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A2000	Section 295.2000 Residency Requirements This Regulation is not met as evidenced by: TYPE 1 VIOLATION Section 295.2000 Residency Requirements a) No individual shall be accepted for residency or remain in residence if the establishment cannot provide or secure appropriate services, if the individual requires a level of service or type of service for which the establishment is not licensed or which the establishment does not provide, or if the establishment does not have the staff appropriate in numbers and with appropriate skill to provide such services. (Section 75(a) of the Act) c) A person shall not be accepted for residency if: 1) The person poses a serious threat to themselves or to others; 4) The person requires the assistance of more than one paid caregiver at any given time with an activity of daily living; 3) Develop and implement policies and procedures that ensure the continued safety of all residents in the establishment including, but not limited to, those who: A) May wander; These requirements were not met as evidenced by:	A2000		

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Based on observation, record review and interview the establishment failed to assess a change in mental condition and behavior and for continued appropriate placement.
This was found in 2 out of 3 residents (R5,R9) identified as having wandering behavior, elopement risk, and high fall risk.
This failure resulted in:
R9 wandered out of the establishment after midnight via a side door. R9 was found at a local fast food establishment and returned by police.
R5 sustaining 13 falls with and without injuries.

This failure creates the substantial probability of severe harm or death for R1, R5 and other residents.

Findings include:

1) R9 is a 74 year old resident who moved into assisted living 1/7/26. R9 has diagnoses including unspecified dementia, cognitive communication deficit, Wernicke's encephalopathy, hypertension and muscle wasting and atrophy to right & left upper arms. R9 was transferred from assisted living to the memory care unit on 2/2/26.

The progress notes show the following:
2/1/26, 2:00pm: R9 very anxious, packed all his stuff and stated he is going home and will call the police because he cannot find his cell phone. Redirected R9 and PRN (as needed) anxiety medication given. Z5 notified and stated R9 never had his cellphone.

2/2/2026, 12:30pm Incident Note:
at 11pm R9 was observed in his room. During routine rounds, the staff team conducted a wellness check and noticed that R9 was packing his belonging and attempting to leave the

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community. Despite their attempts to redirect R9, R9 continued to follow the caregivers around the community. At 11:45pm, the staff escorted R9 back to his room so that they could assist another resident. After completing their task, the caregiver returned to the R9t's room, but R9 was nowhere to be found. The staff searched the community noting R9's last location via care center was near exit 169. Surveillance footage revealed that R9 left the community unsupervised at 0008 (12:08am). The police transported R9 back to community, but R9 refused to return inside. Z5 was informed about the current incident and educated of the significance of requiring a 1-1 sitter during this time due to multiple attempts of exiting seeking. R9 was administered PRN (as needed) Xanax and was escorted back to his room without incident. Every 2hr safety checks implemented per staff team. R9 was offered a snack to help decrease agitation. All safety measures in place including emergency pendant, Staff will continue to monitor any changes.

The Incident Accident Report dated 2/2/26 shows at 11pm R9 was observed in his room. During routine rounds, the staff team conducted a wellness check and noticed that R9 was packing his belongings and attempting to leave the community. Despite their attempts to redirect R9, R9 continued to follow the caregivers around the community. At 11:45pm, the staff escorted R9 back to his room so they could assist another resident. After completing their task, the caregiver returned to R9's room, but R9 was nowhere to be found. The staff searched the community noting his last location via care center was near exit 169, surveillance footage revealed that R9 left the community unsupervised at 0008 (12:08am). The police transported the resident back to the community but R9 refused to return inside. R9's

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family was informed about the current incident and educated of the significance of requiring a 1:1 sitter during the time due to multiple attempts of exit seeking. R9 was administered prn (as needed) Xanax and was escorted back to room without incident. Q (every) 2 hours safety checks implemented per staff team and R9 was offered a snack to help decrease agitation. All safety measures in place including emergency pendant. Staff will continue to monitor any chances. R9 stated that that he was going out to see his wife. This incident report shows that R9 predisposing physiological factor is confusion. The predisposing situation factor is active exit seeking.

On 2/24/26 at 4:00pm via telephone interview E14 (LPN, night shift) stated, "the night shift starts at 11pm. I got report that the resident had been staff throughout the day looking for his wife. He was given a prn to calm down. His wife doesn't live in the facility. He was initially at the beginning of the shift he was found in his room. At the beginning of the night shift he started again. Then around 11:45 another resident needed help. After the was finished with the other resident, she came back around 12 midnight to check on him but he wasn't in his room. That's when she called me. caregiver. The care center, which is his pendant shows he was last seen at exit 169 and exited to the parking lot. We checked the camera, that's how we knew he exited the building at 12:08am. He took the stairs. Two staff went outside to search around the building. He was found at the front entrance.. The police escorted him into the building because he didn't want to come in. Another prn dose of Xanax was administered again."

When E14 was asked if R9 was found at a fast

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food restaurant up and across the street, E14 said yes, R9 was there.

On 2/25/26 at 12:35pm via telephone interview E2 (wellness director) stated, "prior to the beginning of the night shift R9 was up and following the caregiver around on AL (Assisted living). The caregiver had R9 walk with her as she went to the memory care unit to pick up her walkie. The caregiver assisted R9 to his room and went to check on another resident. The caregiver went to check on R9 but he wasn't in his room. The police who were at the only fast food restaurant open 24 hours asked R9 his name. R9's pendant was around his neck. The police brought R9 back. E14 is the one who called me to alert that one of the doors (169) pinged. The caregiver looked on the computer, saw that R9 exited the side door, exit 169. It's called that because the last room in that hallway is 169. We had a conversation with the family. We suggested either a night time private caregiver or the memory care unit which is more secure. In the daytime R9 is fine, participating in activities and able to be in eye view. At night R9 starts to wind down, wanders and asks about his wife who doesn't live in the community. R9 walks very fast. R9 was moved into the memory care unit 1 to 2 days after this incident."

On 2/26/26 at 1:35pm via telephone interview, E17 (LPN, day shift) stated, "I work the day shift, 7am to 3:30pm. I didn't usually care for R9, but according to the previous shift, R9 starts getting anxious towards the end of the day. R9 would follow staff around. He is redirectable and he likes snacks. Those distractions last a short while and then he is back to wandering."

2) R5 was admitted to the establishment on

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A2000	Continued From page 5 6/30/22 with diagnoses that included Ataxia. R5's cognitive assessment indicated the resident had mild cognitive impairment. The fall assessment documented R5 was a high fall risk. R5's Progress Notes/Incidents addressed thirteen resident falls from 4/28/25 through 1/9/26. Additional information was requested but not received. R5's SP addressed the falls from 7/27/25 until 1/9/26. Additional information from the resident's record was requested but not received.	A2000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: TYPE 1 VIOLATION Section 295.4010 Service Plan a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the Act) The establishment shall respect and accept the residents' choices regarding the service plan. b) The service plan shall be developed by: 1) The resident, resident's representative or any individual requested by the resident; c) The service plan shall be signed and	A4010		

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A4010	Continued From page 6 dated by all individuals involved in its development. e) The service plan shall be reviewed and revised, if necessary, immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000). This requirement is not met as evidenced by: Based on record review and interviews the establishment failed to: -develop and implement fall prevention measures and care needs for 6 out of 10 sampled residents (R1, R4, R5, R6, R7 and R8) who are identified as high fall risk; -develop and implement interventions to address use of continuous oxygen for 2 of 10 sampled residents (R2, R4) reviewed for oxygen use. -develop and implement interventions to address two residents who received fractures from falls (R6 and R7). -revise interventions to address wandering and history of exit seeking behavior for 1 of 3 sampled resident (R9) reviewed for these behaviors. R9 eloped from the establishment in the middle of the night and was found by police at a local fast food restaurant. These failures creates the substantial probability of severe harm or death to R1,R2,R4,R5,R6,R7,R8,R9 and other residents. Findings include:	A4010		

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A4010	Continued From page 7 1). R1 was admitted to the establishment 9/14/24 with diagnoses that included Encephalopathy, Unspecified Dementia, CKD (Chronic Kidney Disease), Hypertension and Bradycardia. The resident's cognitive assessment indicated R1 had dementia, the fall assessment indicated R1 was a high fall risk. R1's History and Physical (H&P) 10/7/25 assessed the resident as having dementia, forgetfulness and an unsteady gait. Progress Notes/Incident Reports document R1 fell five times: 10/31/25, 11/10/25, 11/19/25, 11/29/25, and 12/6/25. Hospice Notes 11/5/25-11/28/25 mention R1 having an indwelling catheter but failed to document care provided by nurses besides monitoring for change in condition and for safety. Progress Notes do not identify who is to take care of R1's indwelling catheter when the resident's hospice nurses are not in the establishment. Review of R1's current service plan presented showed the establishment failed to develop and implement effective interventions in an attempt to prevent falls, failed to identify what R1's catheter care consisted of, failed to identify the services hospice provides to the resident, and failed to contain the signatures and dates of individuals involved in developing R1's service plan. 2). R2 was admitted to the establishment 5/1/24 with diagnoses that includes COPD (Chronic Obstructive Pulmonary Disease (COPD), Hypertension, and Chronic Ischemic Heart Disease.	A4010		

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R2 was identified as using oxygen and using a BiPaP (assists with breathing during sleep). When interviewed 2/17/26 at 4:55PM the resident was observed using oxygen at 5L per minute via an oxygen concentrator and wearing the BiPaP machine. R2 stated the oxygen is used 24 hours a day.

Review of R2's undated service plan presented by the establishment failed to identify what type of care and monitoring the resident requires for the oxygen, failed to identify the number of liters per minute the resident is to use and failed to contain the signatures and dates of individuals involved in developing R2's service plan.

3). R3 was admitted to the establishment 4/30/23 with diagnoses including Essential Hypertension. Review of R3's current service plan presented by the establishment showed the establishment failed to contain signatures and dates of individuals involved in developing R3's service plan.

4). R4 was admitted to the establishment 10/29/22 with diagnoses including Osteoarthritis Pathology, Pathological fracture of the hip and Unspecified Dementia.

R4's cognitive assessment score indicated the resident has dementia. R4's fall assessment indicated the resident was at high risk for falls.

Review of Incident Reports documented R4 fell 9/23/25, 10/12/25 and 12/18/25.

On 2/17/26 at 4:30PM R4 was observed using oxygen at 2 liters via nasal cannula which the resident stated is used "all the time" and denied ever having fallen. E16 (Caregiver) was present

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and verified the resident uses oxygen "24-7" and has fallen in the past.

Review of R4's service plan (SP) presented by the establishment showed the service plan wasn't revised and interventions developed and implemented to try to prevent additional falls, two of which occurred on 9/23/25 and 10/12/25. The SP also failed to identify the number of liters per minute the resident is to use, failed to indicate how often the nebulizer treatments are to be given and failed to contain the signatures and dates of individuals involved in developing R4's service plan.

5). R5 was admitted to the establishment 6/30/22 with diagnoses including Ataxia.

Fall assessments indicated R5 was a high risk for falls. R5's cognitive assessment indicated mild neurocognitive impairment.

Post Fall Interventions documented R5 fell on 11/30/25, 12/19/25, and 1/9/26.

R5's Progress Notes 5/3/25 and 5/20/25 document the resident fell.

Review of R5's current SP presented by the establishment showed it was not revised with new interventions developed and implemented in an attempt to prevent further falls when it was noted that previous interventions were not effective. Additionally the SP identified "Assurance Checks" was to be used to ensure R5's safety but failed to identify what the assurance checks consisted of.

6). R6 was admitted to the establishment 6/30/20 with diagnoses that included Intervertebral Disc

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A4010	Continued From page 10 Degeneration, Lumbar Region, Dizziness and Giddiness. R6's cognitive assessment indicated the resident had severe dementia. Post Fall Notes and Progress Notes dpcument R6 had fallen 16 times from 6/14/25 to 2/17/26 with the fall on 7/24/26 resulting in the resident sustaining a right orbital fracture and facial bruising. Review of R6's SP shows the establishment failed to revise the SP to develop and implement new interventions in an attempt to prevent additional falls. There were no signatures identifying who participated in developing the SP. 7). R8 is a 89 year old resident who resides in the memory care unit of the establishment. R8 has diagnoses including Dementia, Alzheimer's disease, Acute embolism and thrombosis of deep veins of left lower extremity, pulmonary embolism, acute respiratory failure. The Incident Note dated 1/30/2026, 4:40pm shows Writer (E13, LPN) left nurses station to enter dining room when she heard another resident say "She's on the floor, she fell on the floor. "E13 looked over and noted R8 lying on the floor on her right side. Per E13 and the RSAs (resident service aides) were present in the dining room but were serving dinner to other residents. Bleeding was noted from right arm. E13 asked R8 what happened. R8 stated she was trying to cross the street. R8 stated that her head, neck, spine, right shoulder and right arm was hurting. No bleeding, bruising, or bumps palpated or seen on the head. Bleeding noted on right wrist and	A4010		

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elbow. R8 able to bend legs on the floor and arms. R8 was sent to hospital and returned to the community the same day. No injuries noted,

The service plan dated 5/31/25 shows a goal that R8 will participate with fall prevention measures to reduce risk of fall occurrence.
Intervention: R8 will be positioned to ensure that she is comfortable.

The fall prevention measures lists that R8 is expected to participate in are not listed in the service plan. This service plan was not signed or dated by all individuals responsible for its develop.

8). R9 is a 74 year old resident who moved into assisted living 1/7/26. R9 has diagnoses including unspecified dementia, cognitive communication deficit, Wernicke's encephalopathy, hypertension and muscle wasting and atrophy to right & left upper arms. R9 was transferred from assisted living to the memory care unit on 2/2/26.

The progress notes dated 2/1/26, 2:00pm shows R9 very anxious, packed all his stuff and stated he is going home and will call the police because he cannot find his cell phone. Redirected R9 and PRN (as needed) anxiety medication given. Z5 notified and stated R9 never had his cellphone.

The progress note dated 2/1/26 shows R9 was wandering, following care staff during the evening shift.

The Incident Note dated 2/2/2026 shows in part that R9 was able to elope from the establishment at 12:08am. R9 walked to a local fast food restaurant, which is approximately 1.9 miles away

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and a 10 to 15 minute walk from the establishment. R9 was discovered by police and escorted back to the establishment.

On 2/25/26 at 12:35pm via telephone E2 (wellness director) stated, "prior to the beginning of the night shift R9 was up and following the caregiver around on AL (Assisted living). The caregiver assisted R9 to his room and went to check on another resident. The caregiver went to check on R9 but he wasn't in his room. The police who were at the only fast food restaurant open 24 hours asked R9 his name. R9's pendant was around his neck. The police brought R9 back. E14 is the one who called me to alert that one of the doors (169) pinged. The caregiver looked on the computer, saw that R9 exited the side door, exit 169. It's called that because the last room in that hallway is 169. We had a conversation with the family. We suggested either a night time private caregiver or the memory care unit which is more secure. In the daytime R9 is fine, participating in activities and able to be in eye view. At night R9 starts to wind down, wanders and asks about his wife who doesn't live in the community. R9 walks very fast. R9 was moved into the memory care unit 1 to 2 days after this incident."

This incident report shows that R9 has confusion as predisposing physiological factor. The predisposing situation factor as active exit seeking.

The service plan dated 12/31/25 shows: Interventions: resident requires assistance with redirection due to occasional confusion, deficits

Under reasoning: resident requires assistance with redirection due to occasional confusion,

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A4010	Continued From page 13 deficits in judgement, wandering or exit seeking. There are no revised interventions addressing R9 behavior of wandering and several attempts at exit seeking while residing in assisted living after transfer to the memory care unit.This service plan was not signed or dated by all individuals responsible for its develop. 9). R7's SP provided by the establishment failed to address R7's multiple fractures, failed to revise the identified goal for "Reasoning" when it was apparent the goal hadn't been met and didn't address R7's fall on 12/6/25. There weren't signatures identifying who participated in developing the SP.	A4010		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: TYPE 1 VIOLATION Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 5) The right to receive the services specified in the service plan, to review and renegotiate the service plan at any time; and to be informed of the cost of the changes;	A6000		

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	ASL510497	A. BUILDING: _____ B. WING _____	03/09/2026

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A6000	Continued From page 14 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; These requirements were not met as evidenced by: Based on, record review and interview the establishment failed to ensure that a resident was free from abuse. This failure involves 1 of 3 residents (R9) identified as having wandering behavior and at risk for elopement. This failure resulted in R9 being neglected, resulting in R9 wandering out of the side door of the establishment after midnight early one frigid morning. R9 was found at a local fast food restaurant several blocks away from the establishment. These failures creates the substantial probability of severe harm, or death for R9, and other residents. Findings include: R9 is a 74 year old resident who moved into assisted living 1/7/26. R9 has diagnoses including unspecified dementia, cognitive communication deficit, Wernicke's encephalopathy, hypertension and muscle wasting and atrophy to right & left upper arms. R9 was transferred from assisted living to the memory care unit on 2/2/26. The progress notes in part show the following: -2/1/26, 2:00pm: R9 very anxious, packed all his stuff and stated he is going home and will call the police because he cannot find his cell phone. Redirected R9 and PRN (as needed) anxiety	A6000		

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A6000	Continued From page 15	A6000		

medication given. Z5 notified and stated R9 never had his cellphone.

-2/2/2026 Incident Note:
at 11pm R9 was observed in his room. During routine rounds, the staff team conducted a wellness check and noticed that R9 was packing his belonging and attempting to leave the community. Despite their attempts to redirect R9, R9 continued to follow the caregivers around the community. At 11:45pm, the staff escorted R9 back to his room so that they could assist another resident. After completing their task, the caregiver returned to the resident room, but R9 was nowhere to be found. The staff searched the community noting R9's last location via care center was near exit 169. Surveillance footage revealed that R9 left the community unsupervised at 0008 (12:08am). The police transported resident back to community, but R9 refused to return inside. Z5 was informed about the current incident and educated of the significance of requiring a 1-1 sitter during this time due to multiple attempts of exiting seeking. R9 was administered PRN (as needed) Xanax and was escorted back to his room without incident. Every 2 hourr safety checks implemented per staff team. R9 was offered a snack to help decrease agitation. All safety measures in place including emergency pendant, Staff will continue to monitor any changes.

The Incident and Accident Report dated 2/2/26 shows at 11pm R9 was observed in his room. During routine rounds, the staff team conducted a wellness check and noticed that R9 was packing his belongings and attempting to leave the community. Despite their attempts to redirect R9, R9 continued to follow the caregivers around the community. At 11:45pm, the staff escorted R9

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back to his room so they could assist another resident. After completing their task, the caregiver returned to R9's room, but R9 was nowhere to be found. The staff searched the community noting his last location via care center was near exit 169, surveillance footage revealed that R9 left the community unsupervised at 0008 (12:08am). The police transported the resident back to the community but R9 refused to return inside. R9's family was informed about the current incident and educated of the significance of requiring a 1:1 sitter during the time due to multiple attempts of exit seeking. R9 was administered prn (as needed) Xanax and was escorted back to room without incident. Q (every) 2 hours safety checks implemented per staff team and R9 was offered a snack to help decrease agitation. All safety measures in place including emergency pendant. Staff will continue to monitor any chances. R9 stated that that he was going out to see his wife.

This incident report shows that R9's predisposing physiological factor as confusion. The predisposing situation factor as active exit seeking.

On 2/24/26 at 4:00pm via telephone E14 (LPN, night shift) stated, "the night shift starts at 11pm. I got report that the resident had been staff throughout the day looking for his wife. He was given a prn to calm down. His wife doesn't live in the facility. He was initially at the beginning of the shift he was found in his room. At the beginning of the night shift he started again. Then around 11:45 another resident needed help. After the was finished with the other resident, she came back around 12 midnight to check on him but he wasn't in his room. That's when she called me. caregiver. The care center, which is his pendant shows he was last seen at exit 169 and exited to

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the parking lot. We checked the camera, that's how we knew he exited the building at 12:08am. He took the stairs. Two staff went outside to search around the building. He was found at the front entrance.. The police escorted him into the building because he didn't want to come in. Another prn dose of Xanax was administered again.
When E14 was asked if R9 was found at a fast food restaurant up and across the street, E14 said yes, R9 was there.

On 2/25/26 at 12:35pm via telephone E2 (wellness director) stated, "prior to the beginning of the night shift R9 was up and following the caregiver around on AL (Assisted living). The caregiver had R9 walk with her as she went to the memory care unit to pick up her walkie. The caregiver assisted R9 to his room and went to check on another resident. The caregiver went to check on R9 but he wasn't in his room. The police who were at the only fast food restaurant open 24 hours asked R9 his name. R9's pendant was around his neck. The police brought R9 back. E14 is the one who called me to alert that one of the doors (169) pinged. The caregiver looked on the computer, saw that R9 exited the side door, exit 169. It's called that because the last room in that hallway is 169. We had a conversation with the family. We suggested either a night time private caregiver or the memory care unit which is more secure. In the daytime R9 is fine, participating in activities and able to be in eye view. At night R9 starts to wind down, wanders and asks about his wife who doesn't live in the community. R9 walks very fast. R9 was moved into the memory care unit 1 to 2 days after this incident."

The service plan dated 12/31/25 shows under

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A6000	Continued From page 18 Interventions: resident requires assistance with redirection due to occasional confusion, deficits Under reasoning: resident requires assistance with redirection due to occasional confusion, deficits in judgement, wandering or exit seeking. There aren't revised interventions addressing R9 behavior of wandering and several attempts at exit seeking.	A6000		
A7000	Secton 295.7000 Resident Records This Regulation is not met as evidenced by: GENERAL VIOLATION Section 295.7000 Resident Records a) Service delivery contracts and related documents executed by each resident or resident's representative shall be maintained by the establishment from the date of execution until three years after the date the contract is terminated. (Section 105 of the Act) d) An establishment shall ensure that a resident's record is: 1) Confidential and only released with written permission from the resident or the representative, or as otherwise provided by law; These requirements were not met as evidenced by: Based on record review and interview, the establishment failed to	A7000		

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-present the requested medical record for 1 of 3 residents (R10) reviewed for medical record requests. The establishment failure to present the correct medical record. As of the time of this investigation, the establishment has not delivered the requested medical record to R10's family as requested;

-correctly bill a resident as assessed by level of care for 1 of 3 residents (R10) reviewed for billing and assessment of care. R10 was assessed as a level 3 for care in memory care but was later charged more without informing R10's family of the increase.

This failure has the probability to affect R10 and other residents.

Findings include:

R10 was a 91 year old resident who moved into the establishment 3/24/25. R10 had diagnoses including Cognitive communication deficit, Pneumonia, COPD (chronic obstructive pulmonary disease) with acute exacerbation, Syncope and collapse, GI (gastrointestinal) hemorrhage, Diaphragmatic hernia, Wedge compression fracture of vertebra, Rheumatoid arthritis, Muscle wasting and atrophy.

R10 expired at the hospital 7/7/25.

On 2/11/26 at 3:35pm, E1 (executive director) stated, "there are 6 levels of care which are resident focused and have different benchmarks. Residents receiving oxygen are a higher care level. The difference between level 3 and 4 depends on the care level. The family didn ' t always want to take his oxygen with them when they would take him out 2-3 times a week. As far

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as the service plan, escorts, transfers increase the care level points. Oxygen is always a number increase. Incontinence, cueing escorts, etc. R10 lived in memory care from the beginning. R10 was assessed at care level 3. Before a resident can move in, we go out to do an assessment. We evaluate the potential resident in the next 3 days. An assessment is done initially, at 30 days and then at 6 months. A change in care will change the care level. I'll print out a copy of R10's ledger."

E1 returned with a General and Supplemental Fee policy for R10 dated 3/24/25. Under memory care essential service rate level of care for memory care show's R10 was at a level 3 for care.
The second level of care for memory care sheet shows R10 at a level 4 which is a $800 a month more. This sheet does not include a date.

E1 was not sure when and where the discrepancy happened but admitted there was a mix up with the documented care levels and charges.

On 2/ 2/24/26 at 12:15pm via telephone, Z3 stated, "we had a meeting with the establishment. They said R10 was a level 3 for care however we were paying level 4 cost. R10 was on 2 liters of oxygen at the time. E1 said R10 is a level 3. The E1 admitted the documentation was wrong. They credited us for one month. By that time R10 had passed."