

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0054833		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/18/2025	
NAME OF PROVIDER OR SUPPLIER PRAIRIE OASIS				STREET ADDRESS, CITY, STATE, ZIP CODE 16000 SOUTH WABASH , SOUTH HOLLAND, Illinois, 60473			
(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 Complaint Investigation: 2692024/IL25912220- 300.651 a)b)1)2)3)c), 300.3310 a)1)2)4, 300.3240 a)b)d)f, 300.1210 a)b)4)A)B)5)		S0000			12/31/2025	
S9999	Final Observations Statement of Licensure Violations (1 of 3): 300.610a) 300.690b) 300.1010h) 300.1210b) 300.1210d)3)5) 300.3240a) 300.3240b) 300.3240c) 300.3240d) 300.3240g) 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.		S9999			12/31/2025	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 Section 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. 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 300.1210 General Requirements for Nursing and Personal Care 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. 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. 5) A regular program to prevent and treat pressure			S9999			

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S9999	Continued from page 2 sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.3240 Abuse and Neglect a) An owner, licensee, 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 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. These requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to prevent staff to resident physical abuse and neglect. These failures resulted in R1		S9999				

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S9999	Continued from page 3 sustaining a fractured left humerus and R3 sustaining moisture associated skin damage/skin breakdown. These failures affected two (R1 and R3) of six residents reviewed for abuse/neglect. Findings include: 1) R3's face sheet documents, R3 is an 80-year-old resident and has diagnoses including, but not limited to: cirrhosis of the liver, unspecified supracondylar fracture of the left humerus, dementia without behavioral disturbance, unspecified protein calorie malnutrition, other disorders of bone density and structure, functional quadriplegia and metabolic encephalopathy. R3's minimum data set (MDS) dated 10/21/2025, documents, R3 has a brief interview of mental status (BIMS) summary score of 3, indicating R3 has severe cognitive impairment. Additionally, the MDS documents indicates R3 requires assistance from staff with activities of daily living (ADLs), that R3's height is 65 inches and weighs 163 pounds. R3's care plan (6/19/2024) documents R3 is at risk of abuse/neglect and that symptoms of abuse may be manifested by verbal expressions of distress, generalized mood distress, and observable signs of distress. R1's MDS dated 11/25/2025, documents R1 has a BIMS summary score of 13, indicating that R1 is cognitively intact. R2's MDS dated 9/26/2025, documents R2 has a BIMS summary score of 15, indicating that R2 is cognitively intact. On 12/13/2025 at 10:27 AM, R1 stated, "I have had issues with (V5, Certified Nursing Assistant) in that past. (V5) is very rude when (V5) is caring for people. She's lied on me saying I hit her, I never done anything like that. I wasn't in the room when it (the incident) happened, but I heard that (R3's) arm broke". On 12/13/2025 at 10:37 AM, R2 explained, "About 4 or 5 days ago, I was sitting here in the room and V5 (Certified Nursing Assistant) was being really rough with (R3). (V5) was bossing her around, pulling on her by her clothes. (R3) doesn't talk much but (V5) was getting real smart, mouthy with her. I couldn't see exactly what happened because V5 was standing in-between me and (R3), but I heard a loud bang, and I		S9999				

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S9999	Continued from page 4 think (R3)'s arm hit the side rail. (R3) cried out and screamed, "B***h you broke my arm!". (R3) was screaming in pain after the incident. I told a nurse what happened, I can't remember exactly which one. (R3) is in a cast now. I don't recall (R3) having any recent falls. (V5) was acting real weird after the incident and kept asking me if I needed anything, which is not like her. She is normally very rude". On 12/13/2025 at 10:56 AM, R3 was observed sitting in a wheelchair with a splint/sling to R3's left arm. R3 stated, "I don't know what happened, my arm, my arm broke. It hurts real bad. My arm hurts real bad." R3 was observed having difficulty answering questioning due to severe cognitive deficits. On 12/13/2025 at 11:37 AM, V5 (Certified Nursing Assistant) was unsure the cause of R3's fracture, denied witnessing any staff physically abuse any resident and denied hitting/handling R3 roughly. V5 stated, "I don't yell at them (residents), but I am firm. I have boundaries, like when (R1) hit me in the head during the summer, I was real mad. I was so heated. I left the room and told social services, but I didn't hit her back. I didn't handle (R3) roughly, look at (R3's) size. I am small. Their weight versus mine. What could I do to (R3)? I couldn't hurt her. (R3) likes to put herself on the ground and is wiggly." Review of V5's healthcare worker background check form (3/16/2020) documents that V5 is 5 foot tall and weighs 134 pounds. On 12/13/2025 at 12:51 AM, V7 (R1's Family Member) recalled when visiting a few days prior, R2 had told V7 that V5 had hit R3's arm. V7 denied ever witnessing V5 hit another resident, but recalled "during the summer one time, I recall (R1) telling me that (V5) got mad, raised her and raised her arm up like (V5) was going to hit (R1). (R1) said V5 called her a b***h. I am not sure if (V5) ever hit her. I have not personally seen (V5) hit any residents, but I know she refuses to care for (R1)". On 12/13/2025 at 3:45 PM, V1 (Administrator) affirmed V1 is aware of R3's fracture and that the facility does not know how R3 got the fracture. V1 explained, "(R3) wasn't able to say what happened, (R3) just kept saying 'woo'. (R2) had mentioned there was an issue between (R3) and (V5), but when I was asking what happened, (R2) stated that they were arguing and did not see anything else. (R2) stated she did not see her hit (R3). When I looked up the type of fracture, it said it was commonly from a fall. I was not aware of any		S9999				

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S9999	Continued from page 5 allegation that (V5) hit (R3) or handled (R3) roughly until today but (V5) was suspended this morning pending the investigation. V1 affirmed that there was an active investigation into the fracture by V2 (Director of Nursing)". On 12/15/2025 at 10:22 AM, V9 (Wound Care Nurse, Licensed Practical Nurse) denied knowing how R3 sustained the fracture. V9 stated V9 has not seen V5 ever abuse any residents but V5 is firm. V9 explained, "Firm meaning like if a resident is able to do something, (V5) is not going to do that for them. Like she will tell them, no you need to wash your own private area or chest if they can." On 12/15/2025 at 11:00 AM, V10 (Certified Nursing Assistant) denied knowing how R3 sustained the fracture. V10 explained, "I work part time. I was off for a bit but then when I came back, I saw (R3) was in the splint. Though, you really should talk to (R2). (R2) is sharp, writes things down. If something happened, (R2) would know. I would trust what (R2) says." On 12/15/2025 at 11:39 AM, V11 (Certified Nursing Assistant) recalled an incident occurring in the afternoon of 12/9/2025. V11 explained, "I was at the nurse's station speaking with (V15, Dialysis Registered Nurse). I heard almost a crying sound; it got louder and louder and we went towards the noise. V4 (Social Services Director) heard too and came out of (V4's) office. It was coming from (R3's) room, it was (R3). (R3) was in bed and (V5) was standing at the foot of the bed, it looked like (V5) was performing care in the room. I saw (R3) in bed and not the floor, so I wasn't really concerned. I thought (R3) was crying from a fall. I didn't ask (R3) what was wrong, I left at that point. I can't say how it (R3's fracture) happened. I know there were issues with (R1) and (V5) in the past, but I don't know what it is. I think they had an argument or something. I try to keep everything together and make the work environment positive. I remember them hugging it out later on, I thought they were cool (with each other). I have not witnessed (V5) abuse any residents and I am not sure if (R2) was in the room at the time of the incident. I left pretty quick." On 12/15/2025 at 12:15 PM, V4 (Social Services Director) explained, "Last Tuesday (12/9/2025) I was getting ready to leave around 4:15 PM. I heard noises from my office. Loud yelling, louder than normal. Loud enough for me to have concerns. I went out of my office; my office is a couple doors down from (R3's)		S9999				

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S9999	Continued from page 6 room. V11 and V15 were also going to the room. I was in the doorway and saw (R3) lying in bed and it looked like (R3) was getting changed. (R3) was holding her left arm, the one that is broken. I asked (R3) what happened and (R3) told me (R3's) arm hurts. So, I told V16 (Licensed Practical Nurse). I don't really remember if there were other residents in the room at the time. (R2) told me on Thursday (12/11/2025) that she saw (V5) hurt (R3). I brought (R3) to (V2 Director of Nursing) and (V1 Administrator) was there. The story changed when (R2) was talking to (V1) and (V2) and (R2) stated that (R2) heard a loud bang and thought R1's arm hit the bed and that R2 couldn't see what happened because (V5) was standing in between. I would say that is an allegation of physical abuse. (R2's) cognition is intact, I would believe an interview from (R2). (R3's) cognition is in and out, some days (R3) can tell me things, other days (R3) can't. A fracture can be a sign of physical abuse." On 12/15/2025 at 12:31 PM, V1 (Administrator) affirmed that V1 is the abuse prevention coordinator, and that physical abuse includes hitting a resident or handling a resident roughly. V1 explained, "(V4) came and got us (V2) and (R2) told us (R2) was in the doorway and witnessed (R3) screaming out and (V5) was in the room. (R2) said it was louder than normal. I asked what was going on and (R2) stated, "I don't know I couldn't see. (V5) back was turned". (V4) told me that (R2) was in the DON office and wanted to talk to you. V4 never said anything about abuse between (R2) and (V5), I never received any allegation of abuse". On 12/15/2025 at 1:46 PM, V12 (Licensed Practical Nurse) recalled, "On Thursday Morning (12/11/2025), I was assigned to care for (R3). A staff member, I can't remember who, told me something was wrong with (R3's) arm, (R3's) screaming. I went to the room, and it was pretty bad, swollen and (R3) was guarding the arm. V13 (Nurse Practitioner) was here, assessed R3, and gave orders for an X-ray and pain medication. Around 12:30 or 1 PM, I showed (V2) (R3's) arm and (V2) instructed me to send (R3) to the hospital. When I asked (R3) what happened, (R3) stated, "That woman did this to me, that woman did this to my arm". I reported this to (V2). There was no fall, (V5) never said there was any fall. I was told on Thursday (12/11/2025) by (V11 Certified Nursing Assistant) that V5 was working a double on (12/9/2025) and (V11) gave me this look. I don't remember her exact words but (V11) told me that (V11) and (V15) were talking at the nurse's station and (V11) heard (R3) scream, "This b***h broke my arm!". (V11) had concerns (V5) was being rough with (R3). On that same day, (R2) told me that (V5) was being rough with		S9999				

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S9999	Continued from page 7 (R3), that (V5) snatched (R3's) arm and went bam bam bam hitting it on the rail of the bed. I told (V2) about it because I was shocked and (V2) was the closest staff that was there. I did not tell V1, I should have. I was very concerned after hearing (V11) tell me about (R3's) yelling and saying and then (R3) telling me a woman broke (R3's) arm, I was very concerned with physical abuse. I would think this fracture could be a sign (R3) was physically abused. I have not witnessed (V5) abuse any residents but (V5) has no patience for the residents. No fall caused this injury. (V1) called me in and asked if (R3) had fell and I told (V1) not to my knowledge. They (V1 and V2) are trying to put this on me that this was caused potentially by a fall-- it was not a fall. I told them it wasn't the fall. I told them my concerns, and they are going to pin this on me that I didn't chart a fall. No fall caused that fracture". Record review of corrective action given to V12 on (12/16/2025) documents that during an investigation for injury of unknown origin, V12 did not report, document, or inform the nurse manager of a fall by (R3) and, "after 2 different witness statements given during the investigation then said the resident had a fall". On 12/15/2025 at 2:51 PM, V2 (Director of Nursing) recalled on 12/11/2025, "I did go back and look at R3's arm. I didn't lift it because she was complaining of pain. It was more swollen more than normal. (V6) was in and had ordered pain meds and an Xray. She was in so much pain, so we sent her out. I asked (R3) what happened she didn't say anything about a fall. (R3) stated, "She turned me too hard". (R3) couldn't say who did it. Her doctor had concerns about bone density. I don't know how (the fracture) happened. Yes, I remember being in the office with (R2) and (V1). I was working on many items and was in and out of the conversation. I heard (R2) say something about the CNA hurting (R3's) arm. (R2) said it was (V5). (R2) then said in the conversation (R2) heard a loud noise but didn't see what (V5) did. I did not report abuse to (V1), (V1) was there for that conversation." On 12/15/2025 at 3:41 PM, V13 (Nurse Practitioner) explained, "I am (R3's) provider. I recall (on 12/11/2025) being notified by the nurse that her left upper extremity was swollen and painful. I went in and assessed her. It was swollen, it didn't look deformed though, it was tender to the touch. (R3) had very limited range of motion due to pain. (R3's) nurse at the time was unaware of any recent trauma or falls at that time. (R3) was alert times 1 (to self), (R3) could not report what happened to (R3's) arm. (R3) was sent		S9999				

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S9999	Continued from page 8 to the hospital and diagnosed with a subcapital left humeral fracture. I was not told that there was any suspicion of abuse. I am not ortho, but that (a subcapital fracture) can be caused by trauma, it depends on how hard someone is hit against something. If (R3) was screaming, that isn't (R3's) baseline. It would make sense if it (the fracture) was related to trauma. It doesn't take a lot for an older adult to have a fracture. I did tell the facility they needed to investigate what happened, these fractures don't happen for no reason." On 12/17/2025 at 9:57 AM, V15 (Dialysis Registered Nurse) affirmed that V15 provides dialysis to the residents and is not an employee of the facility. V15 recalled, "I was talking to another staff member, I can't remember who, when I was doing my rounds, and I heard someone scream. At least 2-3 times. I thought maybe someone had fallen. Once I had went there with the facility staff, I saw a CNA in the room with the resident standing by the resident who was lying in bed. It was not one of my dialysis residents, so I don't know the resident's name. The staff were talking to her, so I left. I heard an "ahh" sound, it sounded like the resident was in pain." During this survey, multiple attempts were made to contact V16 (Licensed Practical Nurse) during the survey but V16 was unable to be reached. Record review of facility final investigation (12/16/2025) completed by V2 (Director of Nursing) indicates that the facility believed the injury of unknown origin was caused by a "fall that wasn't reported. V12 was terminated for not reporting the fall incident and V5 was terminated for discourteous behavior". Record review of facility witnesses' statements gathered to make the investigative outcome determine do not indicate evidence of a fall. V5's statement (perpetrator of abuse) states that V5 was told by V20 that R3 and fell and got R3 back into bed. Then before lunch, V5 observed R3 on the ground and the nurse (V12, Licensed Practical Nurse) assisted V5 in getting R3 back to bed. Then on second shift R3 was complaining of pain so V5 told V16 (Licensed Practical Nurse) about the pain. Interview statements from V12, V20, and V16 do not corroborate V5's statement and do not indicate that there was any observed fall, R3 on the ground, pain, or fall related injury. One witness statement submitted with no discernable staff/resident name, time, states, "On 12/13/2025 (after the survey had			S9999			

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S9999	Continued from page 9 begun), I was told by a (unknown) staff member that (they) were told (R3) had a fall earlier in the week. I am not aware of what day/time of the fall". Witness statements obtained by R2 do corroborate allegations of physical abuse. R2's witness statement(s) indicates that R2 saw V5 be rough with R3 and a loud bang was heard while V5 was providing care. These statements corroborate V4 (Social Services Director), V11 (Certified Nursing Assistant) and V15 (Dialysis Nurse, Registered Nurse) witness "a loud noise" and "yelling" while a CNA was in the room on 12/9/2025. There is no other evidence within the witness statements that indicate R3 had any fall. Review of R3's progress notes indicate that on 12/11/2025 at 10:10 AM, documents, "CNA notified writer of resident complaint of pain at Lt arm. Upon arrival to resident's room, resident in lying in bed alert and oriented x 2. During assessment resident's Lt arm is swollen, painful to touch, and resident is yelling out in when she attempts to move Lt arm. No other apparent abnormalities noted. Writer gently placed Lt arm on pillow. T 98.1 P 65 R 20 BP 100/66 02 sat 95% RA. (V6) to be notified for pain medication orders.". At 10:15 AM, R3 was seen by V13 (Nurse Practitioner) at the bedside. At 1:36 PM, R3 was sent to the hospital for evaluation and returned at 10:16 PM with a diagnosis of a closed supracondylar fracture of left humerus. There is no indication of a fall or any potential indicators of a fall or change of plane (e.g. R3 observed on the ground) within R3's progress notes reviewed since 10/1/2025-12/18/2025. Record review of R3's hospital records (12/11/2025) document, "...presents emergency department today for arm pain. Per daughters at bedside, patient may have injured her elbow 2 days ago at the nursing home. They are unsure if somebody pulled out or if she hit her arm against something. Patient complains of pain to her left elbow. Denies any numbness or tingling. Limited history due to patient's history of dementia...XR HUMERUS 2 VIEWS LEFT (Final result) ...FINDINGS/IMPRESSION: Advanced osseous demineralization. Interval closed reduction and splinting of a displaced transverse supracondylar fracture at the distal humerus. Persistent medial displacement of 2.5 cm and impaction up to 1.4 cm. Distal radius and ulna appear radiographically intact. Ulnotrochlear and radiocapitellar joints are in anatomic alignment. Mild associated osteoarthritis. Trace elbow effusion... XR ELBOW 3 VIEWS LEFT (Final result) ... FINDINGS/IMPRESSION: Advanced osseous demineralization. Interval closed reduction and splinting of a displaced transverse supracondylar		S9999				

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S9999	Continued from page 10 fracture at the distal humerus. Persistent medial displacement of 2.5 cm and impaction up to 1.4 cm. Distal radius and ulna appear radiographically intact. Ulnotrochlear and radiocapitellar joints are in anatomic alignment. Mild associated osteoarthritis. Trace elbow effusion..." On 12/17/2025 at 10:30 AM, V18 (Physician) affirmed that V18 is the primary care physician for R3. V18 explained, "I was at the facility and spoke with the facility/family after (R3) was in the hospital. We had a discussion for what possibly happened, I am not aware of a fall. There may be potential for some demineralization. I don't know what happened or how the fracture was caused. We call that type of fracture (R3) has an avulsion fracture. It is where the tendon gets ripped of the bone. I don't know if abuse is the cause, the fracture may be caused if it (the arm) was hit at a certain angle." On 12/17/2025 at 1:14 PM, witness statements for the allegation were reviewed with V2. V2 affirmed that the cause of the injury was a fall and that the only statement that mentioned a fall occurred was V5's statement (perpetrator of abuse). V2 stated that V12 told V2 there was a fall. V2 reviewed V12's witness statement and affirmed V12 statement does not include any documentation of a fall. V2 affirmed that V2 "didn't get the other statement that (V12) made about the fall" and surveyor observed V2 fabricate a statement. Surveyor requested any documentation that indicates R3's injury was caused by a fall or any evidence that a fall occurred. No documentation was provided that indicated R3 had a fall prior to the exit of the survey. Record review of the observed fabricated statement collected on 12/17/2025 (dated 12/18/2025) gives V2's statement that indicates, "I was informed by administrator (V1) that (V12) informed (V1) that the resident (R3) did have a fall. (V12) was too busy and forgot to report the fall. (V12) said I'll take my hit for not reporting the fall." On 12/17/2025 at 2:04 PM, V19 (Medical Director) affirmed V19 is the medical director of the facility. V19 explained, "Subcapital fractures, there is variability on how they are caused. In young people, it is nearly always caused by trauma. In the elderly, the majority of the time it is caused by trauma, but if the resident has osteopenia, a sudden movement or mobility change can cause that fracture. Suddenly twisting or putting a lot more pressure on an arm, or when an arm is stretched there is a potential. I believe it is		S9999				

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S9999	Continued from page 11 roughly 10-12% of the time pathologically related. Physical abuse can cause fractures. I am aware of the incident; I was made aware by (V1 Administrator) and was told the statements were not corroborating enough. I heard there was another person, I am unsure if it was a roommate or staff, saw another staff member giving care but couldn't really see. If the resident fell, yes, that has to be documented. If this was caused by a fall or abuse, it would have been documented. Even if there was a fact (R3) was in pain, that would have to be documented and assessed when it happened. Even if (R3) was being combative at the time of the incident and there was a change in status, I would expect to see that (documentation). If the CNA actually abused (R3) with the fracture, it's hard to say. None of the actual statements really corroborated is my understanding. If (R3) was receiving care and then had pain, there should have been care provided right away. They (the facility staff) should have taken that more seriously". On 12/18/2025 at 2:19 PM, V20 (R3's Family Member) explained that on 12/9/2025 R3's roommates (R1, R2) left a voicemail on V20's sister's phone stating that a staff member was being rough with V3 and that R3 was in pain. V20's sister did not see the voicemail until 12/11/2025 when R3 was in the hospital. V20 recalled getting a call from the facility stating that R3 was being sent to the hospital for arm pain. V20 went to the hospital and R3's arm was "in really bad shape". The emergency room doctor told me that this fracture is usually caused by someone "pulling or twisting an arm too hard". V20 stated, "(R3) can't speak for herself. (R3) couldn't defend herself against a staff member. If someone was rough with (R3), (R3) would probably start yelling or crying. Bottom line, (R3's) arm is broken and no one caught it till Thursday? How? There's a lot of incompetence up there at that facility." On 12/18/2025 at 2:46 PM, V19 (Certified Nursing Assistant) reviewed her witness statements and affirmed they were correct. V19 affirmed that R3 never had any fall. V19 recalled that V19 was the staff member that discovered R3's swollen arm. V19 stated, (R3's) elbow was swollen above the arm. When I asked what happened, (R3) was screaming, "a female CNA broke my arm" and that R3 "wanted to go home". V19 explained, "I went and immediately told (V12). (V12) came and I stepped out of the situation once (V12) took over. (V5) is very mean-spirited and verbally aggressive with the residents. It's very inappropriate. Like if someone needs help putting on their clothes, (V5) will help them, but the whole time (V5) will be like, "Why can't you do that yourself?" All nasty". V19 affirmed that V19 never picked R3 up off the ground, V12 was never		S9999				

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S9999	Continued from page 12 told R3 fell, and that R3 has not had any falls. V19 denied R3 would be able to defend herself against physical abuse and that a fracture could be a sign of abuse. V19 affirmed that R2 does not make false allegations and "would believe if (R2) made an allegation". During this survey, multiple attempts were made to contact V16 (Licensed Practical Nurse) for interview. V16 was unable to be reached for interview prior to the exit of the survey. Facility abuse policy (undated) documents , "This policy affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion...Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means... Abuse is the willful infliction of injury, unreasonable confinement , intimidation or punishment resulting in physical harm, pain or mental anguish... Physical abuse is the infliction of injury on a resident that occurs other than accidental means and that requires medical attention..." 2) R1's face sheet documents that R1 is a 70-year-old resident with a prior medical history including: hemiplegia affecting left side, type 2 diabetes mellitus, depression, hypothyroidism, and hypertension. R1's MDS dated 11/25/2025, documents R1 has a BIMS summary score of 13, indicating that R1 is cognitively intact. Additionally, the MDS indicates that R1 does not have any moisture associated skin damage at the time of the assessment. On 12/13/2025 at 10:27 AM, R1 affirmed that R1 is incontinent of bowel/bladder and explained, "They (staff) never change me regularly. I have had open areas on my buttocks and thighs for about a week or two. I have told my daughter and the staff, I know my daughter has told the administration too about them not changing me. I am in a lot of pain on my butt, it's burning pain at like 7/10. There's no dressing or treatment in place for my skin". R2's MDS dated 9/26/2025, documents R2 has a BIMS summary score of 15, indicating that R2 is cognitively intact. On 12/13/2025 at 10:37 AM, R2 (R1's Roommate) affirmed that R1 regularly does not get incontinence care/changed by the facility staff and that R1 waits		S9999				

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S9999	Continued from page 13 long periods of time to be changed by staff. On 12/13/2025 at 12:51 PM, V7 (R1's Family Member) explained, "(R1) has not gotten a shower in a couple weeks maybe longer. I have to constantly remind them (staff) to give (R1) a shower, and they always blame other shifts. (R1) has breakdown on (R1's) bottom from sitting in urine and feces, the staff just blame the other shifts. (R1) keeps talking about being in pain and (R1's) butt burning. I came in a few days ago in the morning and (R1) was still in bed, soaked in urine. She is gotten up from the night shift, she should already be up and have had incontinence care provided by the time I get there. (V2, Director of Nursing) was made aware of these issues and (V2) apologized, I think this was Wednesday (12/10/2025) morning. It's constant incontinence care issues. It's becoming overwhelming to me that (R1) isn't receiving basic care." On 12/13/2025 at 1:16 PM, V2 (Director of Nursing) and V12 (Licensed Practical Nurse) denied knowledge of R1 having any skin impairment or breakdown. V2 recalled R1's family member coming to the facility and that the family member had concerns with incontinence care. V2 stated that V2 went with the family member and did observe R1 still in bed during day shift. V2 confirmed that R1 is "a 3rd shift get up" and should have been up by the time the family was in the facility. V2 reviewed the last 30 days of ADL charting within R1's electronic health record and affirmed that there are multiple shifts within the last 30 days where there is no documentation that R1 received incontinence care. V2 affirmed that if there is no documentation that the service was provided, then the care was not provided. Surveyor requested any additional documentation that confirms R1 received the needed care as identified within the care plan/MDS and no further evidence was provided prior to the exit of the survey. On 12/13/2025 at 2:12 PM, V2 stated, "The staff just was in here, placed (R1) in bed and performed incontinence care". Observed R1 laying in left side-lying position with no pants or brief. V2 asked R1 to rate R1's current level of pain and R1 replied, "4/10, on my left side and butt". Observed V2 and V12 perform a skin check of R1's legs, peri-area and bottom. Observed V2 displace R1's buttocks and noted a large amount of feces covering the area between R1's buttocks. V2 (Director of Nursing) stated "Oop (sic). Guess they didn't do it (peri-care) well, (the staff) left bowel movement". V12 observed and affirmed there was feces covering the area between R1's buttocks. Observed two 0.5x0.5x<0.1 cm open areas draining serosanguinous fluids on R1's left upper leg, near the		S9999				

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S9999	Continued from page 14 buttocks with a red wound bed and intact edges. Measurements were confirmed with V2. When asked to describe the drainage coming from the open area, V2 replied, "No, I think that's urine". R1 exclaimed and yelled in pain as the open areas were measured. V2 apologized. Surveyor asked V2 to continue to assess R1's skin. Observed one open area 0.2x0.5x<0.1 cm open area with a pink/red wound bed, intact edges and one open area 0.5x0.5x<0.1 cm open area with a pink/red wound bed and intact edges to R1's left buttock. Additionally, observed one 0.5x0.5x<0.1 cm open area with a pink/red wound bed with intact edges to R1's right gluteal fold. V2 educated R1 that R1 "needed some cream on that (open areas)". V2 placed the sheet over R1 and V2 and V12 left the room without providing R1 any peri-care after observing the feces between R1's buttocks. Record review of R1's toileting assistance provided 11/16/2025-12/15/2025 does not document that toileting assistance was provided on the following shifts: 11/17/2025 1st Shift; 11/21/2025 2nd shift; 11/22/2025 1st shift, 2nd shift; 11/29/2025 2nd Shift; 12/2/2025 1st shift; 12/5/2025 2nd shift; 12/10/2025 (into 12/11/2025) 3rd shift; 12/13/2025 2nd and 3rd shift (into 12/14/2025); 12/14/2025 1st, 2nd and 3rd shift. Record review of R1's shower sheets for 11/2025 through 12/2025 does not document that R1 had a shower between 11/30/2025 and 12/13/2025. This indicates that R1 did not have a shower for 13 days. Additionally, this indicates that R1 did not get showers as required until after the survey began and that the concerns within the grievance related to showers were not resolved. R1's care plan documents that R1 "is totally dependent on staff for toilet use" (3/17/2025), and instructs staff to: "Toilet at regular intervals, such as following meals, as indicated" (5/29/2024), "Administer appropriate cleansing & peri-care after each incontinent episode" 5/29/2024), "Observe for signs of skin irritation &/or breakdown. Report irritation/breakdown to the physician." (5/29/2024), "Evaluate side effects of prescribed medications to assess causes of incontinence." (5/29/2025). Additionally, the care plan identifies that the moisture associated skin damage was identified on 12/13/2025. R1's progress notes identify that R1 has a history of moisture associated skin damage and candidiasis and		S9999				

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S9999	Continued from page 15 that it was healed on 10/21/2025. On 12/13/2025 at 14:53 PM, V9 documented, "Resident noted with MASD to bilateral posterior thighs and buttocks continue nystatin cream as previously ordered, check and change and apply after incontinence episodes. Hydrocolloid applied to posterior thighs for MASD". On 12/15/2025 at 9:44 AM, V8 (Restorative Nurse, Licensed Practical Nurse) affirmed that staff are not required to document every episode of incontinence but are required to document the highest amount of care provided for the activity of daily living (ADL) that shift. If the resident has refused or if there is a reason that care was not provided, the nurse would complete a progress note. V8 stated, "They (CNA's) are required to document every shift". V8 reviewed R1's incontinence care charting and confirmed that on multiple shifts that there is no documentation/evidence that R1 received incontinence care. V8 stated the standard of care is that incontinent residents are checked and changed if needed every 2 hours. V8 stated, "If you are performing good peri-care, you wouldn't see any feces afterward". V8 stated, "If incontinence care is not provided every 2 hours, skin breakdown can occur. Urine can eat away at the skin which causes burning. I was not that (R1) had any skin breakdown. V9, Wound Care Nurse, Licensed Practical Nurse monitors shower sheets and skin breakdown. Anytime there is moisture associated skin damage, (V9) is notified". On 12/15/2025 at 10:22 AM, V9 (Wound Care Nurse, Licensed Practical Nurse) affirmed that R1 had a history of moisture associated skin damage but "we healed it out". V9 explained, "(R1) had some when (R1) first admitted, (R1) is heavy wetting. (R1) was followed by the wound care doctor for moisture associated skin damage and we have been providing cream for a while. (R1) has a history of fungal yeast infections. We found the open areas yesterday. We have been creaming her for a while, (R1) should be getting cream every incontinence episode. You shouldn't see any feces after peri-care was completed. I went in after you (the surveyor) observed (R1), and the feces was still there when I completed a skin check. I found three open areas caused by moisture associated skin damage on (R1's) bottom". Surveyor informed V9 that there were five open areas discovered on R1's bottom and V9 replied, "Oh, I didn't see those, I thought there was only three". V9 described R1's skin as "wet, wrinkly" and affirmed there was "moisture" present during assessment. When asked if V9 had measured the open areas, V9 replied, "No, we (staff) don't measure MASD (moisture associated skin damage). That's not our policy. But I always thought that was weird because the			S9999			

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S9999	Continued from page 16 wound care doctor does. So why wouldn't we?". V9 recalled notifying R1's nurse practitioner for orders and got orders to get a wound care consult. V9 recalled, "When I told (R1's) family about the new open areas, the family said we were only calling because state was in the building. They (the family) were upset. (R1's) family has brought up concerns with showers, incontinence care, and not being gotten up on the night shift. I've offered to take (R1) off the night shift get up list, but it is (R1's) choice to get up then. If (R1's Family Member) comes in and sees R1 not out of bed in the morning, (R1's family member) gets mad. It is part of my duty to review and ensure shower sheets are completed". V9 reviewed R1's December 2025 shower sheet and affirmed that there was no documentation that R1 had a shower. V9 explained, "The nurses fill out the top part for a skin assessment, but the bottom part is filled out by the CNAs to document the shower was given. The bottom part is blank. Well, textbook would tell you if it wasn't completed, it wasn't done". On 12/15/2025 at 12:31 PM, V1 (Administrator) affirmed that V1 is the abuse prevention coordinator for the facility. V1 stated that neglect "is knowing that a resident has a need and intentionally not caring for them". V1 stated, "skin breakdown occurs if incontinence care is not provided". V1 affirmed that once per shift CNAs are required to document the care provided. V1 stated, "If there is no charting for the shift, I wouldn't assume the care was not provided. Like, if the patient didn't have a negative outcome that would trigger me to think they weren't cared for". When asked if moisture associated skin damage is a negative outcome, V1 replied, "it might mean that they weren't changed timely but not that it wasn't received". On 12/15/2025 at 1:46 PM, V12 (Licensed Practical Nurse) recalled a few days ago that R1's family member was in the facility and upset. V12 explained, "I don't know what (the family member) was upset about. But I know she talked to (V2) and (V2) went down there. I think the last time I saw (R1's) skin intact was maybe Monday (12/9/2025). The other day we assessed (R1's) skin with you (surveyor) and found multiple open areas. If (R1) was changed every 2 hours, we wouldn't have seen that". On 12/17/2025 at 2:04 PM, V19 (Medical Director) stated, signs of incontinence care not being provided is a rash in an area. Stool or urinary incontinence can cause skin breakdown. Not at all an acceptable level of		S9999				

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S9999	Continued from page 17 care. MASD there are many factors, it depends on the level of incontinence and the frequency, some people are very incontinent going about every 20 or 30 minutes. MASD can be caused by not checking or changing diapers. Can be multiple factors. It would be documented if staff were providing incontinence care. Review of the facility assessment (reviewed 4/23/2025) documents in "Section 2: Services and Care Offered Based on Residents' Needs" that the facility provides bathing care services and incontinence prevention/care. Facility policy titled, "Skin Care Dos and Don'ts" (5/2014) documents that facility staff should observing skin during direct care, notifying the treatment nurse/charge nurse of any changes in skin breakdown/moisture associated conditions, completing peri-care with mild soap and water after each incontinence episode, using moisture barrier ointment to protect skin from incontinence and to document skin irritation in progress notes. Facility abuse policy (undated) documents, "This policy affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion...Neglect means the failure to provide, or willful withholding of, adequate medical care mental health treatment, psychiatric rehabilitation, personal care, or assistance with activities of daily living to avoid physical harm, mental anguish, or mental illness of the resident..." (A) (2 of 3) 300.651a) 300.651b)1)2)3) 300.651c) Section 300.651 Whistleblower Protection a) For the purposes of this Section, "retaliatory action" means the reprimand, discharge, suspension, demotion, denial of promotion or transfer, or change in the terms and conditions of employment of any employee of a facility that is taken in retaliation for the employee's involvement in a protected activity as set forth in Section 3-810 of the Act and this Section 300.651. (Section 3-810(a) of the Act)		S9999				

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S9999	Continued from page 18 b) A facility shall not take any retaliatory action against an employee of the facility, including a nursing home administrator, because the employee does any of the following: 1) Discloses or threatens to disclose to a supervisor or to a public body an activity, inaction, policy, or practice implemented by a facility that the employee reasonably believes is in violation of a law, rule, or regulation. 2) Provides information to or testifies before any public body conducting an investigation, hearing, or inquiry into any violation of a law, rule, or regulation by a nursing home administrator. 3) Assists or participates in a proceeding to enforce the provisions of the Act and this Part. (Section 3-810(b) of the Act) c) A violation of the Act and this Section may be established only upon a finding that the employee of the facility engaged in conduct described in subsection (b) of Section 3-810 of the Act and this Section 300.651 and this conduct was a contributing factor in the retaliatory action alleged by the employee. There is no violation of this Section, however, if the facility demonstrates by clear and convincing evidence that it would have taken the same unfavorable personnel action in the absence of that conduct. (Section 3-810(c) of the Act). These regulatory REQUIREMENTS were not met as evidenced by: Based on interview and record review, the facility terminated an employee for participating in protected activity (disclosing abuse to facility administration, disclosing abuse allegations during a complaint investigation). These findings violated V12's whistleblower protection and have the potential to affect all 118 residents that reside in the facility. Findings include: Facility census (12/13/2025) documents in part that 118 residents reside within the facility. Record review of facility witnesses' statements gathered to make the investigative outcome determine do not indicate evidence of a fall. V5's statement		S9999				

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S9999	Continued from page 19 (perpetrator of abuse) states that V5 was told by V20 that R3 and fell and got R3 back into bed. Then before lunch, V5 observed R3 on the ground and the nurse (V12, Licensed Practical Nurse) assisted V5 in getting R3 back to bed. Then on second shift R3 was complaining of pain so V5 told V16 (Licensed Practical Nurse) about the pain. Interview statements from V12, V20, and V16 do not corroborate V5's statement and do not indicate that there was any observed fall, R3 on the ground, pain, or fall related injury. One witness statement submitted with no discernable staff/resident name, time, states " On 12/13/2025 (after the survey had begun), I was told by a (unknown) staff member that (they) were told (R3) had a fall earlier in the week. I am not aware of what day/time of the fall". Witness statements obtained by R2 do corroborate allegations of physical abuse. R2's witness statement(s) indicates that R2 saw V5 be rough with R3 and a loud bang was heard while V5 was providing care. These statements corroborate V4 (Social Services Director), V11 (Certified Nursing Assistant) and V15 (Dialysis Nurse, Registered Nurse) statements, witnessing "a loud noise" and "yelling" while a CNA was in the room on 12/9/2025. There is no other evidence within the witness statements that indicate R3 had any fall. Review of R3's progress notes indicate that on 12/11/2025 at 10:10 AM, documents in part, "CNA notified writer of resident complaint of pain at Lt arm. Upon arrival to resident's room, resident in lying in bed alert and oriented x 2. During assessment resident's Lt arm is swollen, painful to touch, and resident is yelling out in when she attempts to move Lt arm. No other apparent abnormalities noted. Writer gently placed Lt arm on pillow. T 98.1 P 65 R 20 BP 100/66 02 sat 95% RA. (V6) to be notified for pain medication orders.". At 10:15 AM, R3 was seen by V13 (Nurse Practitioner) at the bedside. At 1:36 PM, R3 was sent to the hospital for evaluation and returned at 10:16 PM with a diagnosis of a closed supracondylar fracture of left humerus. There is no indication of a fall or any potential indicators of a fall or change of plane (e.g. R3 observed on the ground) within R3's progress notes reviewed since 10/1/2025-12/18/2025. On 12/15/2025 at 1:46 PM, V12, Licensed Practical Nurse, recalled, "On Thursday Morning (12/11/2025), I was assigned to care for (R3). A staff member, I can't remember who, told me something was wrong with (R3's) arm, (R3's) screaming. I went to the room, and it was pretty bad, swollen and (R3) was guarding the arm. V13 (Nurse Practitioner) was here, assessed R3, and gave orders for an X-ray and pain medication. Around 12:30 or 1 PM, I showed (V2) (R3's) arm and (V2) instructed			S9999			

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S9999	Continued from page 20 me to send (R3) to the hospital. When I asked (R3) what happened, (R3) stated, "that woman did this to me, that woman did this to my arm". I reported this to (V2). There was no fall, (V5) never said there was any fall. I was told on Thursday (12/11/2025) by (V11 Certified Nursing Assistant) that V5 was working a double on (12/9/2025) and (V11) gave me this look. I don't remember her exact words but (V11) told me that (V11) and (V15) were talking at the nurse's station and (V11) heard (R3) scream "this b***h broke my arm!". (V11) had concerns (V5) was being rough with (R3). On that same day, (R2) told me that (V5) was being rough with (R3), that (V5) snatched (R3's) arm and went bam bam bam hitting it on the rail of the bed. I told (V2) about it because I was shocked and (V2) was the closest staff that was there. I did not tell V1, I should have. I was very concerned after hearing (V11) tell me about R3's yelling and saying and then (R3) telling me a woman broke (R3's) arm, I was very concerned with physical abuse. I would think this fracture could be a sign (R3) was physically abused. I have not witnessed (V5) abuse any residents but (V5) has no patience for the residents. No fall caused this injury. V1 called me in and asked if (R3) had fell and I told (V1) not to my knowledge. They (V1 and V2) are trying to put this on me that this was caused potentially by a fall-- it was not a fall. I told them it wasn't the fall. I told them my concerns, and they are going to pin this on me that I didn't chart a fall. No fall caused that fracture". Record review of facility final investigation (12/16/2025) completed by V2 (Director of Nursing) indicates the facility believed the injury of unknown origin was caused by a "fall that wasn't reported. (V12) was terminated for not reporting the fall incident". Record review of corrective action given to V12 on (12/16/2025) documents in part that during an investigation for injury of unknown origin, V12 did not report, document, or inform the nurse manager of a fall by (R3) and "after 2 different witness statements given during the investigation (by V12) then said the resident had a fall". On 12/17/2025 at 1:14 PM, witness statements for the allegation were reviewed with V2. V2 affirmed the cause of the injury was a fall and the only statement that mentioned a fall occurred was V5's statement (perpetrator of abuse). V2 stated V12 told V2 there was a fall. V2 reviewed V12's witness statement and affirmed V12 statement does not include any documentation of a fall. V2 affirmed that V2 "didn't			S9999			

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S9999	Continued from page 21 get the other statement that (V12) made about the fall" and surveyor observed V2 fabricate a statement. Surveyor requested any documentation that indicates R3's injury was caused by a fall or any evidence that a fall occurred. No documentation was provided that indicated R3 had a fall prior to the exit of the survey. Record review of the observed fabricated statement collected on 12/17/2025 (dated 12/18/2025) gives V2's statement that indicates, "I was informed by administrator that (V12) informed (V1) that the resident (R3) did have a fall. (V12) was too busy and forgot to report the fall. (V12) said I'll take my hit for not reporting the fall." On 12/18/2025 at 2:46 PM, V19 (Certified Nursing Assistant) reviewed her witness statements and affirmed they were correct. V19 affirmed R3 never had any fall. V19 recalled V19 was the staff member that discovered R3's swollen arm. V19 stated, (R3's) elbow was swollen above the arm. When I asked what happened, (R3) was screaming, "a female CNA broke my arm" and that R3 "wanted to go home". V19 explained, "I went and immediately told (V12). (V12) came and I stepped out of the situation once (V12) took over. (V5) is very mean-spirited and verbally aggressive with the residents. It's very inappropriate. Like if someone needs help putting on their clothes, (V5) will help them, but the whole time (V5) will be like, "Why can't you do that yourself?!" All nasty". V19 affirmed that V19 never picked R3 up off the ground, V12 was never told R3 fell, and that R3 has not had any falls. V19 denied R3 would be able to defend herself against physical abuse and that a fracture could be a sign of abuse. V19 affirmed that R2 does not make false allegations and "would believe if (R2) made an allegation". On 12/18/2025 at 3:16 PM, V21 (Regional Supervisor) affirmed that V21 oversees the administrator of the facility and is part of the facility's governing body. V21 was aware of the investigation of injury of unknown origin but was not aware that V12 was fired during the investigative process. V21 explained that the facility would never fire an employee for reporting abuse and that staff need an environment where they can freely report abuse without retaliation. If retaliation occurs, it makes an environment where staff wouldn't want to come forward with abuse which can affect the other residents. V21 referred the violation of whistleblower protections to the facility's legal department/lawyers for further action.		S9999				

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S9999	Continued from page 22 Facility abuse policy (undated) documents in part, "... NOTICE All employees of Prairie Oasis have the following responsibilities and rights under federal law... No retaliation Prairie Oasis cannot punish you or otherwise retaliate against you for reporting your reasonable suspicion of a crime against a resident or person receiving care from this facility." (B) (3 of 3) Section 300.3310 a)1)2)4 Complaint Procedures a) A resident shall be permitted to present grievances on behalf of himself or herself and others to the administrator, the Long-Term Care Facility Advisory Board, the residents' advisory council, State governmental agencies, or other persons of the resident's choice, free from restraint, interference, coercion, or discrimination and without threat of discharge or reprisal in any form or manner whatsoever. Every facility licensed under the Act shall have a written internal grievance procedure that, at a minimum: 1) sets forth the process to be followed; 2) specifies time limits, including time limits for facility response; 4) provides for a timely response within 25 days by an impartial and nonaffiliated third party, including, but not limited to, the Long-Term Care Ombudsman, if the grievance is not otherwise resolved by the facility; These regulatory REQUIREMENTS were not met as evidenced by: Based on interview and record review, the facility failed to respond and resolve resident (R1) grievances in a timely manner and failed to follow the facility grievance policy. This failure affects one (R1) of six residents reviewed for grievances. Findings include: Record review of grievances (5/5/2025, 7/3/2025, 11/11/2025) document concerns with R1 receiving showers. The grievance dated 11/11/2025 does not indicate if the grievance was resolved or unresolved,			S9999			

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S9999	Continued from page 23 the complainant's response to the resolution or signature from the administrator. On 12/13/2025 at 10:27 AM, R1 stated R1 has complained about showers to R1's family members and staff and stated that staff do not respond timely to concerns. R1 affirmed R1's family will also complain to staff about concerns and "nothing gets resolved". R1 stated, "I haven't had a shower in over a month". On 12/13/2025 at 12:51 PM, V7 (R1's Family Member) affirmed V7 has complained to many staff members including V2 (Director of Nursing) about not R1 not getting care. V7 affirmed R1 does not get showers regularly and that the lack of care is still an issue after filing grievances. On 12/13/2025 at 1:16 PM, V2, Director of Nursing, affirmed the facility staff are required to document showers on shower sheets. V2 stated if shower sheets are not complete, then there is no documentation that the care was provided. V2 recalled V7 had brought up concerns related to R1's care in the past, including incontinence and peri-care. On 12/13/2025 at 3:45 PM, V1, Administrator, reviewed the grievance dated 11/11/2025. V1 stated it appeared V17 (MDS Nurse) forwarded the grievance to V4 (Social Services Director) to address and R1 received a shower. V1 affirmed the grievance documentation does not indicate if the grievance was resolved or unresolved, the complainant's response to the resolution or signature from the administrator. V1 affirmed all grievances are to be sent to the administrator for review where V1 would sign off they were complete. V1 stated, "They (staff) must have just put this in the grievance binder and forgot to give it to me". On 12/15/2025 at 12:15 PM, V4, Social Services Director, reviewed the grievance (11/11/2025) and recalled the grievance was received by R1's family member during a care plan meeting. V4 explained the family was upset R1 was not receiving showers on R1's shower day. V4 told nursing staff about the incident and recalled staff showered R1 day. V4 was unsure if there was any documentation of any other follow up, auditing, investigation for the validity of the complaint, or resolution/communication to R1's family about the concern being resolved. V4 affirmed the grievance should be considered incomplete because there is no documentation the grievance was resolved, communicated to the family or the administrator was aware/signed off. V4 explained the grievance process is V4 receives the grievances, follow ups with the			S9999			

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S9999	Continued from page 24 appropriate department, communicates and documents the resolution with the complainant and then reviews with the administrator. After, it is filed in the grievance log. Record review of R1's shower sheets for 11/2025 through 12/2025 does not document R1 had a shower between 11/30/2025 and 12/13/2025. This indicates R1 did not have a shower for 13 days. Additionally, R1 did not get showers as required until after the survey began and the concerns within the grievance related to showers were not resolved. Facility policy titled, "Grievances" (6/2014) documents, "... Purpose: to establish a formal system for documentation of grievances and system of resolution... 1. The director of social services will utilize the written concern form method to document concerns... all concerns will be reviewed and signed by the administrator. 8. Concern resolutions are expected within 72 hours unless further time is needed to resolve the concern (example: ordering an item)..." Facility policy titled "Bath/Shower Schedule" (2/2014) documents, "A bath or shower will be given to each resident by a Certified Nursing Assistant two times per week as scheduled and (as needed) ... 3. Certified Nursing Assistant will give shower as scheduled... 6. Bath/shower sheets are to be completed by the Certified Nursing Assistant upon each bath/shower scheduled whether accepted or declined. Bath/shower sheets will be maintained by the facility for the current and entire last month and then may be discarded." (B)		S9999				