse) from 2024, and that staff should be receiving abuse training quarterly and yearly. 07/08/2025 1:39 PM R19 stated V29 (Licensed Practical Nurse) shouldn't be anyone's nurse because he doesn't smile or communicate and R6 stated V29 just needs to be more aware and tolerant of residents' rights. Review of V29's personnel file showed that V3 had a nursing waiver and disciplinary reprimands in his file that were not fully vetted by the V1 and her administrative staff including V2 (director of nursing), V3 (assistant director of nursing and V23(Human Resources). Review of the facility's Abuse Prevention Policy (revised date) states: "All allegations of abuse shall be immediately investigated and documented. Any employee accused of abuse shall be removed from resident care pending investigation. V29 (LPN) employee file lacked documentation of both orientation training on abuse prevention and ongoing annual training, in violation of the facility's own policy and 77III. Admin. Code 300.610 (a) V1 administrator acknowledged that she was unaware of	S9999		

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S9999	Continued from page 11 V29 (LPN) nursing waivers or history of past nursing disciplinary actions and that no system was in place to verify that all new hires had completed abuse training and regular retraining. This failure to enforces multiple critical regulatory requirements and demonstrates a lack of oversight and failure to meet the responsibilities outlined under 300.510 (e). The Administrator failed to ensure that the facility operated in compliance with applicable abuse prevention regulations, including proper investigation of allegations, staff training, and background checks. This constitutes a violation of 77 III. Adm. Code 300.510 (e) placing residents at risk for unaddressed abuse and inadequate protection. (B) 5 of 5 300.3240a) 300.3240b) 300.3240c) 300.3240d) 300.3240g) Section 300.3240 Abuse and Neglect a) No owner, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act) c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative and to the Department. (Section 3-610(a) of the Act) d) When an investigation of a report of suspected abuse	S9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ROLLING MEADOWS,THE	4225 KIRCHOFF ROAD , ROLLING MEADOWS, Illinois, 60008

(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) COMPLETION DATE
S9999	Continued from page 12 of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act) g) A facility shall comply with all requirements for reporting abuse and neglect pursuant to the Abused and Neglected Long Term Care Facility Residents Reporting Act. This regulation was NOT MET as evidenced by: Based on interviews and record reviews the facility failed to follow their policies and procedures for abuse by not reporting or investigating an allegation of staff to resident abuse and mistreatment, and by not ensuring that alleged staff were removed from the resident's care after an allegation of abuse. This failure applies to three of three residents (R6, R15, and R19) reviewed for abuse. Findings include: 1. R6 is a 76-year-old female with a diagnoses history of Heart Disease, Stage 4 Chronic Kidney Disease, Aphasia (Communication Disorder), and Bipolar Disorder who was admitted to the facility 04/02/2025. R19 is a 76-year-old female with a diagnoses history of Generalized Anxiety Disorder, Major Depressive Disorder, Adjustment Disorder, COPD, Heart Failure, and Mild Cognitive Impairment who was admitted to the facility 05/19/2023. On 07/07/2025 at 12:45 PM R6 and R19 reported that V29 (Licensed Practical Nurse) woke them up out of their sleep by tapping them to attempt to pass medications. R6 stated V29 nudged her awake and she told him don't touch me, call my name and I'll wake up. R19 confirmed that V29 has also done this to her and he tapped them on the leg. R6 and R19 stated they reported this to V3 (Assistant Director of Nursing) and V1 (Administrator) a few days ago and V3 said she would take care of it, he's not nice, doesn't talk to anyone or smile. R6 and	S9999		

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S9999	Continued from page 13 R19 reported being woken up by being tapped by V29 startled and scared them when it happened, and they are not comfortable with him as a nurse. R19 stated V3 told her if they receive one more complaint about V29 he is gone. Grievance form completed by V1 (Administrator) dated 06/25/2025 documents staff taking concern including V2 (Director of Nursing), V3 (Assistant Director of Nursing) documents R6 reported nurse did not knock enough and doesn't conversate when passing medications at night, with the resolution including educating the nurse about small conversation and knocking before entering, being careful not to wake residents in the same room. On 07/08/2025 at 9:22 AM V3 (Assistant Director of Nursing) stated she recalls receiving a report from R6 regarding V29 tapping them to wake them up and she and V1 (Administrator) educated V29 to knock or call out her name when knocking and entering her room, not to touch residents or tap them. V3 stated she doesn't recall R19 reporting this to her regarding V29, potential issues this behavior from the nurse includes the fact that V29 is a male and it would be startling to be woken up that way, V2 (Director of Nursing) stated alternatives to tapping residents would include calling out their names and gently tapping them, however she also stated that R6 told her she doesn't want to be touched, V2 stated she can't recall what R19's concern regarding V29 was and believes V1 (Administrator) completed the grievance documentation regarding R6's concern, V3 stated another alternative to tapping a resident awake if they don't hear their name called out or the staff doesn't want to disturb other residents by knocking is to tap on their foot board or possibly turn on their room light. V3 stated V29 apologized for tapping on R6 and suggested tapping on the foot board instead. On 07/08/2025 at 10:33 AM V2 (Director of Nursing) stated V1 (Administrator) completed the report of R6's grievance for 06/25/2025. On 07/08/2025 at 1:39 PM R19 stated V29 (Licensed Practical Nurse) shouldn't be anyone's nurse because he doesn't smile or communicate and R6 stated V29 just needs to be more aware and tolerant of residents.	S9999		

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S9999	Continued from page 14 2. R15 was an 83-year-old female with a diagnoses history of Recurrent Major Depressive Disorder, Anxiety Disorder, Congestive Heart Failure, Peripheral Vascular Disease, and Neuropathy who was admitted to the facility 09/05/2019 and expired 07/08/2025 after being transferred to the hospital for a medical emergency. On 07/08/2025 at 2:08 PM R15 stated V30 (Certified Nursing Assistant) threw her in bed like a sack of potatoes about two weeks ago and V30 was assigned to her once after this incident and she told them she didn't want her and wants to be more comfortable than that, V29 (Licensed Practical Nurse) won't talk to you when he works with you, just walks away from you and this makes her feel terrible and disrespected, and she has only had him as her nurse once, R19 stated V29's behavior also makes her feel disrespected. R15 stated she reported the incident regarding V30 to all the nurses. On 07/08/2025 at 2:10 PM V1 (Administrator), V2 (Director of Nursing), and V3 (Assistant Director of Nursing) stated they were not aware that R15 reported abuse from V30 (Certified Nursing Assistant). On 07/08/2025 at 2:31 PM R15 stated she reported the incident with V30 (Certified Nursing Assistant) to V6 (Registered Nurse). On 07/09/2025 at 11:29 AM V6 (Registered Nurse) stated on 06/14/2025 R15 reported that she was hurt when being transferred from wheelchair to bed by V30 (Certified Nursing Assistant) and that one of V30's hands were on her neck during the transfer, he reported this incident to V1 (Administrator) and also changed the assignment so that V30 would no longer work with R15 for the rest of the shift, he also texted V2 (Director of Nursing) that R15 will probably will report V30, V6 stated V1 advised she would make sure V30 would no longer work on the hall where R15 is located. Reportables for June 2025 received from V1 (Administrator) on 07/09/2025 did not include an allegation of abuse from R15. R15's Quarterly Minimum Data Set Assessment dated 07/02/2025 documents she has a Basic Interview for Mental Status Score of 15.	S9999		

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S9999	Continued from page 15 R15's current care plan documents she has a self-care performance deficit for activities of daily living and is totally dependent on two person staff assistance for transfers. R15's Current Care Plan initiated 07/08/2025 documents resident voiced claims of abuse while being provided care. The facility's Daily Staffing Schedules dated 06/14/2025 and 06/27/2025 documents V30 (Certified Nursing Assistant) was assigned to work on the floor where R15's room is located from 2PM - 10PM and her room assignments included R15's room. The facility's Abuse Investigation Reports dated 07/08/2025 documents R6 reported that a few weeks ago the nurse on night shift was not friendly and tapped the resident to get her attention; and R15 alleged the CNA (Certified Nursing Assistant) threw her like a sack of potatoes while changing her linens. On 07/08/2025 at 10:50 AM V1 (Administrator) stated R6 came into the V2's (Director of Nursing) office and reported she doesn't like V29 (Licensed Practical Nurse), he's not very friendly, and mentioned he was trying to get her up for medicine, and she doesn't think he knocked on the door, she didn't hear him, and you know he tapped her, R6 reported V29 said he knocked on the door but she didn't hear it but she'd rather not be tapped. V1 stated she spoke to V29 by phone on 06/25/2025 and asked him about what was reported. V1 stated she would say R6's cognitive ability is above 12 for sure; she asked R6 about any other concerns and if she felt ok and R6 said there was nothing else. V1 stated R19 also reported V29 was not friendly, and when asked for clarification she just said he doesn't talk too much. V1 stated she educated V29 on the phone that next time he goes in to see the resident say hello, maybe call their name a few times, and informed him that R6 doesn't want to be tapped. V1 stated she has not had any face-to-face customer service or abuse in-services with V29; When asked by the surveyor why she continues to reference abuse when being asked about what R6 reported about V29, V1 replied because if the resident's say V29's just not friendly they would attempt to get more information from the resident to rule out abuse and determine their wellbeing. When asked by the surveyor why the information regarding being tapped by V29 reported by R6 was not included in the grievance, V1 stated I thought "I had it covered,	S9999		

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S9999	Continued from page 16 sorry", and she confirmed there was nothing in the grievance about R6 being physically touched. V1 stated we did ask V29 about the incident, and he said he tapped R6, but she doesn't recall the exact area where she was tapped, maybe next to the knee. When asked what the concern may be if grievances are not filled out correctly or are missing information, V2 replied there may be an incomplete investigation. V2 stated neither R6 or R19 are cognitively impaired. V1 replied yes when asked if R19 or R6 are vulnerable for abuse, due to age, being in a nursing home, and being dependent; R6 is vulnerable for abuse due to age, being away from her daughters and not having that emotional support, being in a nursing home, being physically petite, and R19 is vulnerable for abuse due being wheelchair bound, and age. V1 stated she doesn't know abour the concept of "reasonable person". V23 (Human Resources Coordinator) stated "yes, she would consider that a staff may need abuse or customer service training if she receives multiple concerns from residents about the staff being unfriendly". On 07/09/2025 at 1:36 PM V2 (Director of Nursing) stated yesterday she asked R15 what happened, and R15 told her V30 (Certified Nursing Assistant) threw her like a sack of potatoes, when she asked R15 when this happened R15 said about two weeks before she was sent to the hospital. V2 stated V6 (Registered Nurse) texted her on 06/14 and stated in the text maybe R15 will complain about V30. V2 stated she didn't see the text right away, and can't recall seeing it other than today, and she has tons of messages. V2 stated if she saw a text like that she would call right away and ask V6 about it and if V6 reported an incident between a resident and staff then she would advise to send staff home, she would send staff home to keep patients safe and ensure no other incidents would happen, then have the resident assessed, and then there would be an investigation. V2 stated staff are directed to call to report this type of information, and what V6 reported in the text would be considered an incident. V1 (Administrator) stated she had not received this information from V2 and V6 and that today V6 informed her that he tried called her on 06/14 but she doesn't recall it or have any missed calls from the facility. When asked by the surveyor what would be the concern with what was communicated to V2 by V6 via text on 06/14/25 and what R15 reported, V1 replied the concern would be whether this information was reported as abuse and if an investigation took place. "The facility's Abuse Policy received 07/08/2025	S9999		

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S9999	Continued from page 17 states: "Residents have the right to be free from abuse or mistreatment." "The purpose of this policy and the Abuse Prevention Program is to describe the process for identifiction, assessment, and protection of residents from abuse." "The facility prohibits abuse. The facility has a "no tolerance" philosophy." "Abuse means any physical or mental injury inflicted upon a resident other than by accidental means. Abuse is also intimidation with resulting physical harm or mental anguish to a resident. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes physical abuse and mental abuse. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm." Mental Abuse is also the use of nonverbal conduct which causes or has the potential to cause the resident to experience fear, agitation, or degradation." "Employees are required to report any allegation of potential abuse, mistreatment to an immediate supervisor who must then immediately report it to the administrator. In the absence of the administrator, reporting can be made to an individual who has been designated to act in the administrator's absence." "Reports will be documented and a record kept of the documentation." "The resident's physician and representative, if necessary, shall be notified of any incident or allegation of abuse or mistreatment." "The facility will remove any alleged perpetrator(s) of abuse or neglect from any further contact with residents pending an investigation." "If the alleged perpetrator is an employee, the employee will be sent home and/or advised not to return to work until further notice." "As soon as possible after an allegation of abuse, mistreatment, the administrator or designee will initiate an investigation into the allegation which may include the following elements:	S9999		

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S9999	Continued from page 18 Interviewing all persons who may have knowledge of the alleged incident, included but not limited to: all persons who reported the suspicion, allegation, or incident; The alleged victim (if the victim is unable to be interviewed, this shall be documented); The alleged perpetrator; any witnesses or potential witnesses to the alleged occurrence or incident; any staff having contact with the resident during the period of the alleged incident; Any staff having contact with the resident during the period of the alleged incident; Roommates, other residents, family, or visitors; A review of the medical record, including care plan." A review of all circumstances surrounding the incident." "An initial report to the State Licensing Agency, Illinois Department of Public Health, shall be immediately after the resident has been assessed and the alleged perpetrator has been removed." (B)	S9999		