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A 000	Initial Comment Facility Reported Incident conducted IL199988/FRI 1/21/26: 295.6000 a) 1) 13) IL199841/FRI 1/25/26: substantiated, no vioaltion cited IL200206/FRI 2/10/26: 295.4010 a) b) 1) d) e) g) 2), 295.6000 a) 1) 13), 295.4060 a) b) c) e) 3) B)	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Section 295.4010 Service Plan - Level 2 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 resident's 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; d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident	A4010		

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A4010	Continued From page 1 (see Section 295.2030). (Section 15 of the Act) 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). g) Service plans shall address: 2) The amount, type, and frequency of health-related services needed by the resident. These requirements were not met as evidenced by: Based on record review and interview, the establishment failed to: -revise the service plan with interventions for two out of 3 residents (R1, R2) reviewed for behaviors. Revised interventions were not included in the service plan for R1 who has a history of drinking or attempting to drink harmful liquids. -develop and implement interventions on the service plan for 1 out of 2 residents (R2) who has a history of physically aggressive behavior towards residents and staff. R2 punched R3 in the face. R3 sustained a closed fracture of the right ramus of the mandible, lip contusion, and lip laceration; -revise with interventions to address one resident out of 2 (R2) altercation with R3 nor the physical aggression displaced towards staff, the use of a	A4010		

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A4010	Continued From page 2	A4010		

private caregiver, the outside service of the psychiatric nurse pratitioner to visit every other week and routine lab tests.

These failures have the probability of harm to affect residents who reside in the Memory Care unit.

Findings include:

1. R1 is a 73 year old resident who moved into the establishment 11/9/22, R1 has diagnoses including Unspecified dementia, Persistent mood (affective) disorder, Heart disease, unspecified, Asthma, Essential (primary) hypertension, unspecified, Acute embolism and thrombosis of unspecified deep veins of distal lower extremity bilateral.

The progress notes for January 2026 show the following:

-1/21/26, 4:30am, Incident:
E2 (Wellness Director) reviewed and documented the event as reported by E4 (LPN). Per E4's statement, R1 was observed on the bedroom floor with vomitus and thick phlegm present. R1's bed linens were noted to be wet with phlegm and emesis. E5 (CNA) assisted E4 with lift assist. R1 was assisted to the bathroom for hygiene care. Per E4, a small bottle of liquid laundry detergent was observed in R1's room. R1 was asked if he drank the detergent and verbally responded "yes." E4 contacted Z1 and requested review of in-room camera footage to verify possible ingestion. Z1 later reported that video review did not show R1 ingesting detergent. Per E5, R1 was noted to sound congested. E5 endorsed the findings to the oncoming shift and

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A4010	Continued From page 3	A4010		

planned for R1 to be evaluated the Z2 durng their visit on that day.

1/21/26, 9:30am, Incident
-E2 documented follow-up to prior incident per report from morning shift nurse (E3). Per E3, Z1 arrived at the facility and reported that upon further review of in-room video footage, Z1 believes (R1) ingested liquid laundry detergent. At the time of Z1's report, Z2 was present in the facility. Vital signs were rechecked and noted with elevated blood pressure and pulse. Oxygen saturation measured at 81%. No episodes of vomiting were reported since 0700. Due to concern for suspected ingestion of laundry detergent and abnormal vital signs, decision was made to transfer R1 to the emergency department for further evaluation and treatment. Emergency services (911) were activated. R1 was transported to a local hospital. Resident departed the facility at approximately 09:30am.

The progress note dated 1/29/26, 3:51pm, shows R1 entered another resident's room. CNA followed R1 to redirect. R1 removed a lotion bottle from the room, unscrewed the top, and threw the top bottle toward the CNA. CNA attempted to retrieve the bottle as R1 attempted to drink the lotion. R1 became verbally aggressive and used profane language toward staff. CNA successfully retrieved the bottle before ingestion occurred. R1 did not drink any of the lotion. R1 was redirected back to his room, and all doors was closed. No injuries noted. R1 remains under observation.

R1 returned to the community on 1/23/26 with hospital diagnosis of Acute Hypoxic Respiratory Failure.

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A4010	Continued From page 4 On 3/19/26 at 2:45pm via telephone, E4 (LPN) stated, "I found out because the CNA (E5) told me. E5 said R1 wasn't feeling well and he threw up. I went to R1's room. I saw the laundry detergent. It was a small bottle. R1 couldn't tell us if he drank some of it. The phlegm was clear. That's why I called Z1. R1 has a camera in his room. At first Z1 said she didn't think R1 drank any of the detergent. I gave report to the oncoming nurse. This happened towards the end of the night shift. Later that day R1 was sent out to the hospital by the day shift nurse. That detergent wasn't supposed to be left in R1's room. Z1 claimed she gave that bottle to a CNA and it was supposed to be locked up." On 3/23/26 at 9:30am via telephone,, E5 (CNA) stated, "I work on the night shift in memory care. When I first checked on R1, he was asleep. I checked on R1 again a few hours later, R1 was laying on the floor. R1 said he was sick. R1's shirt was wet. R1 had vomited on his shirt and there was vomit on the bed. The vomit was clear. I went to get another CNA and the nurse. We took R1 to the bathroom to clean him up. I noticed a small bottle of liquid laundry detergent on the counter. The cap was off of the bottle. I don't know where that bottle came from because I didn't see it the last time I had checked on him. R1 usually sleeps through the night. R1 admitted he drank some of it" On 3/23/26 at 3:34pm via telephone E1 (executive director) stated, "for R1 we did room sweeps. We will continue to do room sweeps. We try to keep everything in the unit child safety. We had a one on one with Z1 so she would be aware of what is allowed and what isn't. The resident room doors locked in general not just for R1 but for those who wander."	A4010		

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A4010	Continued From page 5 The service plan dated 1/24/26 does not address R1 ingesting inedible liquids. The service plan does not address room sweeps or keeping the room door locked for R1's safety. 2. R2 is a 60 yeat old resident who moved into the establishment 7/31/24. R2 has diagnoses including Dementia, mild cognitive impairment, Hyperthyroidism, Primary Hypertension and Benign Prostatic Hypertrophy. The progress note dated 2/10/2026 shows the following: Incident: At around 4pm, a male resident in memory care (identified as R3) reported being punched in the face by another male resident, (identified as R2) resulting in a bleeding mouth. The incident was not witnessed by staff. Upon assessment, R2 was combative and agitated, preventing vital signs or a full assessment. Redness was observed on R2's fist knuckles. CNA reported that R2 also threatened a female resident (identified as R4). Due to safety concerns, no further assessment was completed. 911 was called, and EMS (emergency medical services) transported R2 to the local hospital for psychiatric evaluation. Police Incident Report was filed. R3 is a 85 year old resident who moved into the establishment 1/30/26. R3 has diagnoses including Dementia, Cognitive communication deficit, fracture of vertebrae T9 & T10 (1/28/26), Spondylosis thorac lumbar region, Hypertensive heart disease, Glaucoma, Low back pain, Abnormality of gait & mobility and Ataxia, The progress note dated 2/10/26 for R3 shows the following:	A4010		

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A4010	Continued From page 6 Summary of Incident: at approximately 4:00pm, an unwitnessed resident-to-resident altercation occurred in the Memory Care Unit involving R2 and R3. R3 was observed with a laceration to the lips. R2 was seen in the hallway near the area where blood was noted. R3 was brought to the nurse's station for assessment. R3 stated, "I was at my house and R2 was driving too fast in the driveway and I told R2 to stop driving too fast. That's when I got attacked." Nursing staff provided first aid, completed a head-to-toe assessment and EMS transported R3 for further evaluation. R2 was agitated and resisted assessment. Redness was noted to R2's knuckles. Staff redirected R2 and a CNA remained with R2 until EMS arrived to ensure the safety of other residents. EMS transported R2 to a local hospital for psychiatric evaluation. Police were notified, and a report was filed. The update to the incident shows R3 returned from the Emergency room with diagnoses of closed fracture of the right ramus of the mandible, lip contusion, and lip laceration. On 3/17/26 at 11:30am, E1 (executive directive) stated "this happened in the memory care unit. The second resident involved was R3. R3 said he didn't like R2 driving past his house. R2 was the aggressor. R3 is pleasantly confused. In R3's mind, he thought R2 was driving past his house." On 3/18/26 at 2:30pm via telephone, E2 (wellness director) stated, "I was here in the office. I heard some commotion. R2 is a ex cop. R2 has behaviors towards new residents. R3 had only been here for about a week. R2 has to warm up to new residents. The CNA saw R3 with blood	A4010		

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A4010	Continued From page 7	A4010		

on his face. When asked what happened, R3 said someone punched him in the face. R2 said R3 was driving by his drive way too fast. We saw blood on the floor in front of R3's apartment. R2 was standing in front of R3's apartment. R2 has late stage dementia. R2 didn't admit to hitting R3. R3 was bleeding so we took him to the nurse's office to apply first aid. We had a male CNA sit with R2 until the paramedics came."

On 3/23/26 at On 3/23/26 at 9:33am via telephone E5 (CNA) stated, "R2 attacked me the other night. I asked E2 what plan was in place to address R2's aggressive behavior and protect residents and staff because whatever was in place was not working. R2's not appropriate for the unit. The other night I tried to get R2 to change his brief because it was soiled. R2 said no. The other CNA felt R2 was irritated with her so we left him alone. I asked the nurse if R2 had some medicine to help him calm down. R2 was irritated and had stool on him. I asked again if I could help him, R2 said no and slapped my hand away. R2 was moving toward a resident (R4) we had seated in her geri chair in the common area because she is a fall risk. I was trying to redirect R2 because R2 was hovering over her, that's when R2 attacked me. R2 punched me in my head. R2 then pulled at my jacket. I managed to break free and place the cart between us. I called for help twice on the radio. The only male CNA on the night shift came up. R2 had calmed down when he heard me call for help and he saw the male CNA. The nurse called 911 to have R2 sent out to the hospital. I'm still a little shaken up about that."

On 3/23/26 at 2:05pm via telephone, E8 (LPN) stated, "I was on duty that day. I was in the nurse's office. R3 said call the police! I saw he

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A4010	Continued From page 8 had blood coming from his mouth. I didn't know if he had fallen. The CNA brought R3 to me. The CNA said she thought R2 had hit R3. R3 said R2 was driving too fast and he was trying to stop him. I couldn't assess R2 because he was so agitated. I continued to assess and clean R3 up. E2 called 911." On 3/23/26 ag 3:34pm via telephone E1 stated, "R2 had a 16 hour a day caregiver that way there was someone with him at all times if there was any level of agitation R2 would be removed from the situation having that one on one. R2 also was seen by the psych nurse practitioner every other week. Also blood work and urinanylsis ran immediately and put nto a regular routine. R2 was admitted to a psych hospital and he won't be returning, R2 became aggressive with a team member. We tried a lot with him. R2 may do better with a smaller environment." The service plan dated 11/6/25 was not revised with interventions to address R2's altercation with R3 nor the physical aggression displaced toward E5. The caregiver E1 mentioned was not addressed. The outside service of the psych nurse pratitioner to visit R2 every other week and the lab tests were not addressed as well.	A4010		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Type 1 Violation Section 295.4060 Alzheimer's and Dementia Programs - Level 2	A4060		

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A4060	Continued From page 9 a) In addition to this Section, Alzheimer and dementia programs shall comply with all of the other provisions of the Act. (Section 150(a) of the Act) b) No person shall be admitted or retained in an assisted living or shared housing establishment if the establishment cannot provide or secure appropriate care, if the resident 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 150(b) of the Act) c) No persons shall be accepted for residency or remain in residence if the person's mental or physical condition has so deteriorated to render residency in such a program to be detrimental to the health, welfare or safety of the person or of other residents of the establishment. The assessment must be approved by the resident's physician and shall occur prior to acceptance for residency, annually, and at such time that a change in the resident's condition is identified by a family member, staff of the establishment, or the resident's physician. (Section 150(c) of the Act) e) No person shall be accepted for residency or remain in residence if the person is dangerous to self or others and the establishment would be unable to eliminate the danger through the use of appropriate treatment modalities. (Section 150(d) of the Act)	A4060		

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A4060	Continued From page 10 g) If an establishment accepts any individuals with cognitive impairments that prevent them from safely evacuating the establishment independently, sufficient staff members shall be present and awake 24 hours a day to assist in evacuation. 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: These requirements were not met as evidenced by: Based on record review and interview, the establishment failed to provide or secure appropriate care for one out of three residents (R2.) On several occasions R2 displayed physically aggressive behavior towards other residents and staff. R2 punched a new resident (R3) in the face. R3 sustained a broken jaw, laceration and contusion to his lips. R2 also attacked a CNA after not responding to redirection. These failures create a substantial probability of severe harm to all residenst who reside in the memory care unit. Findings include: R2 is a 60 year old resident who moved into the establishment on 7/31/24. R2 has diagnoses including Dementia, Mild cognitive impairment, Primary Hypertension, Benign Prostatic	A4060		

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Hyperplasia and Hyperthyroidism, R2 resides in the memory care unit.

The progress notes dated 12/13/2025, 7:09pm show R2 was observed exhibiting aggressive behavior toward a new male staff member. Resident appeared unfamiliar with surroundings and reacted with aggression toward the staff member. To prevent escalation, E6 (LPN) and another staff member intervened promptly. R2 was safely separated from nearby residents and staff without injury. E6 assessed R2's behavior, maintained a calm demeanor, and spoke gently to R2 during the interaction. R2 was easily redirected and walked in a different direction with E6 without further incident. Z2 was notified and ordered a psychiatric consult for further evaluation. Z3 was notified. E1 and E2 were made aware of the incident.

The progress note dated 2/10/2026, 7:26pm by E8 (LPN) shows Incident: At around 4pm, a male resident (R3) in memory care reported being punched in the face by another male resident (R2), resulting in a bleeding mouth. The incident was not witnessed by staff. Upon assessment, R2 was combative and agitated, preventing vital signs or a full assessment. Redness was observed on R2's fist knuckles. E5 (CNA) reported that R2 also threatened a female resident (R4). Due to safety concerns, no further assessment was completed. 911 was called, and EMS (emergency medical service) transported R2 to a local hospital for psychiatric evaluation. Police Incident Report was filed.

The progress note dated 3/19/2026 shows at 4:45AM an incident occured. E11 (LPN) called to floor by panicked care staff members. E11 observed R2 chasing staff around unit. E11 and

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A4060	Continued From page 12	A4060		

other care staff tried to redirect R2 away from attacked care staff member. Situation deescalated and blood noted on back of R2's head. E11 attempted to assess R2 but couldn't due to agitation. 911 was called. All parties aware of incident.

On 3/17/26 at 11:30am, E1 (executive directive) stated "this happened in the memory care unit. The second resident involved was R3. R2 said he didn't like R3 driving past his house. R2 was the aggressor. R3 is pleasantly confused. In R3's mind, he thought R2 was driving past his house."

On 3/18/26 at 2:30pm via telephone, E2 (wellness director) stated, "I was here in the office. I heard some commotion. R2 is a ex cop. R2 has behaviors towards new residents. R3 had only been here for about a week. R2 has to warm up to new residents. The CNA saw R3 with blood on his face. When asked what happened, R3 said someone punched him in the face. R2 said R3 was driving by his drive way too fast. We saw blood on the floor in front of R3's apartment. R2 was standing in front of R3's apartment. R3 has late stage dementia. R2 didn't admit to hitting R3. R3 was bleeding so we took him to the nurse's office to apply first aid. We had a male CNA sit with R2 until the paramedics came."

On 3/23/26 at On 3/23/26 at 9:33am via telephone E5 (CNA) stated, "I wasn't working on the shift when R2 attacked R3. R2 attacked me the other night. I asked E2 what plan was in place to address R2's aggressive behavior and protect residents and staff because whatever was in place was not working. R2's not appropriate for the unit. The other night I tried to get R2 to change his brief because it was soiled. He said no. The other CNA felt R2 was irritated with her

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A4060	Continued From page 13 so we left R2 alone. I asked the nurse if R2 had some medicine to help him calm down. R2 was irritated and had stool on him. I asked again if I could help him, R2 said no and slapped my hand away. R2 was moving toward a resident (R4) we had seated in her geri chair in the common area because she is a fall risk. I was trying to redirect R2 because he was hovering over her, that's when R2 attacked me. R2 punched me in my head. R2 then pulled at my jacket. I managed to break free and place the cart between us. I called for help twice on the radio. The only male CNA on the night shift came up. R2 had calmed down when he heard me call for help and he saw the male CNA. The nurse called 911 to have R2 sent out to the hospital. I'm still a little shaken up about that." On 3/23/26 at 2:05pm via telephone, E8 (LPN) stated, "I was on duty that day. I was in the nurse's office. R3 said call the police! I saw R3 had blood coming from his mouth. I didn't know if R3 had fallen. The CNA brought R3 to me. The CNA said she thought R2 had hit R3. R3 said R2 was driving too fast and he was trying to stop him. I couldn't assess R2 because he was so agitated. I continued to assess and clean R3 up. E2 called 911."	A4060		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Section 295.6000 Resident Rights - Level 2 Violation a) No resident shall be deprived of any	A6000		

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A6000	Continued From page 14 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: 1) The right to live in an environment that promotes and supports each resident's dignity, individuality, independence, self-determination, privacy, and choice and to be treated with consideration and respect; 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: -secure an enviornment that promotes resident safety for one (R1) out of 4 residents reviewed for neglect. R1 ingested liquid laundry detergent that was left unsecured in his room. R1 was sent to the hospital approximately 4 hours later and diagnosed with Acute Hypoxic Respiratory Failure; -ensure that a resident was free from abuse. This failure involves 1 of 2 residents (R3). R3 was punched in the face by another aggressive male resident (R2) and sustained a closed fracture of the right ramus of the mandible (jaw), lip contusion and lip laceration.	A6000		

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These failures have the probability of harm to affect residents who reside in the Memory Care unit.

Findings include:

1. R1 is a 73 year old resident who moved into the establishment 11/9/22, R1 has diagnoses including Unspecified dementia, Persistent mood (affective) disorder, Heart disease, unspecified, Asthma, Essential (primary) hypertension, unspecified, Acute embolism and thrombosis of unspecified deep veins of distal lower extremity bilateral.

The progress notes for January 2026 show the following:

-1/21/26, 4:30am, Incident:
E2 (Wellness Director) reviewed and documented the event as reported by E4 (LPN). Per E4's statement, R4 was observed on the bedroom floor with vomitus and thick phlegm present. R4's bed linens were noted to be wet with phlegm and emesis. E5 (CNA) assisted E4 with lift assist. R1 was assisted to the bathroom for hygiene care. Per E4, a small bottle of liquid laundry detergent was observed in R1's room. R1 was asked if he drank the detergent and verbally responded "yes." E4 contacted Z1 and requested review of in-room camera footage to verify possible ingestion. Z1 later reported that video review did not show R1 ingesting detergent. Per E5, R1 was noted to sound congested. E5 endorsed the findings to the oncoming shift and planned for R1 to be evaluated the Z2 durng their visit on that day.

-1/21/26, 6:58am, Nursing:
Resident was observed laying on the floor, with

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vomit on the floor next to him. Resident bed was full of vomit, resident states his stomach was hurting .Resident cleaned up. Will continue to monitor and endorse to the next shift to monitor.

1/21/26, 9:30am, Incident
-E2 documented follow-up to prior incident per report from morning shift nurse (E3). Per E3, Z1 arrived at the facility and reported that upon further review of in-room video footage, Z1 believes (R1) ingested liquid laundry detergent. At the time of Z1's report, Z2 was present in the facility. Vital signs were rechecked and noted with elevated blood pressure and pulse. Oxygen saturation measured at 81%. No episodes of vomiting were reported since 0700. Due to concern for suspected ingestion of laundry detergent and abnormal vital signs, decision was made to transfer R1 to the emergency department for further evaluation and treatment. Emergency services (911) were activated. R1 was transported to a local hospital. Resident departed the facility at approximately 09:30am.

The incident report Incident report dated 1/21/26 shows the following:

Incident: Suspected Accidental Ingestion of Chemical With Hospital Transfer
Time: 4:30-5:00 AM
Resident (R1) a memory care resident was observed at approximately 4:30 a.m. on the floor with active vomiting and complaints of stomach pain. Upon assessment, emesis and thick phlegm were observed on the floor and bed. No apparent injuries related to the fall were noted. During assessment, a small bottle of liquid detergent was observed in R1's room. When asked, R1 stated that he drank the detergent. Z1 was contacted and initially reported that camera

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footage did not confirm ingestion, however, later that morning Z1 reported that upon further review, R1 may have ingested the detergent.
R1 experienced continued vomiting and was sent out to a local hospital at around 9:30am. The emergency department later notified the facility that R1 was admitted for observation with diagnoses of accidental or unintentional ingestion of a substance and acute hypoxic respiratory failure. In response to the incident, E4 (night shift nurse involved) was suspended pending investigation.

The progress note dated 1/29/26, 3:51pm, shows R1 entered another resident's room. CNA followed R1 to redirect. R1 removed a lotion bottle from the room, unscrewed the top, and threw the top bottle toward the CNA. CNA attempted to retrieve the bottle as R1 attempted to drink the lotion. R1 became verbally aggressive and used profane language toward staff. CNA successfully retrieved the bottle before ingestion occurred. R1 did not drink any of the lotion. R1 was redirected back to his room, and all doors was closed. No injuries noted. R1 remains under observation.

R1 returned to the community on 1/23/26 with hospital diagnosis of Acute Hypoxic Respiratory Failure.

On 3/18/26 at 2:30pm via telephone E2 (wellness director) stated, "this incident happened on the night shift, close to the end of that shift. The night nurse was E4. E5 (CNA/certified nurse aide) was doing rounds. E5 found R1 on the floor in diarrhea and vomit. E5 went to get E4. Z1 told us she brought the laundry detergent and stored it under the sink. The door under the sink wasn't locked and Z1 forgot to tell staff she placed the

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detergent there. R1 does wander. R1 found the detergent. E4 didn't call me after this incident happened. E4 called Z1 to confirm if R1 drank the laundry detergent. There is a camera in R1's room. Z1 at first said no R1 didn't drink the detergent, But after reviewing the video again, Z1 came in on the day shift and said yes R1 did drink it. E4 was terminated because of neglecting to inform me about the incident and there was a delay in seeking medical treatment."

On 3/19/26, 12:40pm via telephone, E3 (LPN) stated, "I was coming in for the day shift. I work on the day shift in memory care. I didn't receive report from the previous nurse (E4). E4 said she thought R1 ingested something. Z1 came in and showed the video. That's when I sent R1 out to the hospital for evaluation. There wasn't any vomiting or diarrhea on my shift."

On 3/19/26 at 2:45pm via telephone, E4 (LPN) stated, "I found out because the CNA (E5) told me. E5 said R1 wasn't feeling well and he threw up. I went to R1's room. I saw the laundry detergent. It was a small bottle. R1 couldn't tell us if he drank some of it. The phlegm was clear. That's why I called Z1. R1 has a camera in his room. At first Z1 said she didn't think R1 drank any of the detergent. I gave report to the oncoming nurse. This happened towards the end of the night shift. Later that day R1 was sent out to the hospital by the day shift nurse. That detergent wasn't supposed to be left in R1's room. Z1 claimed she gave that bottle to a CNA and it was supposed to be locked up."

On 3/23/26 at 9:3am via telephone,, E5 (CNA) stated, "I work on the night shift in memory care. When I first checked on R1, he was asleep. I checked on R1 again a few hours later, R1 was

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laying on the floor. R1 said he was sick. R1's shirt was wet. R1 had vomited on his shirt and there was vomit on the bed. The vomit was clear. I went to get another CNA and the nurse (E4). We took R1 to the bathroom to clean him up. I noticed a small bottle of liquid laundry detergent on the counter. The cap was off of the bottle. I don't know where that bottle came from because I didn't see it the last time I had checked on him. R1 usually sleeps through the night. R1 admitted he drank some of it."

2. R2 is a 60 yeat old resident who moved into the establishment 7/31/24. R2 has diagnoses including Dementia, mild cognitive impairment, Hyperthyroidism, Primary Hypertension and Benign Prostatic Hyperplasia.

The progress note dated 2/10/2026 shows Incident: At around 4pm, a male resident in memory care (identified as R3) reported being punched in the face by another male resident, (identified as R2) resulting in a bleeding mouth. The incident was not witnessed by staff. Upon assessment, R2 was combative and agitated, preventing vital signs or a full assessment. Redness was observed on R2's fist knuckles. CNA reported that R2 also threatened a female resident (identified as R4). Due to safety concerns, no further assessment was completed. 911 was called, and EMS (emergency medical services) transported R2 to the local hospital for psychiatric evaluation. Police Incident Report was filed.

3. R3 is a 85 year old resident who moved into the establishment 1/30/26. R3 has diagnoses including Dementia, Cognitive communication

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deficit, fracture of vertebrae T9 & T10 (1/28/26), Spondylosis thorac lumbar region, Hypertensive heart disease, Glaucoma, Low back pain, Abnormality of gait & mobility and Ataxia,

The progress note dated 2/10/26 for R3 shows the following:
Summary of Incident: at approximately 4:00pm, an unwitnessed resident-to-resident altercation occurred in the Memory Care Unit involving R2 and R3. R3 was observed with a laceration to the lips. R2 was seen in the hallway near the area where blood was noted. R3 was brought to the nurse's station for assessment. R3 stated, "I was at my house and R2 was driving too fast in the driveway and I told R2 to stop driving too fast. That's when I got attacked." Nursing staff provided first aid, completed a head-to-toe assessment and EMS transported R3 for further evaluation.

R2 was agitated and resisted assessment. Redness was noted to R2's knuckles. Staff redirected R2 and a CNA remained with R2 until EMS arrived to ensure the safety of other residents. EMS transported R2 to a local hospital for psychiatric evaluation. Police were notified and a report was filed.

The update to the incident shows R3 returned from the Emergency room with diagnoses of closed fracture of the right ramus of the mandible, lip contusion, and lip laceration.

On 3/17/26 at 11:30am, E1 (executive directive) stated "this happened in the memory care unit. The second resident involved was R3 was driving. R2 said he didn't like R3 driving past his house. R2 was the aggressor. R2 is pleasantly confused. In R2's mind, he thought R3 was

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driving past his house."

On 3/18/26 at 2:30pm via telephone, E2 (wellness director) stated, "I was here in the office. I heard some commotion. R2 is a ex cop. R2 has behaviors towards new residents. R3 had only been here for about a week. R2 has to warm up to new residents. The CNA saw R3 with blood on his face. When asked what happened, R3 said someone punched him in the face. R2 said R3 was driving by his drive way too fast. We saw blood on the floor in front of R3's apartment. R2 was standing in front of R3's apartment. R2 has late stage dementia. R2 didn't admit to hitting R3. R3 was bleeding so we took him to the nurse's office to apply first aid. We had a male CNA sit with R2 until the paramedics came."

On 3/23/26 at On 3/23/26 at 9:33am via telephone E5 (CNA) stated, "I wasn't working on the shift when R2 attacked R3. R2 attacked me the other night. I asked E2 what plan was in place to address R2's aggressive behavior and protect residents and staff because whatever was in place was not working. R2's not appropriate for the unit. The other night I tried to get R2 to change his brief because it was soiled. R2 said no. The other CNA felt R2 was irritated with her so we left R2 alone. I asked the nurse if R2 had some medicine to help him calm down. R2 was irritated and had stool on him. I asked again if I could help him, he said no and slapped my hand away. R2 was moving toward a resident (R4) we had seated in her geri chair in the common area because she is a fall risk. I was trying to redirect R2 because he was hovering over her, that's when R2 attacked me. R2 punched me in my head. R2 then pulled at my jacket. I managed to break free and place the cart between us. I called for help twice on the radio. The only male CNA on

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A6000	Continued From page 22 the night shift came up. R2 had calmed down when he heard me call for help and he saw the male CNA. The nurse called 911 to have R2 sent out to the hospital. I'm still a little shaken up about that." On 3/23/26 at 2:05pm via telephone, E8 (LPN) stated, "I was on duty that day. I was in the nurse's office. R3 said call the police! I saw he had blood coming from his mouth. I didn't know if R3 had fallen. The CNA brought R3 to me. The CNA said she thought R2 had hit R3. R3 said R2 was driving too fast and he was trying to stop him. I couldn't assess R2 because he was so agitated. I continued to assess and clean R3 up. E2 called 911."	A6000		