

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ASL510342	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/20/2026
NAME OF PROVIDER OR SUPPLIER EDEN VISTA OF BARRINGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 510 NORTHWEST HIGHWAY BARRINGTON, IL 60010		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comment Complaint Investigations IL200200 295.2050 a) b) c) 295.6000 a) 13) IL200165 295.3000 a) h) 1) 2) 3) 6) During the course of the survey and upon review of records the following deficiencies were found and cited: 295.4010 a) b) 1) 2) 3) c) d) g) 1) A) cited.	A 000		
A2050	Section 295.2050 Incident and Accident Reporting This Regulation is not met as evidenced by: TYPE 1 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	A2050		

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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A2050	Continued From page 1 Department within 24 hours after the occurrence of the incident or accident. c) A copy of the report shall be maintained by the establishment for one year after the date of the incident or accident. (Source: Amended at 47 Ill. Reg. 13264, effective August 30, 2023) This requirement is not met as evidenced by: Based on record review and interview the establishment failed to report incidents of verbal abuse to IDPH. This involves 1 of 3 residents reviewed (R1). This failure resulted in establishment not reported incident of employee to resident verbal abuse. This failure creates a substantial probability of severe harm to a resident or residents. Findings include: The only abuse allegation reported to IDPH was made by EMS staff. E3 caregiver was hired on 7/28/2025 and terminated on for excessive absences on 2/10/2026. No reports provided to surveyor documenting abuse report being made to IDPH involving E3 yelling at R1. Reports of staff member E3 caregiver yelling at residents and talking to residents like children "a couple months ago" to E2 Wellness Director were not reported to IDPH. E6 Licensed Practical Nurse/LPN heard about	A2050		

Illinois Department of Public Health

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A2050	Continued From page 2 allegations of E3 yelling at R1 and did not report this allegation to anyone. E5 caregiver did not report witnessed verbal abuse by E3 to R1 to anyone. No report provided to surveyor documenting verbal abuse allegation regarding weight by E3 to R7. On 2/19/2026, at 11:23 am, E2 Director of Wellness/Licensed Practical Nurse (LPN) stated I did receive reports from staff E5 caregiver regarding E3 caregiver being loud yelling at residents. I do not remember when E5 reported it, I think it was a couple months ago E5 reported it. E4 caregiver also stated E3 talks to the residents like children. That was also around the same time E5 caregiver reported it. E5 caregiver works in am and pm and E4 caregiver works in am and pm. There was not a state reportable done on this. I have worked with E3 caregiver on this and E3 had customer service training on code of conduct and customer service. Yelling at a resident is considered abuse. Talking to a resident like a child may be abuse, depending on the context. I do not recall who in particular E5 caregiver reported that E3 caregiver was yelling at. The reason I did not do a state reportable for yelling at residents by E3 is that after discussion, E3 is hard of hearing and E3 talks loud. We spoke to 3 residents and I asked if they were experiencing any issues with care staff and no one had any complaints. On 2/19/2026, at 12:04 pm, E6 Licensed Practical Nurse/LPN stated I have heard of allegations of abuse that happened, but they were not reported directly to me. One did have to do with R1. The daughter of R4 did not report to me about E3	A2050		

Illinois Department of Public Health

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A2050	Continued From page 3 caregiver yelling at R1, but I did hear about it. It was not reported to me directly. I heard it from multiple care staff. It was already reported so I did not report it. For the incident involving R4 and E3 speaking to the daughter regarding consumption of meals and I spoke to Tasha after it was reported. For the incident involving E3 yelling at R1, I can't remember who told me or who reported it. But someone did tell me about it. I did not report it because I thought it was already reported. If you witness the actual action of abuse you report to E2 Wellness Director or E1 Executive Director. In hindsight I should have reported both incidents just to make sure they were reported. On 2/19/2026, at 12:55 pm, E5 caregiver stated I did report to E2 Wellness Director that E3 caregiver was yelling at residents and that residents were not happy. I heard E3 yelling at residents that they would have to wait. E3 did tell a daughter about her mom declining. E3 would make comments to R7 about her weight stating R7 was too big and she would have to stay in the bed because R7 was too heavy. R7 told me that and I have heard her make comments to her as well. E3 would ridicule residents and staff. E3 would be talking about me behind my back as well. I did not tell E2 about the weight comments to R7. I did not report the weight comments to E2 because I forgot. My mind was just blown that day. I think that day there were 3 residents complaining of E3 being mean to them. I was upstairs and downstairs all day that day. I believe E2 was aware of this. I assumed E2 was aware. I should have reported it as well. I have talked to E2 Wellness Director on other occasions regarding E3 not doing her job, not paying attention, yelling at residents, her demeanor towards the residents was not friendly. I did not	A2050		

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A2050	Continued From page 4 report to E2 about her belittling or making fun of her weight. I heard E3 tell R7 that she was too heavy for E3 to pick up. Abuse Policy & Procedure dated 9/11/22 documents in part: Policy: It is the policy of the facility to ensure that all reporting of abuse and neglect is handled in accordance with state rules and regulations. All forms of abuse is taken seriously and will not be tolerated including but not limited to, abuse of our residents by staff, family members, volunteers, other residents or anyone else interacting with residents of our communities. Definition: For the purposes of this policy, abuse shall be defined as: (e) Verbal abuse, including the use of oral, written, gestured communication to a visitor or staff about a resident within that resident's presence or hearing distance that describes the resident in derogatory terms including humiliating, intimidating, harassing, threatening, frightening, knowingly unwanted comments, or actions. (f) Mental abuse including humiliation, harassment, threats of punishment or deprivation directed toward a resident; Procedure: 1. All employees who have reasonable cause and/or suspicion to believe a resident has suffered abuse or an injury of unknown origin, are responsible for reporting that information to the Executive Director or immediate supervisor. If to a supervisor, he/she shall pass along the information to the Executive Director immediately.	A2050			

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A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: GENERAL VIOLATION Section 295.3000 Personnel Requirements, Qualifications and Training a) The establishment shall have staff sufficient in number with qualifications, adequate skills, education and experience to meet the 24 hour scheduled and unscheduled needs of residents and who participate in ongoing training to serve the resident population. (Section 35(a) (3) of the Act) h) The establishment shall have sufficient personnel to provide the following for its current resident population: 1) All mandatory services; 2) Services established in each resident's service plan; 3) Service to meet the needs of each resident, including 24 hour scheduled and unscheduled needs, general supervision, and the ability to intervene in a crisis; 6) Evacuation of residents during emergencies; and This requirement is not met as evidenced by: Based on record review and interviews, the establishment failed to have staff sufficient in	A3000			

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A3000	Continued From page 6 number to care for residents scheduled and unscheduled needs. This involves 9 of 10 residents reviewed (R1, R3, R7, R8, R9, R10, R11, R12, and R13). This failure has the probability to affect all residents. Findings include: List of residents requiring 2-person assistance provided to surveyor on 2/20/2026 documents 9 residents requiring 2 person assistance. (R1, R3, R7, R8, R9, R10, R11, R12, and R13) Timecard for E7 documents E7 clocked out at 4:09 am on 2/17/2026. February schedule documents E7 was scheduled to work 11pm starting on 2/16/2026 and scheduled to be off shift at 7 am on 2/17/26. E8 was scheduled to work starting 2/26/26 at 10 pm and scheduled to be off on 2/17/2026 at 6 am. These were the only two staff members scheduled for overnights on this day. On 2/17/2026, at 4:09 AM, one of two staff members in the establishment left sick a few hours prior to completing shift. This left only one staff member in the building to care for several residents that require two person-assist, including two residents who require the use of a mechanical lift (R7 and R9) On 2/19/2026, at 12:04 pm, E6 Licensed Practical Nurse/LPN stated I do know that there has been an occurrence that a care staff went home early on night shift at like 4 am and there was only a nurse in the building recently. On 2/19/2026, at 3:20 pm, surveyor interviewed	A3000		

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A3000	Continued From page 7 with E1 Executive Director/ED and E2 Wellness Director. E2 Wellness Director stated I am not sure from the top of my head how many residents require two-person assistance. E1 ED I stated R9 does at times, R9 has Parkinson's. E2 Wellness Director stated I want to say 5-6 down here and I think two upstairs. I will get back to you with the total number. E1 ED stated there is always at least two staff in the building. E2 stated there was a day on overnights that a caregiver went home at like 4 am just a few days ago that the caregiver got sick at work and went home. I have to check my other phone what day that was. Per time punch report E2 stated yes it would have been 2/17/2026 at 4 something am that E7 caregiver went home. No one came in to cover E7. The nurse (E8) was left to work by herself. There was no one called to cover E7's shift. E2 Wellness Director stated it takes 35-40 minutes for me to get to the building. E1 stated it takes me 20 minutes. In the case of a fire E2 stated me and E1 would have to come to the building. We would have to add staff in that instance. We are trying to add staff now. E1 ED stated normally before anyone would leave their post they should be notifying E2 as Director of Wellness. Which they did. In that case, E2 Wellness Director should arrange for or E2 would take their place before that person goes home. That did not happen. When asked how long it takes to get one mechanical lift person out of the building in an emergency evacuation E2 Wellness Director stated like 12 minutes. E1 ED stated our evacuation time is 13 minutes. When asked how many staff it takes to get 5-6 two person assist residents and all other 21 residents out in 13 minutes in an emergency situation E1 ED stated more than 2. On 2/19/2026, at 9:13 am, E2 Wellness Director	A3000		

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A3000	Continued From page 8 stated I do the scheduling now. It is a new task for me. For the nurses there is one per shift, so 3 for a 24-hour period. For the caregivers it is 3 in the morning for a full 8-hour shift, 2 for pm that work a full 8-hour shift, and 1 that comes in 4-8 for pm shift. Overnights 1 caregiver comes in 11pm-7 am. We are working on something with the scheduling to have a caregiver come from 11pm-3 am. We are able to cover shifts when we have call offs. We have a pm shift open right now but other workers are able to pick up as of right now. We do not use agency at all right now, because we don't need it. I do feel we have enough staff to care for the residents' needs. I am working with the nurses right now regarding implementing comfort, wellness and safety rounds with our QAPI right now regarding falls. Also, I am working with the nurses to track changes of conditions like vitals to track falls. We have noticed an increase in falls. We do have some residents that just get up. Some have had UTI's without signs and symptoms presenting and that has caused some falls. We are still in process of finding root causes of increase in falls. I do not believe it has anything to do with staffing. The minimum staffing which is very rare is 2 caregivers and a nurse on ams and pms, and one overnight. On 2/19/2026, at 10:11 am, E4 Caregiver stated I do think we have enough staff to care for resident's needs. We have one caregiver in memory care, one in assisted living. and one floats between the two. We don't have a lot of residents right now. There have been more falls recently. In the morning, we have showers and two meals and maybe another care monitor would help reduce falls. Before we had 2 upstairs and 2 downstairs. I know the census is low but like with R2 she always tries to stand up and she	A3000		

Illinois Department of Public Health

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A3000	Continued From page 9 is fast. If we are helping someone else, there may be a fall. On 2/19/2026, at 10:21 am, E9 caregiver stated I do feel like we have enough staff to take care of residents' needs but I do think it would help to have one more staff so we could have 2 upstairs and 2 downstairs. We do have some challenging residents. We do try to make their priorities but sometimes we are helping someone else, and it may take a few minutes to get to someone, and they may get upset. When a resident gets upset and we do get their needs taken care of they are usually ok. I have noticed an increase in falls recently. I think that is because we need 2 caregivers upstairs and 2 downstairs. We have 12 resident's downstairs, and I think it is like 13 upstairs. On 2/19/2026, at 10:37 am, E10 caregiver stated we have told E1 the Executive Director/ED we need more caregivers on the floor. I am the float. There are days we have diarrhea, showers, etc. They say due to the census we can't have another one yet. I feel we need 2 caregivers' downstairs and 2 upstairs. The nurses do help us out a lot. We do not really have a lot of call offs. It is hit or miss. I do think we have had more falls recently. On 2/19/2026, at 11:46 am, Z1 stated I know I have caused some of them (bruises) myself when I help R1 to the bathroom as they (establishment) are short staffed. On 2/19/2026, at 12:04 pm, E6 Licensed Practical Nurse/LPN stated I feel in all honesty that we do not have adequate staff to take care of the resident's needs. We have had more falls lately. I think that the more falls are contributed to the	A3000		

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STATE FORM

Illinois Department of Public Health

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A4010	Continued From page 11 a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the Act) The establishment shall respect and accept the resident's choices regarding the service plan. b) The service plan shall be developed by: 1) The resident, resident's representative or any individual requested by the resident; 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. d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act) g) Service plans shall address: 1) The level of service the resident is receiving, including: A) assistance with activities of daily living; This requirement is not met as evidenced by:	A4010		

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A4010	Continued From page 12 Based on record review and interview the establishment failed to: ensure service plans were signed by a registered nurse, manager/manager designee and resident/resident representative for three (R1, R2, and R3) of three residents reviewed and, ensure service plan addressed the level of service resident required for transferring and oral hygiene for one (R2) of three residents reviewed. This failure has the probability to affect all residents. Findings include: R1 is an 83-year-old resident that was admitted to establishment on 12/11/2025 with diagnoses including but not limited to chronic venous insufficiency and hyperlipidemia. R2 is a 96-year-old resident that was admitted to establishment on 7/31/25 with diagnoses including but not limited to dementia and anxiety disorder. R3 is an 89-year-old resident that admitted to establishment on 9/3/24 with diagnoses including but not limited to essential hypertension and anemia. Service plans provided for R1, R2, and R3 were not signed by a registered nurse, manager or manager's designee or resident/resident representative. R2's service plan with focus of ADL (Activities of Daily Living) self-care performance deficit dated 12/4/25 does not address what services resident	A4010		

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A4010	Continued From page 13 needs regarding transferring and oral hygiene. On 2/18/2026, at 1:42 E1 Executive Director/ED stated we do not have any signed service plans for the 3 residents (R1, R2, and R3) you asked for. I can check and see if R3 has any signed previous service plans since R3 has been here longer. The other two (R1 and R2) recently moved in so I know I do not have a signed service plan for them. On 2/18/2026, at 1:59 pm, E2 Wellness Director stated here are all my signed service plans. I am new and I know I am missing some. Signed service plans provided for 14 residents of 27 residents. No signed service plans noted for R1, R2, and R3. On 2/19/2026, at 9:13 am, When asked to show surveyor where transferring and oral hygiene is addressed on R2's service plan, E2 Wellness Director stated I do not see it. It is not in the service plan. It should be there. R2 is a one person transfer. We do standby assist for her.	A4010		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: TYPE 1 VIOLATION Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an	A6000		

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A6000	Continued From page 14 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 is not met as evidenced by: Based on record review and interview the establishment failed to ensure residents were free from abuse. This involves 2 of 3 residents reviewed (R1,R). This failure resulted in R1 and R7 being abused by an employee (E3). This failure creates a substantial probability of severe harm to a resident or residents. Findings include: R1 is an 83-year-old resident that was admitted to establishment on 12/11/2025 with diagnoses including but not limited to chronic venous insufficiency and hyperlipidemia. R7 is an 80-year-old resident that was admitted to the establishment on 9/7/2023 with diagnoses including but not limited to essential hypertension and major depressive disorder. E3 caregiver was hired on 7/28/2025 and terminated on for excessive absences on 2/10/2026. E3 One to one staff education form dated 11/7/25 documents in part: Educated E3 on code of conduct and customer service policies. Resident complained of E3 having poor customer service and not servicing her requests. A different resident complained of this same issue.	A6000		

Illinois Department of Public Health

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A6000	Continued From page 15 E3 Corrective Action Form dated 12/5/25 documents in part: Type of violation: Performance - Customer Service. Description of Incident documents: Resident and staff report that E3 comes across aggressive (speaking loudly) and sometimes rude (speaking to residents like children). Residents request not to be serviced by E3. Staff report that E3 is difficult to work with. E3 does not assist with specific tasks even when other staff perform duties for residents that are assigned to E3. For example, showering. E1 Executive Director and Assistant Director of Wellness have both spoken with E3. Customer Service Policy reviewed, and a copy of the policy has been provided. E3 Corrective action Form dated 12/24/2025 documents in part: type of violation: conduct-Disrespect/Insubordination/Disobedience Description of incident documents in part that E3 began to speak over E2 Wellness Director and at times cutting E2 off while speaking. E3 ended the call abruptly by hanging up the phone on E2. E3 Employee Corrective Action Form dated 2/2/26 and signed 2/10/26 documents corrective action taken: termination of employment. Type of violation attendance - unauthorized absence. On 2/19/2026, at 9:45 am, R1 stated they have been doing this since I got here because I resisted. The other staff members are ok. They had to replace one. She was pretty bad yelling and threatening me all the time. She was the worst. But she is gone now. They fired her. If you don't get up when they want you to, they go after you. When asked what they do, she stated they scratch you. I wouldn't put my mother here. Other	A6000		

Illinois Department of Public Health

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A6000	Continued From page 16 than the scratches they always make threats. Like your husband doesn't love you, your husband doesn't want you. On 2/19/2026, at 10:37 am, E10 caregiver stated I have heard complaints of abuse from R1. I reported that to E2 Wellness Director. Me and room Z2 reported it. Me and Z2 reported it because Z2 let me know about another caregiver on p.m.'s (E3) was yelling at R1. Z2 said Z2 heard another caregiver was loud in tone talking/shouting to room R1, so I reported to the nurse on call E6 and E6 told me we had to report to E2 Wellness Director and E1 Executive Director. I reported to E2 that I did not feel comfortable working with E3 as E3 is rude to residents. I only worked one pm shift with E3 but that was enough, I do not feel comfortable working with E3 again. I told that to E2 Wellness Director the day after I worked the pm shift and it was months ago. I have picked up on pm shift, but I make sure I do not have to work closely with E3. I do know R8 did not like E3 and E3 would argue with R8. I think that is the only thing I have heard of. I have not had any other complaints from residents. E3 does not work here anymore. E3 was let go after the statement from Z2 and my statement. That was about a week or two ago. On 2/19/2026, at 11:06 am, E1 Executive Director/ED stated E3 was a caregiver that was terminated maybe 2/10/2026. E3 was terminated for excessive absenteeism. I did receive reports of her yelling/loud talking to residents. E3 was coached on that. We did have reports of E3 being rude to residents. We did coaching with E3. That was not what we named as the reason for dismissal. The excessive absenteeism was more direct, and it was a lot. I think she had like 15 absences in a 6-month period. The allegations of	A6000			

Illinois Department of Public Health

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A6000	Continued From page 17 abuse did not play into the termination because we could not determine if it was valid. Some residents really liked E3, but some didn't. We did talk to Z2 regarding E3's communication with Z2. Z2 reported to me the issue was E3 did not think R4 was doing well and was declining and making judgements that upset Z2. We spoke to E3 and told her that info doesn't come from E3 and needs to come from the nurse. Z2 did not talk to me about E3 being rude or yelling at residents. I do not remember her saying that. Z2 is a dietician and was now worried that R4 is not eating and E3 only was with R4 for one meal a day. On 2/19/2026, at 11:23 am, E2 Wellness Director stated Z2 did not report to me overhearing E3 yell at R1 or being rude to R1. No other staff member reported to me that E3 was rude or yelled at R1. E10 caregiver has not reported to me that E10 does not want to work with E3 on pm shift. E10 did not report any issues to me regarding E3. I did receive reports from staff E5 caregiver regarding E3 being loud yelling at residents. I do not remember when E5 reported it, I think it was a couple months ago E5 reported it. E4 caregiver also stated E3 talks to the residents like children. That was also around the same time E5 reported it. E5 works am and pm and E4 works am and pm. There was not a state reportable done on this. I have worked with E3 on this, E3 had customer service training on code of conduct and customer service. Yelling at a resident is considered abuse. Talking to a resident like a child may be abuse, depending on the context. I do not recall who in particular E5 reported E3 yelling at. The reason I did not do a state reportable for yelling at residents by E3 is after discussion that E3 is hard of hearing and E3 talks loud and we spoke to 3 residents and I asked if they were experiencing any issues with care staff	A6000		

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A6000	Continued From page 18 and no one had any complaints. I cannot recall E10 making any report to me about E3 yelling at or being rude to R1. I can look at my reports and let you know if I find any. On 2/19/2026, at 11:46 am, Surveyor called Z1 spouse of R1. I have had complaints by R1 of abuse. There is suspicion of hallucinations. R1 did mention E3, and verbal abuse and E1 the ED took a report on it. There was some verbal abuse R1 claims. R1 does have some bruises on her arms and legs. I know I have caused some of them myself when I help her to the bathroom as they are short staffed. Sometimes just touching R1, she complains of pain as she says she has fibromyalgia. When R1 came here she had bruises on her arms and legs. R1 bruises really easy. E3 is the only one that I am aware of that there was a verbal abuse allegation. On 2/19/2026, at 12:04 pm, E6 Licensed Practical Nurse/LPN stated I have heard of allegations of abuse that happened, but they were not reported directly to me. One did have to do with R1. I also read something on an incident report of a care staff member regarding R1. Z2 did not report to me about E3 yelling at R1, but I did hear about it. It was not reported to me directly. I heard it from multiple care staff. It was already reported so I did not report it. For the incident involving E3 yelling at R1, I can't remember who told me or who reported it. But someone did tell me about it. I did not report it because I thought it was already reported. In hindsight I should have reported to make sure they were reported. I do not recall the conversation with E10 regarding E3 yelling at R1, but I recall hearing that E3 yelled at R1. have not heard any other reports of abuse from any other caregivers.	A6000			

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A6000	Continued From page 19 On 2/19/2026, at 12:29 PM, E4 caregiver stated I always report everything to E2 Wellness Director regarding how E3 caregiver spoke to residents. I reported to E2 the way she talked to the residents and that residents reported to me E3 is so mean and E3 tells me things I don't like. I saw E3 be impatient with residents. The way she spoke to the residents was not appropriate and nobody liked working with E3 for that reason. E3 was always thinking about herself when transferring residents and wanting to transfer how E3 wanted. E3 would argue with you in front of the residents. E3 never said bad words with them, but E3 would be loud and argue with them. I never heard E3 threaten the residents. E3 would complain about the residents asking for help from us. I have never worked with someone like E3. Thank God E3 is not here anymore. They finally got rid of E3. Every time there was an incident I would tell E2 Wellness Director. I reported residents not feeling comfortable with E3 to E2. I reported at least 5 or more times I reported these things to E2. Nobody felt comfortable working with E3 because of the way E3 is. Her voice was very loud because E3 was hard of hearing. I never heard E3 yelling at a resident. The worst thing E3 did that I witnessed was that E3 told R7 she called a lot for attention, and I don't have time to give you attention. I kept my mouth shut with E3, but I reported this to another nurse as E2 was not here yet. I think that happened around when she started. E3 worked here for a couple months. On 2/19/2026, at 12:55 pm, E5 caregiver stated I did report to E2 Wellness Director that E3 was yelling at residents and that residents were not happy. I heard E3 yelling at residents that they would have to wait. E3 did tell Z2 about Z2's mom declining. E3 would make comments to R7 about R7's weight stating R7 was too big and R7 would	A6000		

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A6000	Continued From page 20 have to stay in the bed because R7 was too heavy. R7 told me that and I have heard E3 make comments to R7 as well. E3 would ridicule residents and staff. E3 would be talking about me behind my back as well. I did not tell E2 about the weight comments to R7. I did not report the weight comments to E2 because I forgot. My mind was just blown that day. I think that day there were 3 residents complaining of E3 being mean to them. I was upstairs and downstairs all day that day. I believe E2 was aware of this. I assumed E2 was aware. I should have reported it as well. I have talked to E2 on other occasions regarding E3 not doing her job, not paying attention, yelling at residents, her demeanor towards the residents was not friendly. I did not report to E2 about E3 belittling or making fun of R7's weight. R7 and R8 were the ones that told me they were not happy with E3. On 2/19/2026, at 1:40 pm, R7 I do recall a caregiver named E3. E3 was mean to me and E3 had a loud voice. E3 got fired. E3 always said she was light and only weighed 73 pounds. E3 told me I was too heavy. E3 was threatening. E3 threatened to report me. E3 never hurt me in any way. E3 said she would kick me out of here and E3 would get me in trouble. I can't remember if I told anyone about E3 being mean to me.	A6000		