STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510493	A. BUILDING: _____ B. WING _____	C 03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIGO AT BARTLETT (THE)	1035 SOUTH ROUTE 59 BARTLETT, IL 60103

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A 000	Initial Comment Facaility Reported Incident Survey IL00200790 295.4060 6) 295.6000 12) 13) 295.6010 c)	A 000		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Violation Section 295.4060 Alzheimer's and Dementia Programs 6) Provide an appropriate number of staff for its resident population. The establishment shall provide staff sufficient in number, with qualifications, adequate skills, education, and experience to meet the 24-hour scheduled and unscheduled needs of the residents and who participate in ongoing training, to serve the resident population. At a minimum, at least one staff member shall be awake and on duty at all times. This requirement was not met as evidenced by: Based on interview and record review the establishment failed to ensure employees have qualifications and adequate skills to deescalate an aggressive dementia resident (R1) resulting to bilateral wrist bruises. This failure has the substantial probability of affecting all residents. Findings include:	A4060		

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A4060	Continued From page 1 R1's medical record showed R1 moved into the establishment on 12/2/2024, resides in the memory care unit, and has multiple diagnoses, including but not limited to Dementia, Abnormal Weight Gain, Hyperlipidemia, Personal History of Adenomatous and Serrated Colon Polyps, Abscess oy eyelid Right Eye. R1's Service Plan, dated 3/17/2026, showed R1 was independent with transfers and mobility R1's Incident Report, date of incident 3/2/2026, was reported to the Department within 24 hours of the occurrence. The report was consistent with the intake information provided by the Department. R1's Incident report dated 3/2/2026 documents - On 3/2/2026 around 1130 am, Z1(R'1 Power of Attorney/POA) notified E1 (Interim Executive Director) that R1 has bruises to her bilateral wrists/forearm areas and top of right hand and Z1 feels a specific (Resident Assistant/ RA) caused this by being rough with her when R1 was refusing or being resistive with cares. Skin assessment completed and noted green bruising to the top of right hand, 4cm x 3cm, faded yellow bruising to left and right wrist/ forearm areas. R1 denies pain or tenderness, no other skin issues noted. PCP notified and investigation initiated. R1's Progress Notes indicated the following: 3/2/2026- Allegation of unknown caregiver being rough with R1 causing bruising to her bilateral forearms and wrists. This nurse completed a head-to-toe skin assessment and physical assessment, no other skin abnormalities or bruising notes... Bright green bruise noted to top of right hand; very faded yellow bruising noted to right and left wrist/forearm areas... Z1 aware as	A4060		

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A4060	Continued From page 2	A4060		

he was who alerted E1 of concerns and bruising.

3/1/2026- Resident Assistant reported to this writer while dressing R1 with a bruise on top of right hand ...

2/24/2026- R1 was given a shower on evening today, noted light purple/red bruising to left and right forearm, above the wrist area, measuring 3.6cmx1.4cm...

2/20/2026- Care Partner notified this writer that R1 observed having skin discoloration (light purplish in color) on both lower arms near the wrist...

9/17/2026- Z1 (POA) made aware (left voice message) re R1's bruise observed by night nurse on left forearm and right hand.

9/17/2025- This writer was notified by RA of bruising observed on the resident's left forearm and right hand. R1t is unable to recall or state the cause of the bruise.

On 3/24/2026 at 11:00AM, E5 (Resident Assistant) said that she was the one who saw the bruises on both hands on R1, and she reported it to E8 (Licensed Practical Nurse/LPN), the nurse working that day. E5 said that she does not remember the date, but it was a Sunday, sometime in February. E5 said that E8 notified Z1(R1's Power of Attorney/POA). E5 said "I made a report in incident report sheet." E5 said that she has not witnessed any staff being verbally or physically aggressive towards R1. E5 said that she would report it to the supervisor immediately. E5 said that she received abuse training upon hired and has had in-services about abuse and when to report it. E5 said that when a resident is

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A4060	Continued From page 3	A4060		

becoming aggressive or refusing care, they always help each other's, they can have someone else assisting with the care, E5 said "we approach residents differently and also ask the nurse to assist."

On 3/24/2026 at 11:11AM, E7 (LPN) said that she has not witnessed any staff member being verbally or physically abusive towards residents. E7 said that R1 is combative with care, often refusing care. E7 said that staff are supposed to redirect a resident if she/he becomes aggressive. Try a couple of times to see if resident agrees to care if not, leave the resident alone for a few minutes and come back again, or ask another staff to assist.
E7 said that if she witnesses staff being verbally or physically abusive towards residents, tell caregivers that behavior is not acceptable and there's no policy, it is against the law.
E7 said she will report to supervisor. Training about abuse and when to report it received-when hire and have in services periodically.

On 3/24/2026 at 2:21PM, E1 (Interim Executive Director/Operations Specialist)
Said "it was my understanding after interviewing everyone, that E3 (Former Resident Assistant) was assisting R1 in the bathroom, R1 became combative and E3 held R1 hands to prevent him from been hurt by R1, E1 said that E3 didn't report the incident and didn't report the change of R1's demeanor to the nurse. E1 said that E3's approach was not the way staff are trained to deal with residents when they get aggressive. E1 said that E3 should have stepped away, returned later or have someone else to assist. E1 said that E3 admitted holding R1's hands."

On 3/24/2026 at 2:35PM, E2 (Regional Director

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A4060	Continued From page 4	A4060		

of Clinical Operations) said that she was on site and was told by E1 that Z1 was upset about bruises on R1's hands. R1 could not recall if anyone was rude to her. E2 said that she performed a head-to-toe assessment as well as an incident report. E2 said that during the investigation someone reported that E3 was seen pulling another resident's hand, that is what prompted E2 to do a Physical Assessment on R2, no bruises or any other injuries were noted, R2 had no recollection of anyone being rude to her, no other information was provided. E2 said that E3 stated that R1 pushed him when E3 was providing care, E3 stated that the push was too strong and that if E3 wouldn't be standing properly, E3 could've been thrown on the floor. E2 said that E3 stated that R1 needed to be taking care by a man because ladies are too weak. E2 said that E3 stated that he had to hold R1's hands to prevent hitting. E2 said that that is not the proper way to approach an aggressive resident. E2 said that staff receive Online training on restraints and abuse upon hired and annually.

On 3/24/2026 at 3:07PM, E7 (LPN) said that on 2/24/2026 during shower it was discovered that R1 had bruises to both forearms, E7 said she notified the doctor, POA and the nurse covering, E7 said that she didn't know she needed to report it to the State because it is unclear which bruises to report and which not.

On 3/24/2026 at 4:09PM, E8 (LPN) said that one of the RAs brought to her attention the bruises on R1's arms. E8 said that the bruises were on R1's thumbs close to the wrist, but the bruises were yellowish, almost fading. E8 said that E8 notified Z1. E8 said that R1 is very tall and R1 is resistive to care, that sometimes takes 3 staff to care for her, E8 said that at times she needs to assist

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A4060	Continued From page 5 RAs to get R1 ready in the morning. E8 said that the bruises are probably from holding R1's arms. E8 said that they received abuse training when hired, E8 also said that staff is supposed to approach R1 calmly, if R1refused care to try later or to get assistance from another staff member that R1 might respond better to. On 3/25/2026 at 11:37, Z1 (R1's Power of Attorney/POA) said that there have been two incidents that R1 has suffered physical abuse. The first time was back in 9/17/2025, a nurse called to let Z1 know that R1 has some bruises on her hands. This last time it was sometime in February, "a nurse, E8, called me to let me know that my mom had some bruises on her hands. I went to see her a couple of days after, and she had shaped like handprints on her wrists; I reported it to management. I was told that a person there was rude to my mom. I heard from other family members that that person was not well liked because he was rude and easily frustrated. I didn't personally witness anything. I never saw this person, All I know is that he is a big guy and other family members say that he was too aggressive and didn't want this person to care for their loved ones. This person is E3. Z1 said "Each time I was called by a nurse to say that she had bruising, no other detail was provided. I would ask if she was okay and they would say yes. When this first happened in September, I made the mistake of not understanding what I was seeing. I thought because older people have fragile skin that maybe it was a little too much force by accident, but you can't do that without squeezing really hard, way past guiding someone."	A4060		

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A6000	Continued From page 6	A6000		
A6000	Section 295.6000 Resident Rights	A6000		

This Regulation is not met as evidenced by:
Violation

Section 295.6000 Resident Rights
12) The right to be free of chemical and physical restraints.

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 interview and record review the establishment failed to ensure residents are free and protected from restraints and abuse for two (R1, R2) residents reviewed for abuse. This failure has the substantial probability of affecting all residents.

Findings include:

R1's medical record showed R1 moved into the establishment on 12/2/2024, resides in the memory care unit, and has multiple diagnoses, including but not limited to Dementia, Abnormal Weight Gain, Hyperlipidemia, Personal History of Adenomatous and Serrated Colon Polyps, Abscess oy eyelid Right Eye.

R1's Service Plan, dated 3/17/2026, showed R1 was independent with transfers and mobility

R1's Incident Report, date of incident 3/2/2026, was reported to the Department within 24 hours of the occurrence. The report was consistent with

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A6000	Continued From page 7	A6000		

the intake information provided by the Department.

R1's Incident report dated 3/2/2026 documents - On 3/2/2026 around 1130 am, Z1(R'1 Power of Attorney/POA) notified E1 (Interim Executive Director) that R1 has bruises to her bilateral wrists/forearm areas and top of right hand and Z1 feels a specific (Resident Assistant/ RA) caused this by being rough with her when R1 was refusing or being resistive with cares. Skin assessment completed and noted green bruising to the top of right hand, 4cm x 3cm, faded yellow bruising to left and right wrist/ forearm areas. R1 denies pain or tenderness, no other skin issues noted. PCP notified and investigation initiated.

R1's Progress Notes indicated the following: 3/2/2026- Allegation of unknown caregiver being rough with R1 causing bruising to her bilateral forearms and wrists. This nurse completed a head-to-toe skin assessment and physical assessment, no other skin abnormalities or bruising notes... Bright green bruise noted to top of right hand; very faded yellow bruising noted to right and left wrist/forearm areas... Z1 aware as he was who alerted E1 of concerns and bruising.

3/1/2026- Resident Assistant reported to this writer while dressing R1 with a bruise on top of right hand ...

2/24/2026- R1 was given a shower on evening today, noted light purple/red bruising to left and right forearm, above the wrist area, measuring 3.6cmx1.4cm...

2/20/2026- Care Partner notified this writer that R1 observed having skin discoloration (light purplish in color) on both lower arms near the

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A6000	Continued From page 8 wrist... 9/17/2026- Z1 (POA) made aware (left voice message) re R1's bruise observed by night nurse on left forearm and right hand. 9/17/2025- This writer was notified by RA of bruising observed on the resident's left forearm and right hand. R1 is unable to recall or state the cause of the bruise. R2's medical record showed R2 moved into the establishment on 5/30/2021, resides in the memory care unit, and has multiple diagnoses, including but not limited to Alzheimer's Disease, Essential Hypertension, Pure Hypercholesterolemia, Castro-esophageal Reflux Disease, History of Falling, Personal History of urinary Tract Infections. R2's Progress Notes indicated the following: 3/2/2026- "Skin assessment completed, and no skin alterations or bruising noted or reported. When asked if staff are nice to her resident smiles and shakes her head yes. Very pleasant and cooperative, no concerns noted." On 3/24/2026 at 11:00AM, E5 (Resident Assistant) said that she was the one who saw the bruises on both hands on R1, and she reported to E8 (Licensed Practical Nurse/LPN), the nurse working that day. E5 said that she does not remember the date, but it was a Sunday, sometime in February. E5 said that E8 notified Z1(R1's Power of Attorney/POA). E5 said "I made a report in incident report sheet." E5 said that she has not witnessed any staff being verbally or physically aggressive towards R1. E5 said that she would report it to the supervisor immediately. E5 said that she received abuse training upon	A6000		

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A6000	Continued From page 9	A6000		

hired and has had in-services about abuse and when to report it. E5 said that when a resident is becoming aggressive or refusing care, they always help each other's, they can have someone else assisting with the care, E5 said "we approach residents differently and also ask the nurse to assist."

On 3/24/2026 at 11:11AM, E7 (LPN) said that she has not witnessed any staff member being verbally or physically abusive towards residents. E7 said that R1 is combative with care, often refusing care. E7 said that staff are supposed to redirect a resident if she/he becomes aggressive. Try a couple of times to see if resident agrees to care if not, leave the resident alone for a few minutes and come back again, or ask another staff to assist.
E7 said that if she witnesses staff being verbally or physically abusive towards residents, tell caregivers that behavior is not acceptable and there's no policy, it is against the law.
E7 said she will report to supervisor. Training about abuse and when to report it received-when hire and have in services periodically.

On 3/24/2026 at 2:21PM, E1 (Interim Executive Director/Operations Specialist)
Said "it was my understanding after interviewing everyone, that E3 (Former Resident Assistant) was assisting R1 in the bathroom, R1 became combative and E3 held R1 hands to prevent him from been hurt by R1, E1 said that E3 didn't report the incident and didn't report the change of R1's demeanor to the nurse. E1 said that E3's approach was not the way staff are trained to deal with residents when they get aggressive. E1 said that E3 should have stepped away, returned later or have someone else to assist. E1 said that E3 admitted holding R1's hands."

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A6000	Continued From page 10 On 3/24/2026 at 2:35PM, E2 (Regional Director of Clinical Operations) said that she was on site and was told by E1 that Z1 was upset about bruises on R1's hands. R1 could not recall if anyone was rude to her. E2 said that she performed a head-to-toe assessment as well as an incident report. E2 said that during the investigation someone reported that E3 was seen pulling another resident's hand, that is what prompted E2 to do a Physical Assessment on R2, no bruises or any other injuries were noted, R2 had no recollection of anyone being rude to her, no other information was provided. E2 said that E3 stated that R1 pushed him when E3 was providing care, E3 stated that the push was too strong and that if E3 wouldn't be standing properly, E3 could've been thrown on the floor. E2 said that E3 stated that R1 needed to be taking care by a man because ladies are too weak. E2 said that E3 stated that he had to hold R1's hands to prevent hitting. E2 said that that is not the proper way to approach an aggressive resident. E2 said that staff receive Online training on restraints and abuse upon hired and annually. On 3/24/2026 at 3:07PM, E7 (LPN) said that on 2/24/2026 during shower it was discovered that R1 had bruises to both forearms, E7 said she notified the doctor, POA and the nurse covering, E7 said that she didn't know she needed to report it to the State because it is unclear which bruises to report and which not. On 3/24/2026 at 4:09PM, E8 (LPN) said that one of the RAs brought to her attention the bruises on R1's arms. E8 said that the bruises were on R1's thumbs close to the wrist, but the bruises were yellowish, almost fading. E8 said that E8 notified Z1. E8 said that R1 is very tall and R1 is resistive	A6000		

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A6000	Continued From page 11	A6000		

to care, that sometimes takes 3 staff to care for her, E8 said that at times she needs to assist RAs to get R1 ready in the morning. E8 said that the bruises are probably from holding R1's arms. E8 said that they received abuse training when hired, E8 also said that staff is supposed to approach R1 calmly, if R1refused care to try later or to get assistance from another staff member that R1 might respond better to.

On 3/25/2026 at 11:37, Z1 (R1's Power of Attorney/POA) said that there have been two incidents that R1 has suffered physical abuse. The first time was back in 9/17/2025, a nurse called to let Z1 know that R1 has some bruises on her hands. This last time it was sometime in February, "a nurse, E8, called me to let me know that my mom had some bruises on her hands. I went to see her a couple of days after, and she had shaped like handprints on her wrists; I reported it to management. I was told that a person there was rude to my mom. I heard from other family members that that person was not well liked because he was rude and easily frustrated. I didn't personally witness anything. I never saw this person, All I know is that he is a big guy and other family members say that he was too aggressive and didn't want this person to care for their loved ones. This person is E3.Z1 said "Each time I was called by a nurse to say that she had bruising, no other detail was provided. I would ask if she was okay and they would say yes. When this first happened in September, I made the mistake of not understanding what I was seeing. I thought because older people have fragile skin that maybe it was a little too much force by accident, but you can't do that without squeezing really hard, way past guiding someone."

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A6000	Continued From page 12 Employee staff statements during establishment's internal investigation are as follows: 3/2/2026- E3 (RA) "Some bruises on arms.... she fights going to bathroom and changing sometimes hits us." 3/2/2026-E7 (LPN) "Yes, bruising unknown cause. I put in report..." 3/2/2026- E5 (RA) "Bruising on arm... 3/2/2026- E12 (RA) "Bruise on arm" 3/2/2026- E11(LPN) "Another nurse called POA... possibly transfer of patient-Don't know... staff need Dementia/transfer training." 3/3/2026- E3 (RA) "2-3 weeks ago, physical when changing in morning overnight shift. Need man to handle when she gets physical, ladies too weak. She hits and I didn't think it was substantial to report. I had to hold arms from hitting..." 3/3/2026- E9 (RA) said another RA said E3 (RA) pulled R2 a while ago and tried to get her up and R2 "ouch your hurting me your pulling me." 3/3/2026- E12 (RA) "Bruise on hand reported. E11 already knew of bruise. Multiple attempts to interview E9, E10, E11were made. Messages left. No answer at the time if survey exit. Establishment policy title Abuse, Neglect, and Injuries of Unknown Sources Revised 3/15/2022 indicated "POLICY: It is the policy of the community to prevent abuse, neglect, and injuries of unknown sources and to report the same, as required by	A6000		

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A6000	Continued From page 13 applicable law. Each staff member must communicate any such incidents to a supervisor, regardless of whether a staff member witnessed an incident firsthand or was made aware of allegations of the incident."	A6000		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr This Regulation is not met as evidenced by: Violation Section 295.6010 Abuse, Neglect, and Financial Exploitation Prevention and Reporting c) Establishment employees and volunteers are obligated to report abuse, neglect, or financial exploitation of a resident to the establishment management and to the Department. This requirement was not met as evidence by: Based on interview and record review the establishment failed to ensure employee report injuries of unknown sources in a timely manner, ensure staff not limited to nurses are oriented to abuse procedures to follow for one (R1) resident of three reviewed. This failure has the substantial probability of affecting all residents. Findings include: R1's medical record showed R1 moved into the establishment on 12/2/2024, resides in the memory care unit, and has multiple diagnoses, including but not limited to Dementia, Abnormal Weight Gain, Hyperlipidemia, Personal History of Adenomatous and Serrated Colon Polyps,	A6010		

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A6010	Continued From page 14 Abscess oy eyelid Right Eye. R1's Service Plan, dated 3/17/2026, showed R1 was independent with transfers and mobility R1's Incident Report, date of incident 3/2/2026, was reported to the Department within 24 hours of the occurrence. The report was consistent with the intake information provided by the Department. R1's Incident report dated 3/2/2026 documents - On 3/2/2026 around 1130 am, Z1(R'1 Power of Attorney/POA) notified E1 (Interim Executive Director) that R1 has bruises to her bilateral wrists/forearm areas and top of right hand and Z1 feels a specific (Resident Assistant/ RA) caused this by being rough with her when R1 was refusing or being resistive with cares. Skin assessment completed and noted green bruising to the top of right hand, 4cm x 3cm, faded yellow bruising to left and right wrist/ forearm areas. R1 denies pain or tenderness, no other skin issues noted. PCP notified and investigation initiated. R1's Progress Notes indicated the following: 3/2/2026- Allegation of unknown caregiver being rough with R1 causing bruising to her bilateral forearms and wrists. This nurse completed a head-to-toe skin assessment and physical assessment, no other skin abnormalities or bruising notes... Bright green bruise noted to top of right hand; very faded yellow bruising noted to right and left wrist/forearm areas... Z1 aware as he was who alerted E1 of concerns and bruising. 3/1/2026- Resident Assistant reported to this writer while dressing R1 with a bruise on top of right hand ...	A6010		

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A6010	Continued From page 15 2/24/2026- R1 was given a shower on evening today, noted light purple/red bruising to left and right forearm, above the wrist area, measuring 3.6cmx1.4cm... 2/20/2026- Care Partner notified this writer that R1 observed having skin discoloration (light purplish in color) on both lower arms near the wrist... 9/17/2026- Z1 (POA) made aware (left voice message) re R1's bruise observed by night nurse on left forearm and right hand. 9/17/2025- This writer was notified by RA of bruising observed on the resident's left forearm and right hand. R1t is unable to recall or state the cause of the bruise. On 3/24/2026 at 11:00AM, E5 (Resident Assistant) said that she was the one who saw the bruises on both hands on R1, and she reported to E8 (Licensed Practical Nurse/LPN), the nurse working that day. E5 said that she does not remember the date, but it was a Sunday, sometime in February. E5 said that E8 notified Z1(R1's Power of Attorney/POA). E5 said "I made a report in incident report sheet." E5 said that she has not witnessed any staff being verbally or physically aggressive towards R1. E5 said that she would report it to the supervisor immediately. E5 said that she received abuse training upon hired and has had in-services about abuse and when to report it. E5 said that when a resident is becoming aggressive or refusing care, they always help each other's, they can have someone else assisting with the care, E5 said "we approach residents differently and also ask the nurse to assist."	A6010		

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A6010	Continued From page 16 On 3/24/2026 at 11:11AM, E7 (LPN) said that she has not witnessed any staff member being verbally or physically abusive towards residents. E7 said that R1 is combative with care, often refusing care. E7 said that staff are supposed to redirect a resident if she/he becomes aggressive. Try a couple of times to see if resident agrees to care if not, leave the resident alone for a few minutes and come back again, or ask another staff to assist. E7 said that if she witnesses staff being verbally or physically abusive towards residents, tell caregivers that behavior is not acceptable and there's no policy, it is against the law. E7 said she will report to supervisor. Training about abuse and when to report it received-when hire and have in services periodically. On 3/24/2026 at 2:21PM, E1 (Interim Executive Director/Operations Specialist) Said "it was my understanding after interviewing everyone, that E3 (Former Resident Assistant) was assisting R1 in the bathroom, R1 became combative and E3 held R1 hands to prevent him from been hurt by R1, E1 said that E3 didn't report the incident and didn't report the change of R1's demeanor to the nurse. E1 said that E3's approach was not the way staff are trained to deal with residents when they get aggressive. E1 said that E3 should have stepped away, returned later or have someone else to assist. E1 said that E3 admitted holding R1's hands." On 3/24/2026 at 2:35PM, E2 (Regional Director of Clinical Operations) said that she was on site and was told by E1 that Z1 was upset about bruises on R1's hands. R1 could not recall if anyone was rude to her. E2 said that she performed a head-to-toe assessment as well as an incident report. E2 said that during the	A6010		

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A6010	Continued From page 17	A6010		

investigation someone reported that E3 was seen pulling another resident's hand, that is what prompted E2 to do a Physical Assessment on R2, no bruises or any other injuries were noted, R2 had no recollection of anyone being rude to her, no other information was provided. E2 said that E3 stated that R1 pushed him when E3 was providing care, E3 stated that the push was too strong and that if E3 wouldn't be standing properly, E3 could've been thrown on the floor. E2 said that E3 stated that R1 needed to be taking care by a man because ladies are too weak. E2 said that E3 stated that he had to hold R1's hands to prevent hitting. E2 said that that is not the proper way to approach an aggressive resident. E2 said that staff receive Online training on restraints and abuse upon hired and annually.

On 3/24/2026 at 3:07PM, E7 (LPN) said that on 2/24/2026 during shower it was discovered that R1 had bruises to both forearms, E7 said she notified the doctor, POA and the nurse covering, E7 said that she didn't know she needed to report it to the State because it is unclear which bruises to report and which not.

On 3/24/2026 at 4:09PM, E8 (LPN) said that one of the RAs brought to her attention the bruises on R1's arms. E8 said that the bruises were on R1's thumbs close to the wrist, but the bruises were yellowish, almost fading. E8 said that E8 notified Z1. E8 said that R1 is very tall and R1 is resistive to care, that sometimes takes 3 staff to care for her, E8 said that at times she needs to assist RAs to get R1 ready in the morning. E8 said that the bruises are probably from holding R1's arms. E8 said that they received abuse training when hired, E8 also said that staff is supposed to approach R1 calmly, if R1refused care to try later or to get assistance from another staff member

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A6010	Continued From page 18	A6010		

that R1 might respond better to.

On 3/25/2026 at 11:37, Z1 (R1's Power of Attorney/POA) said that there have been two incidents where R1 has suffered physical abuse. The first time was back in 9/17/2025, a nurse called to let Z1 know that R1 has some bruises on her hands. This last time it was sometime in February, "a nurse, E8, called me to let me know that my mom had some bruises on her hands. I went to see her a couple of days after, and she had shaped like handprints on her wrists; I reported it to management. I was told that a person there was rude to my mom. I heard from other family members that that person was not well liked because he was rude and easily frustrated. I didn't personally witness anything. I never saw this person, All I know is that he is a big guy and other family members say that he was too aggressive and didn't want this person to care for their loved ones. This person is E3. Z1 said "Each time I was called by a nurse to say that she had bruising, no other detail was provided. I would ask if she was okay and they would say yes. When this first happened in September, I made the mistake of not understanding what I was seeing. I thought because older people have fragile skin that maybe it was a little too much force by accident, but you can't do that without squeezing really hard, way past guiding someone."

Employee staff statements during establishment's internal investigation are as follows:

3/2/2026- E3 (RA) "Some bruises on arms.... she fights going to bathroom and changing sometimes hits us."

3/2/2026-E7 (LPN) "Yes, bruising unknown

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A6010	Continued From page 19 cause. I put in report..." 3/2/2026- E5 (RA) "Bruising on arm... 3/2/2026- E12 (RA) "Bruise on arm" 3/2/2026- E11(LPN) "Another nurse called POA... possibly transfer of patient-Don't know... staff need Dementia/transfer training." 3/3/2026- E3 (RA) "2-3 weeks ago, physical when changing in morning overnight shift. Need man to handle when she gets physical, ladies too weak. She hits and I didn't think it was substantial to report. I had to hold arms from hitting..." 3/3/2026- E9 (RA) said E10 another RA said E3 (RA) pulled R2 a while ago and tried to get her up and R2 "ouch your hurting me your pulling me." 3/3/2026- E12 (RA) "Bruise on hand reported. E11 already knew of bruise. Multiple attempts to interview E9, E10, E11were made. Messages left. No answer at the time if survey exit. Establishment policy title Abuse, Neglect, and Injuries of Unknown Sources Revised 3/15/2022 indicated in part ... Injuries of Unknown Sources An injury should be classified as an injury of an unknown source when both of the following conditions are met: 1. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident. 2. The injury is suspicious because of the extent of the injury, the location of the injury (the injury is located in an area not generally vulnerable to	A6010		

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A6010	Continued From page 20 trauma), the number of injuries observed at any particular point in time, or the incidence of injuries over time.	A6010		