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A 000	Initial Comment Change of Ownership (CHOW) and COI# 2612425/IL00200419 CHOW Violations: 1. Section 295.2000 Residency Requirements a) 2. Section 295.4010 Service Plan - a) d) e) g) 1) A) C) 2) 3) h) COI# 2612425/IL00200419 violations: 1. Section 295.3000 Personnel Requirements, Qualifications and Training - a) h) 1) 2) 3) 7) 2. Section 295.4000 Physician's Assessment - f) 3. Section 295.4010 Service Plan - a) d) e) g) 1) A) C) 2) 3) h) 4. Section 295.6000 Resident Rights - a) 13)	A 000		
A2000	Section 295.2000 Residency Requirements This Regulation is not met as evidenced by: Type 2 Violation Section 295.2000 Residency Requirements (a) 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. These requirements were not met, as evidenced by: Based on interview and record review, the facility failed to evaluate the appropriateness of the	A2000		

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A2000	Continued From page 1 continued residency of R3, a resident identified with behavioral symptoms of agitation, with physical and verbal aggression. These failures resulted in staff and residents (R6) being physically abused by R3. 1. November 21, 2025, R3 pushed and tried to hit staff. 2. December 20, 2025, R3 grabbed a staff member's arm, chased them, and punched the staff member at the back of their head. 3. On January 1, 2026, R3 hit a staff member and a resident (R6). This failure creates a substantial probability of harm to a resident. This applies to one (R3) of one resident reviewed with physical aggression. The findings include: R3 moved into the community on May 8, 2024, with diagnoses to include early onset Alzheimer's disease, anxiety, depression, and agitation/restlessness. March 13, 2026, at 4:00PM, R3 was described by E2 (Health Service Director/LPN) as a wanderer with exit-seeking behavior and requiring "heavy cuing." R3 was described to follow other people out the door and push on the exit doors. R3 was also identified to have a history of "hitting staff and residents, as well as threatening to hurt people." The following incidents were documented in R3's progress notes: 1. November 21, 2025, at 3:00 AM, R3 was trying to open an exit door. R3 pushed and tried to hit the staff member that was trying to redirect R3. R3 was able to exit the building with staff	A2000		

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A2000	Continued From page 2 following behind R3. 2. December 20, 2025, at 10:34 AM, a caregiver tried to stop R3 from taking a pitcher of juice. R3 grabbed the staff member's arm, chased the staff, and punched the staff member at the back of their head. 3. January 1, 2026, at 6:32 PM, a staff member observed R3's pants pulled down. The staff member tried to pull R3's pants up when R3 hit the staff member and stated, "I will kill you." On March 13, 2026, at 4:20PM, E2 explained," R3 was verbally and physically aggressive but was getting better! R3 had to be discharged because of financial issue."	A2000		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: Type 1 Violation Section 295.3000 Personnel Requirements, Qualifications and Training a) The establishment shall have staff sufficient in number with qualifications, adequate skills, education and experience to meet the 24 hour scheduled and unscheduled needs of residents and who participate in ongoing training to serve the resident population. (Section 35(a)(3) of the Act) h) The establishment shall have sufficient personnel to provide the following for its current resident population: 1) All mandatory services. 2) Services established in each resident's	A3000		

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service plan.
3) Service to meet the needs of each resident, including 24 hours scheduled and unscheduled needs, general supervision, and the ability to intervene in a crisis;
7) Any optional services to be provided by the establishment as stated in the service plan.

These requirements were not met, as evidenced by:
Based on interview and record review, the facility failed to:
1. Provide supervision to R1 identified as at "risk for fall."
2. Conduct a thorough assessment after R1's incident of fall.
3. Document and describe the accurate injury sustained by R1.
4. Implement and monitor the effectiveness of interventions.
5. Notify Attending Physician regarding R1's injuries.

These failures resulted in negligent delays in providing treatment for R1's fall incident on February 14, 2026.
1. R1 fell and hit their head on the dining room wall. The wall was left with a visible "hole" measured at 4.0 cm length X 4.0 cm width (with approximate depth of 2.5 cm). R1's head was not assessed for possible injury.
2. R1 sustained a laceration on the left lower leg with evidence of continued bleeding: as evidenced by blood saturating the dressing, bed sheets, left shoe, and blood on the floor.
R1 was admitted into the hospital with head injury and repair (21 sutures) for the laceration sustained to the left lower leg.

This failure creates a substantial probability of

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severe harm or death to a resident or residents. This applies to one (R1) of six residents in the sample.

The findings include:
R1 moved into the community on February 7, 2026, with diagnoses to include chronic kidney disease- Stage 3, anemia, sleep apnea and dementia.

February 15, 2026, at 5:33 AM, E3/LPN (7:00 PM-7:00 AM shift) documented the following in R1's nurse's notes: "Staff called nurse (E3), R1 was found on the floor. R1 stated, 'I was transferring from the wheelchair to the regular chair in the dining area.' Fell and hit head by the wall and broke it, skin tear on the left leg. R1 stated, 'He feels pain in his leg.'"

On March 13, 2026, at 1:10 PM, E1 (Executive Director) and E2 (Health Service Director/LPN) explained R1's incident of fall on February 14, 2026, "R1 had a fall in the dining room, hit his head on the wall and had a cut on the leg. This was not reported to the doctor or to the family and to me (E2) until the next day (February 15, 2026) at around 6:40 AM. E3 called me (E2) when I was already on my way to the community. E3 just said that R1 had a fall, that was it. E3 didn't give me any details! When I got to the community, R1's wife requested to speak with me. I was not aware of R1's condition until I saw R1 in the room and the leg was bleeding. The dressing was saturated with blood."

On March 17, 2026, at 11:10 AM, E3/LPN (7:00 PM- 7:00 AM shift) stated, "I was too exhausted. I was trying to manage. I was the only nurse on duty for all [four of] the cottages. It was almost 8:00 PM, I am scheduled to pass my meds, the

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caregivers kept calling me. I think it was around 9:40 PM, the caregiver said, 'R1 fell in the dining room' ... The caregiver told me that R1's leg had been bleeding a lot. I told them to bring R1 back to the room. At around 10:00 PM, I went to see R1 (in the room). There was blood all over the floor. At that time, I did not know where the blood was coming from. I told the caregiver to remove R1's pants. R1 was "struggling," didn't want his pants taken off. Then, I was able to put a dressing on R1's wound ... Yes, it was bleeding a lot. Maybe the wound was about 3 inches long. No, I didn't check R1's head."

E3 confirmed that a full body assessment was not done and that they only applied a dressing on R1's bleeding left leg. E3 confirmed that the attending physician and the Power of Attorney were not notified.
The written statement of E4 (AM- caregiver) dated February 19, 2026, reads: "I was told during the shift change that the resident (R1) had been bleeding during the night. When we went into the room, R1 was on the pad on the floor. The bandage was saturated through his leg, which was still bleeding ..."
On March 17, 2026, at 1:28 PM, E4 stated, "The night shift caregiver (E7) was cleaning R1's bloody sheets and said 'He's been bleeding during the night.' I saw the mattress was on the floor, the floor with blood, and the wrapping on his leg was bloody as well."

On March 17, 2026, at 3:44 PM, E7 said, "I worked at 11:00 PM, I was told by the nurse (E3) that R1 had a dressing on the leg. I asked why and was told [by the nurse], 'Don't worry about it.' No, I was not told that R1 had a fall, the wife did in the morning."

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A3000	Continued From page 6 On March 13, 2026, at 7:30 AM, Z1 said, "It's good I came, they did not any have plan of sending R1 out [to the hospital] at all. They do not know what they are doing in that place. I told the head nurse (E2) that they need to send R1 out to the hospital because he is still bleeding since yesterday. R1 was on a blood thinner [Eliquis]. The head nurse (E2) gave me 3 options: 'It's up to you, (1) you can take R1 by yourself, (2) pay someone to take him or (3) we can call 911.' What was that? Of course, we choose 911 but I didn't understand why they didn't call 911 with all that blood!"	A3000		
A4000	Section 295.4000 Physician/s Assessment This Regulation is not met as evidenced by: Type 2 Violation Section 295.4000 Physician's Assessment (f) f. The establishment shall monitor and have a reporting procedure in place for notifying a relative or other individual in an emergency situation, significant change in resident's condition, or termination of residency. These requirements were not met, as evidenced by: Based on interview and record review, the facility failed to: 1. Implement the community change of condition notification protocol. 2. Notify R1's Attending Physician, Health Service Director, and R1's Power of Attorney within an acceptable time (an hour after an incident of fall).	A4000		

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These failures resulted in:
1. Delayed notification to R1's attending physician, Health Service Director and R1's family, to obtain order or guidance related to R1's fall incident and R1's "excessive bleeding" on the left lower leg laceration.
2. On February 14, 2026, at 9:40 PM, R1 sustained a fall, hit their head on the dining room wall, sustained a laceration on the left lower leg. R1 was not sent to the hospital until the next day, February 15, 2026, (prior to 10:45 AM), more than 12 hours after the incident.

Type 2 - This failure creates a substantial probability of harm to a resident or residents. This failure has the substantial probability of affecting all residents in the establishment. This applies to one (R1) of six residents in the sample.

The findings include:
On March 13, 2026, at 7:30 AM, Z1 explained, "I was upset with them (community). On February 15, 2026, I got a call from a nurse (E3) and said, R1 had fallen yesterday (on February 14, 2026), at around 9:00 PM and had a skin tear on the leg. They did not call and told me about the fall until 6:45 AM the next day (February 15, 2026). When I arrived, (in the community on February 15, 2026) around 7:30 or 8:00 AM, R1 was sitting in the dining room, in a wheelchair. I immediately saw his left leg pants have blood stained on them. I asked the staff to bring R1 back to the room and I want them to strip R1 so I could see where the blood's coming from. As we entered R1's room, there was blood on the floor. Not sure if that was from that morning or since last night. When they took his pants off, there was a dressing wrapped around R1's left leg but it was soaked with blood and the blood was dripping on

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A4000	Continued From page 8 R1's foot. R1's left leg looked like the wound was from the knee to the ankle. It was a big, long cut. They did not have any plans to send R1 to the hospital. R1 was on a blood thinner, he would have bled out! I requested to talked to the Head Nurse (E2) to send R1 to the hospital." On March 18, 2026, at 11:15 AM, E2 (Health Service Director/LPN) confirmed that E3 did not notify R1's Attending Physician, Power of Attorney and herself regarding R1's incident until the following day (February 15, 2026). E2 stated, "The nurse should have called with in an hour of the incident."	A4000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: TYPE 1 Repeat 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. 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 (see Section 295.2030). (Section 15 of the Act).	A4010		

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A4010	Continued From page 9 e) The service plan shall be reviewed and revised, if necessary, immediately after a significant change in the residents' physical, cognitive, or functional condition (see Section 295.4000). g) Service plans shall address: 1) The level of service the residents receive, including: A) assistance with activities of daily living. C) accommodation for the residents. 2) The amount, type, and frequency of health-related services needed by the residents. 3) Staff responsible for the provisions of the service plan. h) The service plan shall include all support services provided or arranged for by the establishment. These requirements were not met, as evidenced by: Based on observation, interview and record review, the facility failed to: 1. Address the specific problem/behavior and medical symptoms of the residents that require monitoring. 2. Develop and implement individualized interventions based on the identified needs of the residents. 3. Identify the frequency of the required services and the staff responsible for the provision of care and treatment. 4. Develop a preventative plan of service to prevent possible complications. These failures resulted in: A. R3 physical aggression towards staff during care: (a) November 21, 2025, R3 pushed and tried to hit the staff. (b) December 20, 2025, R3 grabbed a staff	A4010		

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member's arm, chased them, and punched the staff member at the back of their head.
(c) January 1, 2026, R3 hit R9 and a staff and stated, "I will kill you."
B. R4's development of a community-acquired Stage 2 pressure injury to the sacrum.
C. R1 sustaining a head injury and a laceration to the left lower leg that required 21 stitches.

Type 1 - This failure creates a substantial probability of severe harm or death to a resident or residents.
This failure has the substantial probability of affecting all residents in the establishment.
This applies to two of six residents (R3, R4) in the sample.

The findings include:
R3 moved into the community on May 8, 202, identified by E2 (Health Service Director/LPN) on March 13, 2026, at 4:00 PM, with behaviors to include physical aggression, wandering and exit-seeking.
R3's progress notes show the following behaviors:
1. November 21, 2025, at 3:00 AM, R3 was trying to open an exit door. R3 pushed and tried to hit the staff member that was trying to redirect R3. R3 was able to exit the building with staff following behind R3.
2. December 20, 2025, at 10:34 AM, a caregiver tried to stop R3 from taking a pitcher of juice. R3 grabbed the staff member's arm, chased the staff, and punched the staff member at the back of their head.
3. January 1, 2026, at 6:32 PM, a staff member observed R3's pants pulled down. The staff member tried to pull R3's pants up when R3 hit the staff member and stated, "I will kill you."

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A4010	Continued From page 11 R3's service plan identified R3 with the following behaviors: 1. Aggression. No interventions were developed to address this behavioral symptom of R3. The action plans documented are the following: - Assistance with aggression: Resident (R3) has a history of aggression previously pushing others. Resident (R3) to be redirected respond well to "Private [last name redacted]" due to his military background. Also, may be compliant when informed "Nancy said to do this!" Per Power of Attorney, R3 responds to being told something was his idea, for example "Didn't you say you wanted to take a shower?" 2. Disruptive/socially inappropriate behavior. - The action plans documented are the following: - Residents have current or history of occasional disruptive, aggressive, or socially inappropriate behavior either verbally or physically improper may require special tolerance or staff training. E2 clarifies (a) inappropriate behavior as R3 urinating in the common areas, (b) aggressive-physical and verbally aggressive and can easily get agitated to others (staff and residents). R3's service plan failed to include specific interventions. These concerns were discussed with E1 (Executive Director) and E2 during this survey. ii. R4 moved into the community on September 14, 2023, with diagnoses to include dementia, muscle wasting, and Barrett's esophagus. On March 13, 2026, at 2:20 PM, R4 was observed to be outside the building, sitting in a wheelchair smoking. E2 identified R4 with wounds on the buttocks. An undated wound note was presented by E2 that reads: Admitted to	A4010		

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A4010	Continued From page 12 health service on May 20, 2025, for wound care on the left buttocks. Stage 2 pressure ulcer noted at 1.3 (cm length) by 1.7 (cm width). R4's skin service plan dated June 11, 2025, documented: "Residents will maintain optimal skin integrity by identifying risk factors and receiving assistance to prevent skin related issues. Residents will maintain and /or maximize healing process. The action plan includes PERSONALIZE. Nurse to observe residents skin breakdown to sacrum area and enter in the progress note." Service plan [addressing the] outside services: Show (home health services) started on May 20, 2025, for the management of R4's wound on the left buttocks and a note that " wound is healed." No description of the wound, including an identified stage, nor was a date of evaluation provided. - On January 19, 2026, a sacral Stage 2 was identified. There was no description or measurement provided. On March 13, 2026, at 2:40 PM, a skin assessment was conducted with E2. R4 was noted with Stage 2 pressure injury to the sacral area measured at 6.0 cm in length x 5.0 cm in width. The progression of the wound was not monitored and documented. The community was unable to present any assessment for this sacral wound. There was no service plan identifying the presence of the sacral wound as a problem/concern to be monitored and no specific interventions were developed. These concerns were discussed with E2 on March 13, 2026, at 4:30 PM.	A4010		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBERGE AT LAKE ZURICH A MEMORY CARE COMM	555 AMERICA CT LAKE ZURICH, IL 60047

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A4010	Continued From page 13	A4010		

iii. R1 moved into the community on February 7, 2026, with diagnoses to include chronic kidney disease- Stage 3, anemia, sleep apnea and dementia.

On March 13, 2026, at 11:00 AM, E2 (Health Service Director/LPN) described R1 with cognitive deficit, requiring one staff assist with activities of daily living's and supervision due to multiple behaviors (e.g., hallucination, refusing care, exit seeking/opening exit doors, impulsivity, trying to stand up from wheelchair unassisted, and risk for fall)."
R1's progress notes dated: (1) February 8, 2026, at 8:30 AM, R1 was found sitting on the floor next to the bed. R1 stated, 'I wanted to transfer myself to the wheelchair.' No visible injury noted. (2) February 8, 2026, at 12:53 PM, R1 was sustained a fall in the dining room. "R1 tried to get up and fell."

R1 service plan February 10, 2026, identify R1 as "at risk for fall," related to cognitive impairment and decreased mobility. The plan of action listed is for the care staff to perform rounds regularly to ensure safety, comfort and address and questions concern. Of note, the frequency of rounding "regularly" was not defined in the plan.
R1's transferring service plan documented by R1 requires full assistance with all transferring segments and staff to provide direction and cuing during the task.

R1's service plan was revised to identify the root causes of R1's fall and failed to revise the intervention based on this identified behavior. This concern was discussed to E2 on March 13, 2026, at 2:41 PM.

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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: 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 interview and record review, the facility failed to: 1. Provide immediate treatment and services to R1 who sustained a fall on February 14, 2026. 2. Implement the community protocol related to changes of conditions: a. Evaluate the seriousness of the injury/issue. b. Call 911 as indicated. c. Consult, notify and obtain instruction or order from attending physician and Health Service Director. d. Notify the Power of Attorney regarding the incident. 3. Conduct a thorough assessment after an incident of fall. These failures resulted in neglect and delayed	A6000		

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A6000	Continued From page 15 provision of treatment: 1. R1's left leg laceration continued to bleed and was not controlled for more than 12 hours, as evidenced by blood-saturated dressing, sheets, shoe, and blood on the floor. 2. R1, a patient known to be on a blood thinner, sustained (a) a head injury where no assessment was performed and (b) a left lower extremity laceration requiring 21 stitches. 3. R1 was not sent to the hospital until 12 hours after the time of the incident, per the request of the Power of Attorney (February 14, 2026, at 9:40 PM-February 15, 2026, at 10:49 AM). This failure creates a substantial probability of severe harm or death to a resident This failure has the substantial probability of affecting all residents in the establishment. This applies to one (R1) of five residents in the sample. The findings include: On March 13, 2026, at 11:00 AM, E2 (Health Service Director/LPN) described R1 with cognitive deficit, requiring one staff assistance with activities of daily living's and supervision due to multiple behaviors (e.g., hallucination, refusing care, exit seeking/opening exit doors, impulsivity, trying to stand up from wheelchair unassisted, and risk for fall)." R1 moved into the community on February 7, 2026, with diagnoses to include anemia, chronic obstructive pulmonary disease, sleep apnea and chronic kidney disease. R1 utilized a wheelchair for mobility. R1 had history of falls (documented in R1's nurses note on February 8, 2026, at 9:41 PM, next to the bed and at 12:53 PM, in the dining room. The community documented that these falls are due to R1's behavior of "attempting to get up from the wheelchair."	A6000		

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A6000	Continued From page 16 On February 15, 2026, a reportable incident marked as "first (initial) and final report" was submitted to the Department that reads as follows: - On February 14, 2026, at approximately 21:40 (9:40PM) resident (R1) acquired a skin tear to the lower left extremity in the dining area. It was reported that the resident (R1) was trying to transfer himself from a wheelchair to a dining room chair and fell. Applied a wound dressing to left lower extremity wound. On February 15, 2026, the wound dressing was noted to be saturated with blood. EMS transported R1 to the hospital ... 1. On March 13, 2026, at 7:30 AM, Z1 explained, "I was upset with them [the community]. On February 15, 2026, I got a call from a nurse (E3) who said R1 had fallen yesterday (on February 14, 2026), at around 9:00 PM and had a skin tear on the leg. They did not call and tell me about the fall until 6:45 AM the next day (February 15, 2026). When I arrived, [in the community on February 15, 2026] around 7:30 or 8:00 AM, R1 was sitting in the dining room, in a wheelchair. I immediately saw his left pant leg had blood stained on them. I asked the staff to bring R1 back to the room and I wanted them to strip R1 so I could see where the blood was coming from. As we entered R1's room, there was blood on the floor. Not sure if that was from that morning or since last night. When they took his pants off, there was a dressing wrapped around R1's left leg soaked with blood and the blood was dripping on R1's foot. R1's left leg looked like the wound was from the knee to the ankle. It was a big, long cut. They did not have any plans to send R1 to the hospital. R1 was on a blood thinner. He would have bled out! I requested to talked to the Head Nurse (E2) to	A6000		

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A6000	Continued From page 17	A6000		

send R1 to the hospital."

Z1 continued and said, "It's good I came, they did not have plan of sending R1 out [to the hospital] at all. They do not know what they are doing in that place. I told the head nurse (E2) that they need to send R1 out to the hospital because he is still bleeding since yesterday. R1 was on a blood thinner (Eliquis). The head nurse (E2) gave me 3 options: E2 said 'It's up to you, (1) you can take R1 by yourself, (2) pay someone to take him or (3) we can call 911.' What was that? Of course, we choose 911 but I didn't understand why they didn't call 911 with all that blood!"

2. The following are the written statements of the caregivers:

A. E7's (caregiver) written statement dated February 18, 2026, read as follows: "Was told R1 was on the pad on the floor because he kept sliding himself out of bed. Was notified (R1) with bandage on the left leg ankle. Asked what happened nurse said, 'It's fine don't worry about it.' R1 was very restless during the night. Around 3:00 AM, nurse was notified about blood on the bed and the leg, called the nurse on the phone, nurse said she would come to take care of it. Around 7:30 AM, had to change the resident and noted still bleeding, blood coming down his leg, on the floor and on the pad."

B. E4 (caregiver) dated February 19, 2026, reads: "Told during shift change the resident (R1) had been bleeding during the night when we went into the room [R1] was on the pad on the floor. The bandage was saturated ... leg is still bleeding ..."

C. On February 20, 2026, E5 (caregiver) written statement read as follows: "Was told by the nurse, the resident (R1) fell hurt his head and had a wound on the leg. Was asked by the wife

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why she wasn't called. Was asked to help check for any other wound. Saw the wound was still bleeding, dressing was saturated through and blood in his shoe. Wife was here and upset."

3. On March 17, 2026, the following are the interviews from the following staff:

1. At 1:28 PM, E4 stated, "The night shift caregiver (E7) was cleaning R1's bloody sheets and said 'R1's been bleeding during the night.' I saw the mattress was on the floor, floor with blood, and the wrapping on his leg was bloody as well!"

2. At 1:50 PM, E5 explained, "The nurse struggled to contain the bleeding. It really looked bad, it looked like a work of art. The front of the leg was bloody, [dressing] heavily saturated. The wife was really upset and asked to give her time to calm down."

3. At 3:44 PM, E7 said, "I worked at 11:00 PM, I was told by the nurse (E3) that R1 had a dressing on the leg. I asked why and was told by the nurse, 'Don't worry about it!' No, I was not told that R1 had a fall. The nurse never told me; the wife did in the morning. At 7:30 AM, R1 was still bleeding. It looked like it was coming from the left knee down to the ankle. It looks like a lot (of blood)."

4. The community "Change of Condition Protocol "was presented as requested. The purpose of the protocol is to: provide guidance (to the staff) and the identification of clinical changes that might constitute a change in condition and require interventions and notifications. This includes the following phases/protocols which were not followed:

#2. Decision phase

D. Evaluate the seriousness of the issue and,

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A6000	Continued From page 19 E. Determine whether a call to 911 is indicated #3. Intervention phase F. Perform a complete evaluation and review the situation G. Notify the attending physician and obtain instructions or orders as directed. H. Document all intervention results and follow up needed. I. Notify the responsible party (Power of Attorney). 5. On March 13, 2026, at 1:10 PM, E1 and E2 stated, "R1's fall was in the dining room. R1 hit his head on the wall; the wall had a circular dent/hole (measured at 4.0 cm length x 4.0 cm width x 2.5 cm depth) and had a cut on the left leg. The nurse (E3) didn't notify the doctor, me (E2), or the family until this morning. When E3 notified me the morning after the incident, E3 didn't tell me the details, just that R1 had a fall, that was it. We terminated E3. Yes, it was neglect and poor judgement. R1 was taking a blood thinner and hit his head on the wall. E3 didn't send R1 out or call the doctor or I for guidance." 6. The hospital record obtained on April 3, 2026, shows R3 had a head injury (unspecified) and laceration to the left lower leg repaired with 21 sutures.	A6000		