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A 000	Initial Comment Facility Reported Incident IL00200602 295.2050 a)b)c 295.5000 d) f) 1) 2) g) h) 1) 2) Complaint Investigation IL00201667 295.2050 a) b) c) 295.4010 a) b) 1) 2) 3) c) e) g) 1) a) 295.4050 295.4060 a) c) f) 295.6000 a) 13) 295.7000 b) 5)	A 000		
A2050	Section 295.2050 Incident and Accident Reporting This Regulation is not met as evidenced by: VIOLATION Section 295.2050 Incident and Accident Reporting a) An establishment shall report to the Department any serious incident or accident. For the purposes of this Section, "serious" means any incident or accident that causes physical or emotional harm or injury to a resident. A change in an individual's (resident's) condition that is due to health or medical decline is not a reportable incident or accident. b) The report shall be made by contacting the Department of Public Health Division of Assisted Living via email at DPH.LTCAL@illinois.gov or as requested by the Department within 24 hours after the occurrence of the incident or accident.	A2050		

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A2050	Continued From page 1 c) A copy of the report shall be maintained by the establishment for one year after the date of the incident or accident. This requirement was not met as evidenced by: Based on record review and interview, the establishment failed to ensure serious incidents and accidents were reported within time limits for two incidents. Findings include: Reportable report that documents missing controlled medication incident documents Director of Nursing/DON was notified of incident on 2/21/26, but incident was not reported to Illinois Department of Public Health/IDPH until 2/23/26 which is after the 24-hour time frame to report. An anonymous complaint was filed with IDPH received on 5/3/2026 regarding mental abuse by R2 to an unnamed female resident. There was no reportable incident reported to IDPH regarding possible mental abuse to other residents by R2 from admission on 3/29/26 until hospital admission on 5/4/2026. On 5/12/2026, at 1:26 pm, E2 Director of Nursing/DON stated the first time I was told about the medication being missing was that Sunday 2/23/26. E5 Licensed Practical Nurse/LPN was the one that found out that the medication was missing and E5 was working only Saturdays and Sundays at that point. Surveyor asked E2 if E2 had text message notification of missing medication. E2 showed surveyor a text message dated 2/21/26 from E5 that stated they could not find the medication. E2 stated my expectation for	A2050		

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A2050	Continued From page 2 IDPH reporting is that it needs to be reported within 24-48 hours and the investigation is within a week of the initial. Surveyor asked E2 if E2 would consider R2's behaviors mental abuse towards the other residents. E2 stated during R2's behaviors I definitely would consider her behaviors to be mental abuse towards the other residents. I think the vulgarity of it all was also traumatic to them. This has been a whole ordeal. I have been fighting with the hospital to get her better placement. My biggest fear is that R2 does not have dementia. We did not report mental abuse to the other residents to IDPH. I guess I never looked at it that way because I was more focused on getting R2 help. Our abuse coordinator here is me. Everyone should be notifying me of any type of abuse allegation. Abuse reporting time is 24 hours to IDPH.	A2050		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 2 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 resident's choices regarding the service plan.	A4010		

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A4010	Continued From page 3 b) The service plan shall be developed by: 1) The resident, resident's representative or any individual requested by the resident; 2) The manager or manager's designee; and 3) A registered nurse, if the resident is receiving nursing services or medication administration, or is unable to direct self-care. c) The service plan shall be signed and 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). g) Service plans shall address: 1) The level of service the resident is receiving, including: A) assistance with activities of daily living; This requirement was not met as evidenced by: Based on record review and interview, the establishment failed to ensure service plans were signed by all required parties for four (R1, R2, R3, and R4) of four residents reviewed, Failed to update service plans immediately after a significant change for two (R3 and R4) of four residents reviewed, And failed to address all activities of daily living	A4010		

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A4010	Continued From page 4	A4010		

and medications for one (R1) of four residents reviewed.

This failure creates a substantial probability of harm to a resident or residents.

Findings include:

R1 is a 96-year-old resident admitted to the establishment on 11/22/24 with diagnoses including but not limited to dementia and major depressive disorder.

R1's service plan dated 1/30/2026 is not signed by a registered nurse/RN or a manager/manager's designee. R1's service plan does not address transfers/mechanical lift use or medication.

R2 is a 69-year-old resident admitted to the establishment on 3/29/26 with diagnoses including but not limited to dementia and major depression.

R2's service plan dated 5/11/26 (after start of survey) does not have any signatures of resident/resident representative, RN, or manager/manager's designee. This was the only service plan provided to surveyor for R2.

R3 is an 89-year-old resident admitted to the establishment on 7/28/23 with diagnoses including hypothyroidism and dementia.

R3's service plan dated 2/6/26 is not signed by an RN or a manager/manager's designee. R3's service plan does not address falls on 10/2/25, 10/17/25, 2/5/26, 4/7/26, 4/14/26, and 4/23/26.

R4 is a 77-year-old resident admitted to the

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A4010	Continued From page 5	A4010		

establishment on 3/10/23 with diagnoses including but not limited to dementia and primary osteoarthritis.

R4's service plan dated 5/1/26 is not signed by an RN or a manager/manager's designee and does not address falls on 6/27/25 and 12/12/25.

On 5/11/2026, at 1:43 pm, E11 Assistant Director of Nursing/ADON stated I do some of the service plans. E11 asked to show surveyor where R1's service plan addresses transferring. E11 stated R1 is a mechanical lift transfer. I do not know why it is not showing up on here. I do not see how R1 transfers on the service plan. R1 started on hospice in September/October. When asked who is supposed to sign service plans, E11 stated the Power of Attorney/POA and I am not sure on the corporate side. R1's nephew is her POA and he signed and that is the only signature on there. Regulations were read to E11. E11 stated I was unaware that the Registered Nurse/RN had to sign or the manager. E11 stated I already looked and I do not have a signed service plan at all for R2, not even an initial. The one I provided with today's date on it is our initial service plan. For R2 she is a total assist for bathing. The RA's do everything for her. R2 gets very anxious very easily. R2 is some hands on assist for dressing. R3's service plan is not signed by an RN or a manager/managers designee. We have a section about falls and we look at risk assessment portion. We do not list each fall or add a new intervention for each fall. There is a question about if the resident has a fall in the last 6 months. If the resident is having multiple falls, we would do a change of condition service plan. We do not add a new intervention for each resident fall. For R4 her falls are not listed on the service plans as we are not listing each individual fall and

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A4010	Continued From page 6 interventions on any resident service plan right now. On 5/12/2026, at 1:26 pm, E2 Director of Nursing/DON stated I talked to E11 ADON about her not having R2's service plan signed or having any initial service plan for R2 and I did not get an answer why. I did not know E11 was not getting them signed. I do not have checks and balances in place as of right now. We just talked about this last week and E11 is going to have to do hand over hand report with me and shadow me for training on service plans, and job duties in general and proper paperwork being received for residents. Service plans should address toileting, safety, dining, redirections, regular activities of daily living/ADL's, behaviors, falls, fall interventions for each fall. If they uses devices, transfers, escorting, medication adminsitration should be on there. Housekeeping, linens, etc. I do not know why R1's service plan does not address use of a mechanical lift or medication administration. You should be able to look at service plan and know how to care for the residents. I am a Licensed Practical Nurse/LPN. On the assisted living/AL side, I do not have an RN signature on my service plans either. I was unaware of that. I do have the Executive Director/ED sign. I am not sure if I am putting the falls and interventions in the care plans. I do not add dates with the falls and interventions.	A4010		
A4050	Seciton 295.4050 Tuberculin Skin Test Procedures This Regulation is not met as evidenced by: TYPE 2 VIOLATION	A4050		

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A4050	Continued From page 7 Section 295.4050 Tuberculin Skin Test Procedures Tuberculin skin tests for employees and residents shall be conducted in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696). Section 696.130 Responsibilities of Health Care Settings a) TB Risk Assessment. Every health care setting shall conduct initial and ongoing evaluation of the risk for transmission of M. tuberculosis, regardless of whether patients with suspected or confirmed active (tuberculosis) TB disease are expected to be encountered in the setting. The TB risk assessment shall address administrative, environmental and respiratory-protection controls needed for the health care setting and shall be reviewed at least annually. f) Records. Records shall be maintained on TB screening test results; TB diagnostic evaluation results (including whether the tuberculosis was drug-resistant); other information about any persons exposed to tuberculosis; and the current written plan as required in subsection (b). Individual and aggregate data shall be analyzed periodically to identify the health care setting's level of risk and changes in the risk of TB transmission. All records required in this subsection shall be made available for inspection by the Department or the local TB control authority upon request by the Department or the local TB control authority. This requirement was not met as evidenced by:	A4050		

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A4050	Continued From page 8 Based on record review and interview, the establishment failed to ensure Tuberculosis (TB) testing was completed for one (R2) of four residents reviewed. This failure has the substantial probability of affecting all residents. Findings include: R2 is a 69-year-old resident admitted to the establishment on 3/29/26 with diagnoses including but not limited to dementia and major depression. No TB test results were provided to surveyor for R2. On 5/12/2026, at 9:38 am, E2 Director of Nursing/DON stated I cannot find the initial TB test for R2. On 5/12/2026, at 1:26 pm, E2 DON stated my expectation of TB testing is that upon admission we ask for one and if they do not have one we administer. I think R2 just fell through the cracks and got missed because R2 had so much going on when R2 admitted.	A4050		
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	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) 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) f) No person shall be accepted for residency or remain in residence if the person meets the criteria provided in subsections (b) through (g) of Section 75 of the Act. (Section 150(e) of the Act) This requirement was not met as evidenced by: Based on record review and interview the establishment failed to discharge one resident (R2) of four reviewed who posed a serious threat to themselves and others. This failure resulted in R2 pulling the hair of E8 Licensed Practical Nurse/LPN and hitting E2 Director of Nursing/DON, E11 Assistant Director of Nursing/ADON and E4 LPN and other staff members. This failure also resulted in R2 eloping from the memory care unit on several occasions including one time she was found on a highway at a gas station. This failure creates a substantial	A4060		

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A4060	Continued From page 10	A4060		

probability of severe harm or death to a resident or residents.

Findings include:

R2 is a 69-year-old resident admitted to the establishment on 3/29/26 with diagnoses including but not limited to dementia and major depression. R2 is currently at a hospital for psychiatric evaluation.

R2's incident report dated 5/1/26 documents in part: At approximately 6:22 the R2 attempted to exit the secured memory care unit without authorization when staff approached and provided redirection. The resident became physically resistant. The resident then pushed staff member into the wall in an attempt to force their way out of the unit. Staff immediately intervened using appropriate de-escalation techniques and insured the safety of both the resident and the staff. The resident was redirected away from the exit and guided back onto the unit.

R2's progress note from day of admission on 3/29/26 documents in part: Little known psychiatric history of R2 as she just arrived to the community. Family did not bring in any medications for R2. R2 was not able to be redirected and was combative and verbally abusive to staff. Family had put the R2 in her room and left without notifying staff. DON here as manager on duty/MOD and was called down to the unit to assess. 911 called to bring resident to hospital for a psychiatric evaluation.

Progress note dated 4/4/26 documents in part: Resident is crying and screaming and pulling POA's hair. She is asking to leave.

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A4060	Continued From page 11 Progress note dated 4/11/26 documents in part: Resident became increasingly agitated and tearful, stating she needed to leave and expressing distress that her husband was not answering the phone. We encouraged resident to wait and try calling again later. Resident continued to escalate. Resident agitation increased including frequent door opening and slamming. Progress note dated 4/11/2026 documents in part: Around 6am resident repeatedly requested help but refused assistance when offered. She was observed going back and forth to her room, slamming the door, and appearing tearful and distressed. Resident expressed that she needs Help though she was unable or unwilling to clarify her needs. Progress note dated 4/12/26 documents in part: Resident was yelling loudly at about 9 pm stating she wanted to leave the facility. Progress note dated 4/13/26 documents in part: Resident continued to Escalate becoming increasingly agitated. Resident repeatedly slamming the door came out and asked if she can get dressed and resident assistant/RA informed resident to allow 2 minutes to assist resident responded by yelling and told RA profanities. After successfully changing resident she came out to dining and sat with another resident and this RA overheard her asking resident what would he do if she attempted suicide. R2 kept telling other resident how she does not want to be here and she wants to die becoming very tearful. Progress note dated 4/18/26 documents in part:	A4060		

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A4060	Continued From page 12 Resident was aggravated this AM during med pass. Refused meds. Resident was crying about her husband, yelling "I don't want him here!" Progress note dated 4/18/2026 documents in part: A guest arrived for another resident and R2 slipped out of the memory care/MC building. R2's husband followed behind R2. This writer went after the resident who was screaming up and down the hallway 'I don't want to go home! Progress note dated 4/21/26 documents in part: Resident husband left and resident agitated. Came out of her room with her jacket on and started yelling "Can I go home? I wanna go home." Attempts to redirect resident were met with her further yelling and shaking. Attempted to open up MC unit doors x 2. Resident approached nurses station numerous times yelling "Can I get out of here? I hate it here I want to get out of here!" Resident continued to yell up and down hall "I hate it here I want to get out of here." Progress note dated 4/21/26 documents in part: At shift's end, resident continues to scream throughout the unit Progress note dated 4/22/26 documents in part: Resident left apartment and approached staff screaming Resident proceeded to open and slam her apartment door several times over the next 15 minutes. Resident could be heard shortly after screaming and yelling in her apartment on her phone. Progress note dated 4/22/26 at 3:30 am documents in part: Resident became verbally upset stating I hate you, I don't want to go to sleep then returned to her apartment and	A4060		

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A4060	Continued From page 13	A4060		

slammed the door.

Progress note dated 4/23/26 documents: Resident was observed walking with (R6 and R7) and appeared engaged. Without any triggers R2 began yelling telling them profanities. Walked to her room and slammed the door.

Progress note dated 4/24/26 documents in part: This writer arrived to work to resident attempting to elope. Staff with resident. Resident remained agitated and was screaming "I wanna get out of here!" Resident compliant with medications. Resident then began yelling profanities and saying "I want out of here!" and went to put on her jacket. Her husband arrived and resident escalated and continued to yell profanities and was slamming her door, going back and forth from her room to the nurse's station to her room.

Progress note dated 4/24/26 documents in part: Resident continues to wander and asking to leave, and screaming "I'm going to die here!" and breaking down crying. Continues to attempt to elope.

Progress note dated 4/26/26 documents: Resident pushed and managed to get out of MC unit, screaming at everyone.

Progress note dated 4/28/26 documents: Resident came out of apartment visibly upset at about 415 am. Resident started yelling that she wants her blush and she wants it now. Staff attempted to redirect, unsuccessfully. Resident continued to yell down the hallways, entering and leaving her apartment several times in a row, slamming her door. Resident then decided that she wanted to leave. Staff intervened to stop resident from leaving unit. Resident started

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A4060	Continued From page 14	A4060		

screaming at staff and pointing fingers in staffs face. Staff told resident if she wants to walk she has to walk back here. Resident screamed down the hallways and returned to her room.

Progress note dated 4/28/26 documents in part: Resident began slamming her door repeatedly as other residents ate dinner. She then began to yell "I want to get out of here" repeatedly and attempted to leave the unit, constantly setting off the alarm. Resident yelled at this writer "I need you to sign the papers!" It was too soon to give the resident her as needed medication/PRN, resident was combative with staff and continued to attempt to elope. Resident then started up again with "I hate it here, I don't want to be here, profanities, I hate this, I hate you, I hate all of you", repeatedly opening up unit door. Other residents began to complain of residents behavior and loud yelling. Resident then left the unit accompanied by 2 RA's, and attempted to leave the side door, while yelling profanities and "I wont go with you". Assisted living/AL resident with family had door open for air and complained about the noise. 911 called by this writer. 2 police officers and two emergency medical service staff/EMS arrived on the scene and attempted to calm resident.

Progress note dated 5/2/2026 documents in part: around 4 am she started screaming that she wants to go out. Caregivers holding the door so that she can't get out. She's swearing and she don't care to wake up the residents.

Progress note dated 5/2/2026 documents: around 4 am resident R2 escaped mc and went through the left single door. pagers went off. and it mc door been open RA'S in AL immediately went and redirected R2 back to mc. resident immediately

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started shouting she didn't want to go back and she wanted to leave. has RA'S started trying to convince her. resident started walking back to mc once we went in.RA"S immediately guard the door. for the rest of the night she kept trying to escape. she kept trying to push in to escape shouting she wants to leave. R2 kept leaving and coming after the 3 time coming back R2 tried to put her hands on me but i told her no she didnt after she tried again but this time she grab my arm and squeezed it and I told her no to not touch me. she walked away. R2 continued to try to leave MC until about 6 am. screaming at staff and up and down the hallways.

Progress note dated 5/2/26 documents in part: During resident's attempted elopement from 4 am to 5 am, resident jumped up onto the nurses station counter and crossed over into the nurses station.

Progress note dated 5/2/26 docuemnts in part: Power of Attorney/POA called this writer on the facility phone approximately 7pm. She stated that she wanted me to call the nurse practitioner/NP to get R2 admitted to a behavioral health as she is concerned that "I don't think she belongs in a memory care." This writer stated that it is unlikely we can reach the NP now on a Saturday evening and that she would not do anything without a proper psychiatric evaluation anyway. POA stated "Can you please try?" NP is a psychiatric NP that comes to the community on Mondays or every other Monday. POA stated "Well she has an emergency on call number can you call that?" This writer stated that she can call with concerns, and she stated that they will need us to say what is going on with her behaviors, something to the effect of she doesn't know if they will believe her. POA reminded that her behaviors are well

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documented, including each time this writer notified her via text message that resident was attempting to elope, was combative or under duress. POA still insisted. It was explained that a nurse manager will be here in the building tomorrow and it can be relayed to her, POA still insisted that "it has to be done right now, it can't wait. I have called around, and there are places, but they will only take her for 10 days. That is not going to work, that is not going to happen." When asked how resident is doing, POA answered "She's fit as a fiddle. I don't know if they are going to keep her for observation or not but I am going to ask them to, to keep her for the night." Writer continually tried to explain to the POA that myself and the other floor nurse are not in a position to handle her request, especially on a weekend night and she was sent out for cardiac concerns.

Progress note dated 5/3/26 documents in part: At approximately 6pm RCM notified staff over the walkie that staff could not locate resident and MC door alarm by nurses station was going off. Writer immediately started perimeter check along with RCM and another RA, followed by checking every room in memory care. Resident still was not located so RCM directed writer to drive around and check near by areas. Writer was about to get into car when another off duty RA pulled in and said she had eyes on resident. This writer got into other RA's car and found resident on highway 31 at local gas station. Staff got out of car and directed resident to get into car. Staff successfully got resident into car and back to facility but resident remains extremely agitated.

Progress note dated 5/3/26 documents in part: This writer by television/TV room with medication cart doing med pass. TV on for resident's loud, unable to hear door alarm. No calls on the walkie

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radio to announce that the alarm by MC 20 door is going off as we usually hear. Approximately 5:50 this writer notified by RA's that resident was missing. This writer headed over to Meijer store across the street from the community on foot, keeping an eye for the resident. Attempted to call DON with no response. Call placed to ADON who stated she would be back at the community in 5 minutes. Call placed to RCM who stated that the RA's were doing room checks, head counts and perimeter sweep and we had 10 minutes left to find her before having to call 911. AL nurse got into her car and drove around Meijer parking lot while other RA's also got into a car to drive around. POA notified and stated she was on her way over immediately. RCM then called that resident had been located by off-duty RA who had just left work on Route 31.

Progress note dated 5/4/26 documents in part: Resident continuing with behaviors, constant exit seeking and requiring 1:1 attention with staff members. Resident seen today NP, who also spoke with DON. Resident became physically aggressive with staff, pulling their hair and slapping them. Rebecca able to redirect resident, but only for a few minutes at a time, which is how resident has been with staff members as well. Social worker/SW met with DON to discuss resident and also saw resident's behaviors when resident was in the front lobby area with staff. This nurse discussed with SW, sending a resident to the local ER and from there, SW could make connections to further psychiatric treatment. SW agreed to this, and resident was sent via emergency medical services/EMS to local hospital.

On 5/11/2026, at 9:40 am, E7 Licensed Practical Nurse/LPN stated I am familiar with R2. R2 can

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be very loud. R2 is going through some psychiatric issues right now. I don't think R2's medication is working. We did have to send R2 out. We sent R2 out due to behavior R2 was hitting and swearing. R2 was hitting the staff in general and throwing things at the nurses. There is no nurse at night. I don't know of anyone R2 wakes up. I do hear R2 wakes up everyone. R2 did elope one day. R2 has been trying to elope since she moved in on 3/29/2026. R2 went out to the hospital 5/4/2026. R2 has been waking up everyone since R2 arrived here. We try to calm her down but all the other residents are scared because R2 is super loud.

On 5/11/2026, at 9:48 am, E8 Registered Nurse/RN stated I have worked with R2. R2 wakes up R8 her neighbor. R2 also wakes up R4, R5, and R6. They are the easiest ones R2 wakes up because R2 goes up and down the hall screaming. R2 has been doing this since she admitted. If R2 comes to me and I am with another resident and wants something R2 expects it at that moment and only her. If R2 can't have it her way R2 will swear at you, yell at you and slam the door. I don't think she has ever hit a resident at night. During the morning, R2 tried to elope and pulled my hair. I definitely do not feel like R2 is appropriate for this setting. R2 is a total assist for bathing. She is total assist for dressing as well. She can put on her shoes. She is independent for grooming except for brushing her hair. R2 is assistance with toileting. R2 is independent with ambulation and transferring. R2 does not need total assistance for anything else. I think R2 has psychiatric issues that are not under control. R2 is a harm to herself and others. It is just a matter of time and R2 will hurt someone else. I overheard R2 tell another resident that R2 would harm herself. Not in those exact words, I

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don't remember the exact words. R2 will curse at residents and staff. I am worried that at some point R2 will hit another resident or push them. I am more worried about them being hurt by R2. R3, R8, R9 and R5, and R6 are the residents I worry more about them not getting enough sleep. They are closest to R2.

On 5/11/2026, at 11:42 am, R2 DON stated R2 went out to the hospital because since the moment she arrived to our facility R2 had bad behaviors that continued to escalate such as trying to elope and physically combative and screaming profanities. R2 and her husband had an altercation where the police had to get involved here at establishment. R2's husband does not reside here. Then since that altercation R2's behaviors got worse and worse. R2's family brought in a social worker. They were able to help us place R2 to get a psychiatric evaluation because R2 came to us with a dementia diagnosis but R2 remembers everything. The social worker is looking into if it is a true dementia diagnosis or if it is due to being overmedicated at the time of diagnosis as in the past R2 could not talk, walk, she was unable to feed herself, drooling, etc. R2 could not perform any activities of daily living/adls. This was at a psychiatric facility. We received R2 from home. R2 was walking, talking, able to feed herself. R2 uses her cell phone fine. Her husband was here almost every day until that incident occurred. R2's family situation is really weird and I feel like it is causing a lot of issues for R2. Since R2 came here R2 has been screaming and cussing. R2 would get really close in staff face and shake fingers but never hit until it progressed around like April 23rd. The first day R2 was here I sent her out to the hospital and R2 returned almost immediately. R2 did see our psychiatrist about a week into her

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stay here. They adjusted R2's medication, but R2 will not always take them. When R2 was assessed I do feel like R2 was appropriate for the establishment but I feel we seen her on a non-triggered day at R2's home where she was comfortable. I do feel R2 is not appropriate for the establishment knowing what we know now. I have been telling the family that since within a week of R2 being here. I do not think we can help R2 the way R2 needs to be helped. R2 has not hit any residents it has mostly been staff. With her screaming and slamming doors, R2 gets the other residents very upset. I have not noticed anything consistent with other residents being not able to sleep, on edge, upset, scared or anything that has lasted for days. The most is one of our residents R7 who had behaviors under control had a couple days that R7 was very wound up due to R2 behaviors. R7 is still here. R2 has hit 2 nurses E4 LPN, E11 ADON and myself. R2 pulled E4's hair. I know R2 has hit a couple RA's. I do not know which ones. We do not have nurses overnight. We are pushing against R2 coming back, but hospital is asking if they get R2 on the right regimen if she can come back. I am trying to not accept her back. Obviously, we will accept R2 back until they can find placement for her. I do not think R2 is a threat to herself or other residents. R2 has not shown signs that R2 would hurt another resident. R2 only attacks people who try to stop her from getting out the doors. I was not informed that R2 made a comment about hurting herself. If I knew that then it would be a no to R2 coming back here. That just means I am going to push against it harder. But in the state of Illinois, I don't know if I can stop R2 from coming back.

On 5/12/2026, at 10:35 am, R5 stated I do remember having someone that screamed and

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yelled profanities. It was a female. It was pretty sad. It happened in the morning and the nighttime but not as much. She (R2) never hit me. I never saw her have any violence that I saw. She (R2) definitely has a problem. She would start with something missing in the morning, she would slam the doors, she would be overheated alot. Sometimes she would be ok for a little while but then not. I hope they don't lock her up anywhere I think she needs help. I felt sorry for her.

On 5/12/2026, at 11:11 am E9 caregiver I have never witnessed abuse here except maybe some residents in memory care get agitated and try to hit us but we try to calm them down. I am familiar with R2. When R2 first admitted here R2 was fine at first, and thought it was a tour. R2 started getting agitated after R2 realized her family was gone and started yelling profanities and attempted leaving the first week R2 was here. R2 did hit other caregivers and attempted to leave. I am unaware of R2 hitting, screaming or yelling profanities at another resident that I seen or heard of. R2 would wake the rest of the residents up by screaming on a regular basis. We would have to attempt to have another caregiver there to watch the doors so R2 would not attempt to leave while the other caregivers would attempt to get all the other residents up. I work am and pm shift. Ever since R2 admitted here this has been going on until she left to the hospital. I do feel for R6, I notice him more agitated after R2 admitted and noticed some more of the MC residents more agitated after R2 admitted as well due to the yelling and screaming and slamming doors. Maybe this could be considered mental abuse for the other residents as they are just getting disrupted with all the noises and wanting to be out of their rooms not to hear that. I do not feel R2 is appropriate for this community and R2 needs

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more attention and needs someone 24 hours with her. It is difficult to complete duties and assignments throughout the day when R2 is here.

On 5/12/2026, at 11:25 am, E10 caregiver stated I am familiar with R2. It was iffy with R2, it depends on the day. R2 would always find a way to try to leave. R2 was not hitting me but R2 would always try to leave. R2 yelled a lot and screamed profanities. R2 would say she did not want to be there and wanted to go home. R2 had a tendency to slam the door a lot. The other residents would say things and wonder what was going on. R2 would wake up the other residents at night by slamming the door and yelling. This was an everyday thing. The only time R2 would not do that is if her family was here and they were keeping R2 busy in her room. I think R2 has psychiatric issues and not dementia. I do not think R2 is a good fit for this community. I have never witnessed abuse here. I do feel like this (R2 behaviors) can be considered mental abuse to the other residents as they are being woke up and have to deal with a chaotic environment. I feel like it triggers the other residents as well.

On 5/12/2026, at 11:42 E4 LPN stated I did work in MC the last day R2 was sent out to hospital. It was last Monday. I think might have been 5/12/26. The ADON took over everything with R2. R2's behaviors were screaming and trying to elope. R2 was back and forth screaming and trying to leave and that is when the ADON stepped in and took care of everything.

On 5/12/2026, at 12:10 pm, E5 LPN stated I have worked with R2 in memory care. I documented extensively about R2. I do not believe R2 was a good fit for this community. R2's behaviors were R2 was a flight risk, R2 was disruptive by her

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A4060	Continued From page 23 yelling, and screaming and profanity. R2 would pull hair, punch at people, slamming doors, refused medications. The as needed/PRN medication R2 was prescribe had no effect. It was pretty much a constant stream of that behavior. R2 had never hit another resident that I am aware of. I am aware of R2 attempting to hit staff members. R2 did make a statement not directly of harming herself. R2 stated that it did not matter if she lived or died. For example, if I was trying to get her to take her medications I would explain that R2 needed her heart medications and R2 would say I don't care if I live. R2 would say she is sad. R2 denied being depressed. R2 would say when she was screaming through the unit that she was going to die here, I don't want to die here. I don't think R2 was thinking of self-harm. I do feel R2 was a threat to herself and others when R2 was here. On 5/12/2026, at 1:26 pm, E2 DON stated within 20 minutes of R2 being admitted here we had to call EMS for her. She was upsetting the other residents, pacing, yelling, no one could calm her down. During R2's behaviors I definitely would consider R2's behaviors to be mental abuse towards the other residents. I think the vulgarity of it all was also traumatic to them. This has been a whole ordeal. I have been fighting with the hospital to get R2 better placement. My biggest fear is that R2 does not have dementia. We did not report mental abuse to the other residents to Illinois Department of Public Health. I guess I never looked at it that way because I was more focused on getting R2 help.	A4060		
A5000	Section 295.5000 Medication Reminders, Supervision of Self Med	A5000		

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A5000	Continued From page 24 This Regulation is not met as evidenced by: TYPE 1 VIOLATION Section 295.5000 Medication Reminders, Supervision of Self-Medication, Medication Administration and Storage d) Medication administration refers to a licensed health care professional employed by an establishment engaging in administering routine insulin and vitamin B-12 injections, oral medications, topical treatments, eye and ear drops, or nitroglycerin patches. Non-licensed staff may not administer any medication. (Section 70 of the Act) f) If an establishment provides medication administration or supervision of self-administered medication, the establishment's medication policies and procedures shall be approved by a physician, pharmacist, or registered nurse and shall address: 1) Obtaining and refilling medication; 2) Storing and controlling medication; g) If an establishment provides medication administration or supervision of self-administered medication, a drug reference guide, no older than 2 years from the copyright date, shall be available and accessible for use by employees. h) Any medication stored by the establishment shall meet the following requirements: 1) Medication shall be stored in a locked	A5000		

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A5000	Continued From page 25 container, cabinet, or area that is inaccessible to residents; 2) Medication shall not be left unattended by an employee; This requirement was not met as evidenced by: Based on record review and interview, the establishment failed to have a drug reference guide in the establishment for use by employees and failed to follow their policy regarding controlled medication. This failure played a part in a controlled medication for R1 going missing and being diverted and R1 (hospice resident) not getting scheduled narcotic medication as ordered for over two weeks and creates a substantial probability of sever harm to a resident. Findings include: R1 is a 96-year-old resident admitted to the establishment on 11/22/24 with diagnoses including but not limited to dementia and major depressive disorder. R1's initial order for Clonazepam 0.5 mg by mouth daily at bedtime was dated for 2/16/2026. Investigation of incident documents medication order as CLONAZEPAM 0.5mg Oral (by mouth) daily at bedtime Give one tablet (0.5mg) PO every night at bedtime Active as of 02/21/2026 at 01 :45 PM R1's Medication Administration Record documents R1 did not get clonazepam 0.5 mg daily at bedtime as ordered and reason	A5000		

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documented is: Refused - medication not available - awaiting pharmacy from 2/21/26-3/2/26.

No drug reference book was provided to surveyor by establishment after requested.

Reportable for missing controlled medication for R1 documents in part: DON (Director of Nursing) notified of inability to locate clonazepam on 02/21/2026 by staff nurse.

Investigation report for missing medication documents:
Notated email of Medication being ordered originally on 02/16/2026
02/17/2026 Emailed hospice back to requested written order with doctor signature to be able to upload to MAR and give resident medication
02/17/2026 niece of R1 delivered medication to Nurse E6.
02/17/2026 E6 wrote a note and left medication on medication cart in locked med room. Note stating there was no order for medication, and E6 was unsure what to do with it.
02/18/2026 Nurse E3 started shift- without wait to narcotic count began
medication pass- Nurse E4 arrived to work and E3 was already on floor passing medications.
On 02/21/2026 Nurse E5 received order for Clonazepam 0.5mg for R1 from hospice. Nurse E5 added order to MAR. Medication no longer able to be found. Nurse E5 spoke with hospice, and texted Nurse E3 who took over for E6 in AM. Nurse E3 stated E3 didn't know where they were.
02/21/2026 and 02/22/2026 Nurse E3 texted and

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called to be inquired about
medication that went missing- E3 denied knowing anything
02/23/2026 E3 texted Director of nursing and quit stating it to be effective
immediately
02/23/2026 Medication still unable to be found. Investigation began. Police
department called, took everyone's statement.

On 5/11/2026, at 11:42 am, E2 Director of Nursing/DON stated when E3 previously employed Licensed Practical Nurse/LPN was questioned about missing medication E3 quit right away without notice. E3 was asked by another nurse (about the missing medication) When I asked E3 by text, E3 would not respond. Then upon calling, E3 would not answer phone calls. E3 quit by text message with no notice. I did not report her to Illinois Department of Financial Regulation/IDFPR. I did report to the police and report number is provided. I do not have a copy of the police report.

On 5/11/2026, at 1:43 pm, E11 Assistant Director of Nursing/ADON stated I do not think we have one, when surveyor requested to see drug reference book. E11 stated if questions come up I think everyone tends to google things. E11 stated I will see if we have one and bring it to you if we do.

On 5/12/2026, at 9:42 am, E2 Director of Nursing/DON was asked to provide drug reference book.

On 5/12/2026, at 10:22 am, receptionist called E2 DON and E2 stated E2 does have a drug reference book in the building. E2 will get it to surveyor as soon as E2 is out of meeting.

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A5000	Continued From page 28 On 5/12/2026, at 11:42 am, E4 LPN stated I am aware of medication missing. The medication was delivered late to E6 LPN. E6 had the medications but no order. I was working with E6 that day. E6 put a note on the medication saying that we needed an order from the doctor. Then E6 took over. E6 told me he was going to put it on the med cart in the locked med room. We went home. The next day E6 was off but I worked. I got here at 8 am and the memory care nurse E3 LPN was already doing her medication pass. We require 2 nurses to do narcotic count but E3 was already here and passing medications. So, I just took my side (assisted living). I did my narcotic count with the E2 DON when E2 got here. On 2/17/26 is when the medications were given to E6. On 2/18/26 is when I worked with E3. I did the narcotic count on medication cart for assisted living only with E2 DON. I told E2 DON that E3 LPN had already started med pass so could E2 do narcotic count with me on AL. I did tell E2 DON that I did not do a narcotic count and that is why I needed E2 to count with me on AL. E3 LPN had the memory care side and memory care medication cart. I do not know when the medication ended up missing. I am not sure when the medication was noticed missing. On 5/12/2026, at 12:03 pm, no drug reference book has been provided. Email sent to E1 Executive Director/ED and E2 DON again requesting it as soon as possible. On 5/12/26, at 12:06 pm, E1 Executive Director/ED stated that they are unable to locate Drug reference Manual. On 5/12/2026, at 12:10 pm, E5 LPN stated I am aware of an incident of missing medication from a	A5000		

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couple months ago. I gave my statement to the police when it happened. I came in on Friday and was looking for the medication and it couldn't be found. Me and E7 LPN was looking for the medication and could not find it. I sent a group text in the nursing group chat to see if anyone had seen the medication. From there on corporate was involved, police called, DON was notified by me. I do not remember what day that was. I know it was a few months back on a friday. So the friday I came in and looked for the medication would have been the 2/20/2026. I don't remember if anyone replied in the group chat about the medication. I think I may have even texted the nurse that worked the shift before me which was E3 LPN and she did not respond. E3 LPN ended up quitting at the same time period when this was going on. I have never had any issues with medications going missing here before. From what I understand is the medication was received from hospice pharmacy, the nurse left it in the med room and from there no one knows what happened to it.

On 5/12/2026, at 1:26 pm, E2 DON stated the first time I was told about the medication being missing was that Sunday 2/23/26. E5 LPN was the one that found that the medication was missing and E5 was working only saturdays and sundays at that point. Surveyor asked to see any text messages regarding medication not being found. E2 DON showed surveyor a text message dated 2/21/26 from E5 that stated they could not find the medication. I really think E3 took the medications by E3's actions. It was just really weird E3 was here and then the medication wasn't here and the medication was missing and E3 stopped answering phone calls and texts and quit. E4 LPN did tell me on 2/18/26 that E3 LPN did not do narcotic count with E4 and requested

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me to help E4 do narcotic count. E3 LPN came in early and that was really weird. E3 LPN also on her first day was here a couple hours and had to leave suddenly because supposedly her apartment got broken into. The niece of R1 delivered the controlled medication to E6 LPN. Hospice put the order through to their pharmacy and the neice picked up the medication. E6 LPN did not do a narcotic count when he received the medication because there was no order. E6 LPN should have not accepted the medication if he did not have the order, It should have been locked under two locks in the narcotic drawer. I should have been called. E6 LPN should have contacted hospice and gotten the order. E6 should have created a narcotic count sheet and done a narcotic count right away. I did do a training with E6 LPN and E4 LPN and E11 Assistant Director of Nursing/ADON regarding narcotic count, orders, receiving medications, etc. I am not sure if I did E7 LPN and E5 yet, I do not remember. Even if it was not a narcotic we should not be receiving medications without an order. That makes us liable. E3 LPN is definitely a no rehire here.
On 5/13/2026, at 10:19 am, When E2 DON was asked if a controlled narcotic count sheet was ever created for R1's missing bottle of clonazepam, E2 stated No. That was part of the education/training provided to the nurses, that and making sure it is locked in narcotic drawer.

Controlled Substances Policy & Procedure with last updated date of 4/29/2022 documents in part:
Policy
All aspects of handling and accounting of controlled substances will be in compliance with all
applicable State and Federal laws. The current Community's Controlled Substance Log will be

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A5000	Continued From page 31 kept in the Narcotic Binder along with each resident's narcotic count sheet. The Controlled Substance Log will be maintained for a minimum of (2) years. Receiving and Storing Controlled Substances: 1) When controlled substances are received from the pharmacy, they are accompanied by a labeled narcotic count sheet. If a Control Sheet is not provided, either remove the extra peel off label and attach it to a blank Controlled Substance Log or write the prescription information on a blank Controlled Substance Log. 2) Note and record the amount of medication received, date received, and signature of Med Aide/Licensed Nurse that received the delivery. 3) Place any/all controlled substances prescribed for a Resident, other than those who selfmedicate, under a double lock e.g., in a locked cabinet in a locked medication room or in a locked cabinet in a locked medication cart. Verifying the accuracy of the count: 1) Verify the number of controlled substances on hand by counting each controlled item in the narcotic drawer and refrigerator at the beginning and end of each shift. 2) Verify and document on the Narcotic Shift Count Log that the pharmacy emergency control box is on-site and secured. Record on Narcotic Shift Count Log. 3) The on-coming Med Aide/ Licensed Nurse will count all controlled substances being stored at the Community while the out-going Med Aide/Licensed Nurse watches and verifies that the amount noted on the log is consistent with the actual amount of medication on hand.	A5000		

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A5000	Continued From page 32 Medication Storage Policy & Procedure with last updated date of 9/22/22 documents in part: Policy: It is expected that medications will be stored appropriately and should meet the following requirements. This is required by law and is a community expectation. Procedures: 1. Delivered medications should be accepted, checked, and appropriately stored in a timely manner. 2. All medications, including treatment items, should be securely stored in a locked cabinet, drawer, cart, or locked medication room that is inaccessible by unauthorized staff, residents, and visitors. 16. Control substances should be stored separately in the resident's locked apartment, a locked box in the cart, or in a med cabinet stored in the med room or wellness office. a. A double lock process should be put in place such as a lock on the med cart and a separate lock on the control lock box. b. If control medications are stored in the med room, there should be a locked cabinet that has a separate lock from the med room door lock.	A5000		
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	A6000		

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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;

This requirement was not met as evidenced by:

Based on record review and interview, the establishment failed to ensure residents in memory care unit were free from mental abuse by R2.

This failure caused a chaotic environment for all residents in the memory care unit with yelling, slamming doors, profanity and hitting and pulling hair of staff. This caused a disturbance in sleep for at least two (R3 and R4) of the three other memory care residents reviewed. R2 also yelled profanities at R6 and R7. This failure creates a substantial probability of severe harm to a resident or residents.

Findings include:

R2 is a 69-year-old resident admitted to the establishment on 3/29/26 with diagnoses including but not limited to dementia and major depression.

R3 is an 89-year-old resident admitted to the establishment on 7/28/23 with diagnoses including hypothyroidism and dementia.

R4 is a 77-year-old resident admitted to the

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establishment on 3/10/23 with diagnoses including but not limited to dementia and primary osteoarthritis.

R3's Progress note dated 5/2/26 documents: Family asked this writer and RA's if the resident was kept up at night. Resident told her niece that someone kept waking her up all night. Niece was informed of R2 being agitated and up.

R4's Progress note dated 4/27/26 at 5:15 am documents: Observation for R4:Resident states she is getting tired of not being able to sleep at night. I'm getting sick of this, it makes me mad. Resident then returned to her apartment.

R2's incident report dated 5/1/26 documents in part: At approximately 6:22 the R2 attempted to exit the secured memory care unit without authorization when staff approached and provided redirection. The resident became physically resistant. The resident then pushed staff member into the wall in an attempt to force their way out of the unit. Staff immediately intervened using appropriate de-escalation techniques and insured the safety of both the resident and the staff. The resident was redirected away from the exit and guided back onto the unit.

R2's progress note from day of admission on 3/29/26 documents in part: Little known psychiatric history of R2 as she just arrived to the community. Family did not bring in any medications for R2. R2 was not able to be redirected and was combative and verbally abusive to staff. Family had put the R2 in her room and left without notifying staff. DON here as manager on duty/MOD and was called down to the unit to assess. 911 called to bring resident to

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A6000	Continued From page 35 hospital for a psychiatric evaluation. R2's Progress note dated 4/4/26 documents in part: Resident is crying and screaming and pulling POA's hair. She is asking to leave. R2's Progress note dated 4/11/26 documents in part: Resident became increasingly agitated and tearful, stating she needed to leave and expressing distress that her husband was not answering the phone. We encouraged resident to wait and try calling again later. Resident continued to escalate. Resident agitation increased including frequent door opening and slamming. R2's Progress note dated 4/11/2026 documents in part: Around 6am resident repeatedly requested help but refused assistance when offered. She was observed going back and forth to her room, slamming the door, and appearing tearful and distressed. Resident expressed that she needs Help though she was unable or unwilling to clarify her needs. R2's Progress note dated 4/12/26 documents in part: Resident was yelling loudly at about 9 pm stating she wanted to leave the facility. R2's Progress note dated 4/13/26 documents in part: Resident continued to Escalate becoming increasingly agitated. Resident repeatedly slamming the door came out and asked if she can get dressed and resident assistant/RA informed resident to allow 2 minutes to assist resident responded by yelling and told RA profanities. After successfully changing resident she came out to dining and sat with another resident and this RA overheard her asking resident what would he do if she attempted	A6000		

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suicide. R2 kept telling other resident how she does not want to be here and she wants to die becoming very tearful.

R2's Progress note dated 4/18/26 documents in part: Resident was aggravated this AM during med pass. Refused meds. Resident was crying about her husband, yelling "I don't want him here!"

R2's Progress note dated 4/18/2026 documents in part: A guest arrived for another resident and R2 slipped out of the memory care/MC building. Her husband followed behind her. This writer went after the resident who was screaming up and down the hallway 'I don't want to go home!

R2's Progress note dated 4/21/26 documents in part: Resident husband left and resident agitated. Came out of her room with her jacket on and started yelling "Can I go home? I wanna go home." Attempts to redirect resident were met with her further yelling and shaking. Attempted to open up MC unit doors x 2. Resident approached nurses station numerous times yelling "Can I get out of here? I hate it here I want to get out of here!" Resident continued to yell up and down hall "I hate it here I want to get out of here."

R2's Progress note dated 4/21/26 documents in part: At shift's end, resident continues to scream throughout the unit

R2's Progress note dated 4/22/26 documents in part: Resident left apartment and approached staff screaming. Resident proceeded to open and slam her apartment door several times over the next 15 minutes. Resident could be heard shortly after screaming and yelling in her apartment on her phone.

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A6000	Continued From page 37 R2's Progress note dated 4/22/26 at 3:30 am documents in part: Resident became verbally upset stating I hate you, I don't want to go to sleep then returned to her apartment and slammed the door. R2's Progress note dated 4/23/26 documents: Resident was observed walking with (R6 and R7) and appeared engaged. Without any triggers R2 began yelling telling them profanities. Walked to her room and slammed the door. R2's Progress note dated 4/24/26 documents in part: This writer arrived to work to resident attempting to elope. Staff with resident. Resident remained agitated and was screaming "I wanna get out of here!" Resident compliant with medications. Resident then began yelling profanities and saying "I want out of here!" and went to put on her jacket. Her husband arrived and resident escalated and continued to yell profanities and was slamming her door, going back and forth from her room to the nurse's station to her room. R2's Progress note dated 4/24/26 documents in part: Resident continues to wander and asking to leave, and screaming "I'm going to die here!" and breaking down crying. Continues to attempt to elope. R2's Progress note dated 4/26/26 documents: Resident pushed and managed to get out of MC unit, screaming at everyone. R2's Progress note dated 4/28/26 documents: Resident came out of apartment visibly upset at about 415 am. Resident started yelling that she wants her blush and she wants it now. Staff	A6000		

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attempted to redirect, unsuccessfully. Resident continued to yell down the hallways, entering and leaving her apartment several times in a row, slamming her door. Resident then decided that she wanted to leave. Staff intervened to stop resident from leaving unit. Resident started screaming at staff and pointing fingers in staffs face. Staff told resident if she wants to walk she has to walk back here. Resident screamed down the hallways and returned to her room.

R2's Progress note dated 4/28/26 documents in part: Resident began slamming her door repeatedly as other residents ate dinner. She then began to yell "I want to get out of here" repeatedly and attempted to leave the unit, constantly setting off the alarm. Resident yelled at this writer "I need you to sign the papers!" It was too soon to give the resident her as needed medication/PRN, resident was combative with staff and continued to attempt to elope. Resident then started up again with "I hate it here, I don't want to be here, profanities, I hate this, I hate you, I hate all of you", repeatedly opening up unit door. Other residents began to complain of residents behavior and loud yelling. Resident then left the unit accompanied by 2 RA's, and attempted to leave the side door, while yelling profanities and "I wont go with you". Assisted living/AL resident with family had door open for air and complained about the noise. 911 called by this writer. 2 police officers and two EMS arrived on the scene and attempted to calm resident.

R2's Progress note dated 5/2/2026 documents in part: around 4 am she started screaming that she wants to go out. Caregivers holding the door so that she can't get out. She's swearing and she don't care to wake up the residents.

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R2's Progress note dated 5/2/2026 documents: around 4 am resident R2 escaped mc and went through the left single door. pagers went off. and it mc door been open RA'S in AL immediately went and redirected R2 back to mc. resident immediately started shouting she didn't want to go back and she wanted to leave. has RA'S started trying to convince her. resident started walking back to mc once we went in.RA"S immediately guard the door. for the rest of the night she kept trying to escape. she kept trying to push in to escape shouting she wants to leave. R2 kept leaving and coming after the 3 time coming back R2 tried to put her hands on me but i told her no she didnt after she tried again but this time she grab my arm and squeezed it and I told her no to not touch me. she walked away. R2 continued to try to leave MC until about 6 am. screaming at staff and up and down the hallways.

R2's Progress note dated 5/2/26 documents in part: During resident's attempted elopement from 4 am to 5 am, resident jumped up onto the nurses station counter and crossed over into the nurses station.

R2's Progress note dated 5/4/26 documents in part: Resident continuing with behaviors, constant exit seeking and requiring 1:1 attention with staff members. Resident seen today NP, who also spoke with DON. Resident became physically aggressive with staff, pulling their hair and slapping them. Rebecca able to redirect resident, but only for a few minutes at a time, which is how resident has been with staff members as well. Social worker/SW met with DON to discuss resident and also saw resident's behaviors when resident was in the front lobby area with staff. This nurse discussed with SW, sending a resident to the local ER and from there, SW could

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make connections to further psychiatric treatment. SW agreed to this, and resident was sent via emergency medical services/EMS to local hospital.

On 5/11/2026, at 9:40 am, E7 Licensed Practical Nurse/LPN stated I am familiar with R2. R2 can be very loud. R2 is going through some psychiatric issues right now. I don't think R2's medication is working. We did have to send R2 out. We sent R2 out due to behavior R2 was hitting and swearing. R2 was hitting the staff in general and throwing things at the nurses. There is no nurse at night. I don't know of anyone R2 wakes up. I do hear R2 wakes up everyone. R2 did elope one day. R2 has been trying to elope since she moved in on 3/29/2026. R2 went out to the hospital 5/4/2026. R2 has been waking up everyone since R2 arrived here. We try to calm her down but all the other residents are scared because R2 is super loud.

On 5/11/2026, at 9:48 am, E8 Registered Nurse/RN stated I have worked with R2. R2 wakes up R8 her neighbor. R2 also wakes up R4, R5, and R6. They are the easiest ones R2 wakes up because R2 goes up and down the hall screaming. R2 has been doing this since she admitted. If R2 comes to me and I am with another resident and wants something R2 expects it at that moment and only her. If R2 can't have it her way R2 will swear at you, yell at you and slam the door. I don't think she has ever hit a resident at night. During the morning, R2 tried to elope and pulled my hair. I definitely do not feel like R2 is appropriate for this setting. R2 is a total assist for bathing. She is total assist for dressing as well. She can put on her shoes. She is independent for grooming except for brushing her hair. R2 is assistance with toileting. R2 is

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independent with ambulation and transferring. R2 does not need total assistance for anything else. I think R2 has psychiatric issues that are not under control. R2 is a harm to herself and others. It is just a matter of time and R2 will hurt someone else. I overheard R2 tell another resident that R2 would harm herself. Not in those exact words, I don't remember the exact words. R2 will curse at residents and staff. I am worried that at some point R2 will hit another resident or push them. I am more worried about them being hurt by R2. R3, R8, R9 and R5, and R6 are the residents I worry more about them not getting enough sleep. They are closest to R2.

On 5/11/2026, at 11:42 am, R2 DON stated R2 went out to the hospital because since the moment she arrived to our facility R2 had bad behaviors that continued to escalate such as trying to elope and physically combative and screaming profanities. R2 and her husband had an altercation where the police had to get involved here at establishment. R2's husband does not reside here. Then since that altercation R2's behaviors got worse and worse. R2's family brought in a social worker. They were able to help us place R2 to get a psychiatric evaluation because R2 came to us with a dementia diagnosis but R2 remembers everything. The social worker is looking into if it is a true dementia diagnosis or if it is due to being overmedicated at the time of diagnosis as in the past R2 could not talk, walk, she was unable to feed herself, drooling, etc. R2 could not perform any activities of daily living/adls. This was at a psychiatric facility. We received R2 from home. R2 was walking, talking, able to feed herself. R2 uses her cell phone fine. Her husband was here almost every day until that incident occurred. R2's family situation is really weird and I feel like it is causing

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a lot of issues for R2. Since R2 came here R2 has been screaming and cussing. R2 would get really close in staff face and shake fingers but never hit until it progressed around like April 23rd. The first day R2 was here I sent her out to the hospital and R2 returned almost immediately. R2 did see our psychiatrist about a week into her stay here. They adjusted R2's medication, but R2 will not always take them. When R2 was assessed I do feel like R2 was appropriate for the establishment but I feel we seen her on a non-triggered day at R2's home where she was comfortable. I do feel R2 is not appropriate for the establishment knowing what we know now. I have been telling the family that since within a week of R2 being here. I do not think we can help R2 the way R2 needs to be helped. R2 has not hit any residents it has mostly been staff. With her screaming and slamming doors, R2 gets the other residents very upset. I have not noticed anything consistent with other residents being not able to sleep, on edge, upset, scared or anything that has lasted for days. The most is one of our residents R7 who had behaviors under control had a couple days that R7 was very wound up due to R2 behaviors. R7 is still here. R2 has hit 2 nurses E4 LPN, E11 ADON and myself. R2 pulled E4's hair. I know R2 has hit a couple RA's. I do not know which ones. We do not have nurses overnight. We are pushing against R2 coming back, but hospital is asking if they get R2 on the right regimen if she can come back. I am trying to not accept her back. Obviously, we will accept R2 back until they can find placement for her. I do not think R2 is a threat to herself or other residents. R2 has not shown signs that R2 would hurt another resident. R2 only attacks people who try to stop her from getting out the doors. I was not informed that R2 made a comment about hurting herself. If I knew that then it would be a no

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to R2 coming back here. That just means I am going to push against it harder. But in the state of Illinois, I don't know if I can stop R2 from coming back.

On 5/12/2026, at 10:35 am, R5 stated I do remember having someone that screamed and yelled profanities. It was a female. It was pretty sad. It happened in the morning and the nighttime but not as much. She (R2) never hit me. I never saw her have any violence that I saw. She (R2) definitely has a problem. She would start with something missing in the morning, she would slam the doors, she would be overheated alot. Sometimes she would be ok for a little while but then not. I hope they don't lock her up anywhere I think she needs help. I felt sorry for her.

On 5/12/2026, at 11:11 am E9 caregiver I have never witnessed abuse here except maybe some residents in memory care get agitated and try to hit us but we try to calm them down. I am familiar with R2. When R2 first admitted here R2 was fine at first, and thought it was a tour. R2 started getting agitated after R2 realized her family was gone and started yelling profanities and attempted leaving the first week R2 was here. R2 did hit other caregivers and attempted to leave. I am unaware of R2 hitting, screaming or yelling profanities at another resident that I seen or heard of. R2 would wake the rest of the residents up by screaming on a regular basis. We would have to attempt to have another caregiver there to watch the doors so R2 would not attempt to leave while the other caregivers would attempt to get all the other residents up. I work am and pm shift. Ever since R2 admitted here this has been going on until she left to the hospital. I do feel for R6, I notice him more agitated after R2 admitted and noticed some more of the MC residents more

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agitated after R2 admitted as well due to the yelling and screaming and slamming doors. Maybe this could be considered mental abuse for the other residents as they are just getting disrupted with all the noises and wanting to be out of their rooms not to hear that. I do not feel R2 is appropriate for this community and R2 needs more attention and needs someone 24 hours with her. It is difficult to complete duties and assignments throughout the day when R2 is here.

On 5/12/2026, at 11:25 am, E10 caregiver stated I am familiar with R2. It was iffy with R2, it depends on the day. R2 would always find a way to try to leave. R2 was not hitting me but R2 would always try to leave. R2 yelled a lot and screamed profanities. R2 would say she did not want to be there and wanted to go home. R2 had a tendency to slam the door a lot. The other residents would say things and wonder what was going on. R2 would wake up the other residents at night by slamming the door and yelling. This was an everyday thing. The only time R2 would not do that is if her family was here and they were keeping R2 busy in her room. I think R2 has psychiatric issues and not dementia. I do not think R2 is a good fit for this community. I have never witnessed abuse here. I do feel like this (R2 behaviors) can be considered mental abuse to the other residents as they are being woke up and have to deal with a chaotic environment. I feel like it triggers the other residents as well.

On 5/12/2026, at 11:42 E4 LPN stated I did work in MC the last day R2 was sent out to hospital. It was last Monday. I think might have been 5/12/26. The ADON took over everything with R2. R2's behaviors were screaming and trying to elope. R2 was back and forth screaming and trying to leave and that is when the ADON

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stepped in and took care of everything.

On 5/12/2026, at 12:10 pm, E5 LPN stated I have worked with R2 in memory care. I documented extensively about R2. I do not believe R2 was a good fit for this community. R2's behaviors were R2 was a flight risk, R2 was disruptive by her yelling, and screaming and profanity. R2 would pull hair, punch at people, slamming doors, refused medications. The as needed/PRN medication R2 was prescribe had no effect. It was pretty much a constant stream of that behavior. R2 had never hit another resident that I am aware of. I am aware of R2 attempting to hit staff members. R2 did make a statement not directly of harming herself. R2 stated that it did not matter if she lived or died. For example, if I was trying to get her to take her medications I would explain that R2 needed her heart medications and R2 would say I don't care if I live. R2 would say she is sad. R2 denied being depressed. R2 would say when she was screaming through the unit that she was going to die here, I don't want to die here. I don't think R2 was thinking of self-harm. I do feel R2 was a threat to herself and others when R2 was here.

On 5/12/2026, at 1:26 pm, E2 DON stated within 20 minutes of R2 being admitted here we had to call EMS for her. She was upsetting the other residents, pacing, yelling, no one could calm her down. During R2's behaviors I definitely would consider R2's behaviors to be mental abuse towards the other residents. I think the vulgarity of it all was also traumatic to them. This has been a whole ordeal. I have been fighting with the hospital to get R2 better placement. My biggest fear is that R2 does not have dementia. We did not report mental abuse to the other residents to Illinois Department of Public Health. I guess I

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A6000	Continued From page 46 never looked at it that way because I was more focused on getting R2 help.	A6000		
A7000	Secton 295.7000 Resident Records This Regulation is not met as evidenced by: VIOLATION Section 295.7000 Resident Records b) An establishment shall maintain a resident's record that contains at least the following: 5) Documentation of orientation to the evacuation plan; This requirement was not met as evidenced by: Based on record review and interview, the establishment failed to ensure resident orientation was completed and documented for four (R1, R2, R3, and R4) of four residents reviewed. Findings include: R1 is a 96-year-old resident admitted to the establishment on 11/22/24 with diagnoses including but not limited to dementia and major depressive disorder. R2 is a 69-year-old resident admitted to the establishment on 3/29/26 with diagnoses including but not limited to dementia and major depression. R3 is an 89-year-old resident admitted to the	A7000		

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A7000	Continued From page 47 establishment on 7/28/23 with diagnoses including hypothyroidism and dementia. R4 is a 77-year-old resident admitted to the establishment on 3/10/23 with diagnoses including but not limited to dementia and primary osteoarthritis. No resident orientations were provided to surveyor for R1, R2, R3, or R4. On 5/11/2026, at 1:43 pm, E11 Assistant Director of Nursing/ADON stated we do not have resident orientation for R1, R2, R3 or R4. On 5/12/2026, at 1:26 pm E2 Director of Nursing/DON stated resident orientation did not get started until after our survey in February 2026. Right now, it is being done by the ED, sales or maintenance. R2 was admitted after this was started and should have resident orientation but I think it just slipped through the cracks.	A7000		