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	ASL510383	A. BUILDING: _____ B. WING _____	09/18/2025

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VILLAS OF HOLLY BROOK CHATHAM	825 EAST WALNUT CHATHAM, IL 62629

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A 000	Initial Comment Original investigation of Complaint 2548497/IL197391. Section 295.4010 d) e) g) 1) A) 3) - Type 2 Violation. Section 295.6000 a) 1) 13) - Type 1 Violation. Section 295.7000 b) 10) - Violation.	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 2 Violation Section 295.4010 Service Plan d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act) 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;	A4010		

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A4010	Continued From page 1 3) Staff responsible for the provisions of the service plan; Based on interview and record review, the facility failed to revise a service plan to accurately reflect a resident's needs and ensure a resident's Activities of Daily Living assistance needs were documented on the service plan for two of two residents (R1 and R2) that caused harm to a resident or creates a substantial probability of harm to a resident or residents. Findings include: 1. R1's medical record documents R1 admitted to the establishment on 08/16/25 and discharged on 09/02/25. R1's pre-admission Fall Risk Assessment (dated 08/06/25) documents a score of 22, indicating a high risk for falls. This same assessment documents the following: "A total score of 10 or greater is considered a High Risk. Don't forget to add Risk to the ADL (activities of daily living) sheets. Assure care planning is completed with the appropriate interventions in place." R1's current Service Plan has no mention of R1's risk for falls. This same Service Plan documents R1 is independent with the following ADLs: Toileting, Ambulation, Bathing/Showers, Grooming/Personal Hygiene, and Mobility/Ambulation/Escorts/Transfers. R1's Service Plan also documents the following focus: "Has memory loss/Cognitive Impairment." On 09/16/25 at 09:10 AM, E2 (Wellness Director) stated the following regarding R1, "(Z1, R1's sister) told us that R1 was independent and	A4010		

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A4010	Continued From page 2	A4010		

completed all of her ADLs independently. We soon discovered otherwise. (R1) was too much care for Assisted Living. Her family was out of town several states away, so we did care for her until they returned to pick her up. I believe her family wanted her to permanently move in, but when (Z1) picked her up, she was told that we could not meet (R1's) needs. (R1) had stayed for respite care in the past, maybe a year or so ago, and it was very noticeable that she had declined since then. She requires much more care now."

On 09/16/25 at 02:40 PM, E3 (Care Partner) stated she often cared for R1 during her recent respite care stay at the establishment. E3 stated, "She was here one other time, and was not in the shape she was in now. It seemed like she continued to decline the longer she was here. I think she should have been sent out to be seen. I discovered she hadn't been taking her medications a few days after she had come, and I took all of her medications to (E2, Wellness Director). (R1) was confused and needed assistance with just about all of her cares. I was told that she had a UTI (urinary tract infection) once we were aware that she hadn't been taking her medications. I provided her assistance with toileting, and her urine had a very strong odor. She definitely mimicked the behavior of someone who has a UTI." E3 stated she was not aware that R1 had ever fallen at the facility.

On 09/16/25 at 03:00 PM, E4 (Care Partner) stated she cared for R1 often during her recent respite care stay at the establishment. E4 stated, "(R1) was a nice lady. She couldn't say much because she'd had a stroke. She could communicate by pointing or using gestures. She shouldn't have even been here because she couldn't do anything for herself. She wouldn't

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come out of her room for meals. We would take her meals, but she didn't always eat. She could walk and would go to the bathroom the first few days while she was here, but seemed to need more and more assistance with each day that passed. It was like she was having a progressive decline right in front of us. She needed assistance with dressing, bathing, and grooming, and she wasn't taking her medications. She was pretty confused and just appeared to be pretty out of it. Sometimes, new residents need some time to adjust to their new surroundings, but (R1) seemed to be getting worse. I notified (E2, Wellness Director) of my concerns with (R1) several times." E4 stated she was not aware that R1 had fallen at the establishment. E4 stated, "We left her door open so we could keep a close eye on her."

On 09/17/25 at 01:40 PM, E5 (Certified Nursing Assistant) stated she had frequently cared for R1 during her respite care stay at the establishment. E5 stated, "(R1) would just sit in her chair. She would call and ask for help getting up. I believe it was a Friday toward the end of her stay around 09:00 AM, I went in her room to give her medications to her, and found her on the floor in front of her bed with her arms stuck underneath her. She was face down on the floor. I radioed (E2, Wellness Director), who told me that she sits on the ground. (E6, Business Office Manager) came and helped me get her up. (E2) told me not to fill out an incident report because she was told that (R1) sits on the floor. When we got her up, I asked her if she was hurt and she nodded her head 'no.' You could tell that she had fallen. She was face down on the floor. She was very confused and was getting worse the longer she was there. We told (E2) every day that (R1) wasn't right and she didn't address any of the

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concerns. (R1) was not appropriate to be in the building because she could not take care of herself. She needed quite a bit of assistance with dressing, bathing, her medications, meals, hygiene and toileting. She would just sit in her chair and wet her pants." E5 denied ever finding R1 seated on the floor and stated, "I only found her after she had fallen on that Friday."

On 09/17/25 at 11:25 AM, E1 (Executive Director) stated she is the individual that conducted an initial assessment on R1 on 08/06/25. E1 stated, "(R1) was alert and oriented and could perform her ADLs (activities of daily living) independently. She was able to communicate her needs. She nodded her head to questions and could verbalize the words 'yes' and 'no' to answer. (R1) came to the building on 08/16/25 and left on 09/02/25. I saw a big change from when I assessed her on 08/06/25. It was noticed during her stay."

On 09/17/25 at 11:45 AM, E2 (Wellness Director) stated she created the following focus on R1's Service Plan: "Has memory loss/cognitive impairment." E2 verified that R1 did not have a diagnosis of memory loss or cognitive impairment and stated she created this focus because, "(R1) wasn't following direction. She had a big change in the middle of her stay. She was found on sitting on the floor. I am aware of one instance of this. She was sitting on the floor in front of her recliner." E2 stated she could not recall the staff member that reported this incident to her. E2 verified that R1's Service Plan did not address her risk for falls was not revised to correctly reflect R1's need for assistance.

2. R2's medical record documents R2 moved into the establishment on 08/25/25.

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A4010	Continued From page 5 R2's current Service Plan did not address R2's needs for the following ADLs (activities of daily living): Toileting Needs, Dressing, Mobility/Ambulation, and Transferring. On 09/16/25 at 11:45 AM, E2 (Wellness Director) confirmed that several of R2's ADLS were not addressed on R2's Service Plan. E2 stated, "That's on me."	A4010		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: T1 Violation Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 1) The right to live in an environment that promotes and supports each resident's dignity, individuality, independence, self-determination, privacy, and choice and to be treated with consideration and respect; 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; Based on interview and record review, the facility neglected to address a resident's declining	A6000		

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condition and neglected to address and investigate a resident fall after an occurrence for one of two residents (R1) reviewed for abuse/neglect that caused severe harm to a resident or creates a substantial probability of severe harm to a resident or residents.

Findings include:

The establishment's Activities of Daily Living (ADL) policy (revised 03/2024) documents the following: "Purpose: to ensure that residents will receive services and care that will maintain their highest level of functioning possible for as long as possible." This policy also documents, "Changes in the resident's ADL needs will be entered into the Community's communication system. Staff will be trained to document daily personal care via the Community's ADL documentation system. Needed assistance will be documented in the Resident's Service Plan."

The establishment's Falls Policy & Procedure (reviewed 02/2024) documents the following: "When a resident has a fall, the Wellness Director (or designee) will: Not move the resident until a thorough assessment is done, Seek emergency medical treatment as appropriate, Notify the resident's medical provider, Notify the authorized responsible party, Ensure a Fall Investigation is completed, Ensure the resident is listed in the Community's communication system post fall monitoring. The service plan will be updated to include (fall prevention) interventions."

R1's Physician's Assessment (dated 07/30/25) documents R1 was assessed as needing no assistance in the following areas of activities of daily living: Eating, Dressing, Toileting, Transferring, Transferring, bathing, Personal

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A6000	Continued From page 7 Hygiene, and Medication Administration. R1's pre-admission Initial Screen (dated 08/06/25) documents the following: R1 is independent with the following ADLs (activities of daily living): Bathing, Hygiene, Dressing, Ambulation, Dining, Medications, and Toileting. This same screening documents the following: R1's General Well Being, "Resident is in sound overall health whereas no serious problems prevent independent living;" and R1's Orientation Status, "Oriented to person, place and time." R1's pre-admission Fall Risk Assessment (dated 08/06/25) documents a score of 22, indicating a high risk for falls. This same assessment documents the following: "A total score of 10 or greater is considered a High Risk. Don't forget to add Risk to the ADL (activities of daily living) sheets. Assure care planning is completed with the appropriate interventions in place." R1's medical record documents R1 admitted to the establishment on 08/16/25, and discharged on 09/02/25. R1's most current Service Plan has no mention of R1's risk for falls. This same Service Plan documents R1 is independent with the following ADLS: Toileting, Ambulation, Bathing/Showers, Grooming/Personal Hygiene, and Mobility/Ambulation/Escorts/Transfers. R1's Service Plan also documents the following: "Has memory loss/Cognitive Impairment (date initiated 08/21/25)." The establishment's monthly Incident Log (dated 07/2025 - 09/2025) documents no incidents were reported for R1 during this time frame.	A6000		

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A6000	Continued From page 8 R1's medical record contains no Progress Notes or documentation of a change in condition for the time frame of her entire recent stay at the establishment (08/16/25 - 09/02/25). On 09/16/25 at 09:10 AM, E2 (Wellness Director) stated the following regarding R1, "(Z1, R1's sister) told us that R1 was independent and completed all of her ADLs independently. We soon discovered otherwise. (R1) was too much care for Assisted Living. Her family was out of town several states away, so we did care for her until they returned to pick her up. I believe her family wanted her to permanently move in, but when (Z1) picked her up, she was told that we could not meet (R1's) needs. (R1) had stayed for respite care in the past, maybe a year or so ago, and it was very noticeable that she had declined since then. She requires much more care now." On 09/16/25 at 10:30 AM, Z1 (R1's sister) stated the following: "I dropped my sister off at (establishment) for a respite care stay because I was going to be out of town for several days. When I dropped her off, she was fine and could do things for herself. We took all of her medications with her to (establishment), which she could take herself. She had been recently diagnosed with a UTI (urinary tract infection) at urgent care, and she had been prescribed antibiotics, which she had been taking. I made sure to tell them (facility staff) this. When I picked her up (on 09/02/25), she was in pretty bad shape. Her clothes were dirty and had dried food on them. She had soiled her pants (incontinent of bowel and bladder), and she was confused. I ended up taking her to the emergency room the following day, and she was admitted to (local hospital). She remained hospitalized for several days, and on 09/07/25, I got a call in the middle of	A6000		

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the night from a hospital staff member who had told me my sister had passed away. I was told they had found her in bed unresponsive. On the day I had picked her up from (establishment), the staff told me that my sister could not return there because she was not appropriate for the building. They told me she had Dementia. My sister has never been diagnosed or told she has Dementia. She was alert and oriented, and able to do most things independently. When she was hospitalized, the doctor explained to me that my sister had a UTI (urinary tract infection), and he said that it can cause confusion, especially in older people. This makes me believe the staff at (establishment) had mistaken her confusion from the infection for Dementia. They had called me several times during her stay and said she was feeling under the weather. They also called me to say she had fallen. Another day I got a call and was told that she hadn't been taking her medications for a few days, so they were going to start administering them to her. It sounds like they just watched her decline. I just wish they would've sent her to the hospital when she started going downhill."

On 09/16/25 at 11:45 AM, E2 (Wellness Director) denied that R1 had fallen at the facility and stated a staff member, whom she could not recall, had informed her that R1 was found sitting on the floor. E2 stated, "I called and spoke with (Z1, R1's sister) and she told me that (R1) liked sitting on the floor and often sat on the floor at home." E2 stated she could not provide a fall investigation on R1 because, "She did not fall while she was at (establishment)."

On 09/16/25 at 12:50 PM, E2 verified that R1's medical record has no Progress Notes documented regarding R1's condition during her

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recent stay at the establishment. E2 provided copies of the establishment's 24-hour Communication Log, and explained care staff note any issues or concerns on this log as a form of communication to the care staff working future shifts. E2 stated these records are not part of the resident's medical record, but she is providing copies, "to show how much the care staff had to monitor (R1)." E2 stated R1 is referred to as #7 on these logs for confidentiality purposes. This log documents the following concerns on the following dates: On 08/18/25, "#7 in house. Confused to take meds (medications);" On 08/20/25, "Keep an eye on #7. She has pills but is not taking them herself. Remind her;" On 08/21/25, "Showers (given to) #7;" On 08/22/25, "Keep an eye on #7. Needs supervision. She is confused. Checked on #5, #6, #7 every hour;" On 08/25/25, "If you could please keep an eye on #7. Checked on #5, #6 and #7 every hour due to confusion;" On 08/28/25, "Keep eye on #6, #7, #5 please due to confusion;" On 08/29/25, "Did one hour check on #5, #6 and #7;" On 08/30/25, "Make sure you watch #7 take her pills;" On 08/31/25, "Did one hour checks on #5,#6 and #7;" On 09/02/25, "#7 showered and going home today!" E2 also provided a typed statement at this time and explained she had just typed up a summary of what she could recall during R1's stay which documents, "Spoke with (Z1, R1's sister) on 08/21/25 regarding antibiotic noted in (R1's) room by staff member. (Z1) stated (R1) was seen at the doctor a few days before coming to (establishment) and had been given the medication for a UTI (urinary tract infection). I informed (Z1) that resident had not been taking her medications at this time and we had found them loose under her bed, as well as other containers in her suitcase and on her kitchen counter. I expressed to her that I was not

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comfortable with her taking her own medication at this time and that we will provide reminders as well as putting medications in secured cabinet in her room. (Z1) agreed with the plan. I discussed with (Z1) that resident sits down in front of recliner. She stated this is something she has been doing at home as well, and that she just prefers to sit on the floor while watching television."

On 09/16/25 at 02:40 PM, E3 (Care Partner) stated she often cared for R1 during her recent respite care stay at the facility. E3 stated, "She was here one other time, and was not in the shape she was in now. It seemed like she continued to decline the longer she was here. I think she should have been sent out to be seen. I discovered she hadn't been taking her medications a few days after she had come, and I took all of her medications to (E2, Wellness Director). (R1) was confused and needed assistance with just about all of her cares. I was told that she had a UTI (urinary tract infection) once we were aware that she hadn't been taking her medications. I provided her assistance with toileting, and her urine had a very strong odor. She definitely mimicked the behavior of someone who has a UTI." E3 stated she was unaware that R1 had ever fallen at the facility, and never found her sitting on the floor watching television.

On 09/16/25 at 03:00 PM, E4 (Care Partner) stated she cared for R1 often during her recent respite care stay at the establishment. E4 stated, "(R1) was a nice lady. She couldn't say much because she'd had a stroke. She could communicate by pointing or using gestures. She shouldn't have even been here because she couldn't do anything for herself. She wouldn't come out of her room for meals. We would take

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A6000	Continued From page 12	A6000		

her meals to her, but she didn't always eat. She could walk and would go to the bathroom the first few days while she was here, but seemed to need more and more assistance with each day that passed. It was like she was having a progressive decline right in front of us. She needed assistance with dressing, bathing, and grooming, and she wasn't taking her medications. She was pretty confused and just appeared to be pretty out of it. Sometimes, new residents need some time to adjust to their new surroundings, but (R1) seemed to be getting worse. I notified (E2, Wellness Director) of my concerns with (R1) several times." E4 stated she was not aware that R1 had fallen at the establishment and denied ever seeing her seated on the floor watching television. E4 stated, "We left her door open so we could keep a close eye on her."

On 09/17/25 at 01:40 PM, E5 (Certified Nursing Assistant) stated she had frequently cared for R1 during her respite care stay at the establishment. E5 stated, "(R1) would just sit in her chair. She would call and ask for help getting up. I believe it was a Friday toward the end of her stay around 09:00 AM, I went in her room to give her medications to her and found her on the floor in front of her bed with her arms stuck underneath her. She was face down on the floor. I radioed (E2, Wellness Director) and told her how I had found (R1), and she told me that she sits on the ground. (E6, Business Office Manager) came and helped me get her up. (E2) told me not to fill out an incident report because she was told that (R1) sits on the floor. When we got her up, I asked her if she was hurt and she nodded her head 'no.' You could tell that she had fallen. She was face down on the floor. She was very confused and was getting worse the longer she was there. We told (E2) every day that (R1) wasn't right and she

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	ASL510383	A. BUILDING: _____ B. WING _____	09/18/2025

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VILLAS OF HOLLY BROOK CHATHAM	825 EAST WALNUT CHATHAM, IL 62629

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A6000	Continued From page 13	A6000		

didn't address any of the concerns. (R1) was not appropriate to be in the building because she could not take care of herself. She needed quite a bit of assistance with dressing, bathing, her medications, meals, hygiene and toileting. She would just sit in her chair and wet her pants." E5 denied ever finding R1 seated on the floor watching television and stated, "I only found her on the floor after she had fallen on that Friday."

On 09/17/25 at 11:25 AM, E1 (Executive Director) stated she is the individual that conducted an initial assessment on R1 on 08/06/25. E1 stated, "(R1) was alert and oriented and could perform her ADLs (activities of daily living) independently. She was able to communicate her needs. She nodded her head to questions and could verbalize the words 'yes' and 'no' to answer. (R1) came to the building on 08/16/25 and left on 09/02/25. I saw a big change from when I assessed her on 08/06/25. It was noticed during her stay."

On 09/17/25 at 11:45 AM, E2 (Wellness Director) stated she created the following focus on R1's Service Plan: "Has memory loss/cognitive impairment." E2 verified that R1 did not have a diagnosis of memory loss or cognitive impairment and stated she created this focus because, "(R1) wasn't following direction. She had a big change in the middle of her stay. She was found on sitting on the floor. I am aware of one instance of this. She was sitting on the floor in front of her recliner." E2 stated she could not recall the staff member that reported this incident to her. E2 verified that R1's Service Plan was inaccurate and was not revised to correctly reflect R1's need for assistance and did not address R1's risk for falls.

On 09/17/25 at 02:00 PM, E6 (Business Office

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A6000	Continued From page 14 Manager) stated she assisted (E5, Certified Nursing Assistant) to get R1 off of the floor after she had fallen during her stay at the establishment. E6 stated, "It was a Friday, because (E5) is the only one who is scheduled to work on Fridays. (E5) called for help on the radio. When I entered R1's room, (R1) was lying on her side and it appeared she had fallen. She was near her suitcase, so I assumed she had fell while she was getting dressed. (E5, Certified Nursing Assistant) and I grabbed under her arms and booster her up. We asked her if she was hurt or had any pain and she shook her head no." E6 stated she did not complete any type of incident report regarding this matter, "The person who found the resident would be the person that completes an incident report." On 09/17/25 at 03:15 PM, Z1 (R1's sister) stated she was informed that R1 had fallen at the facility, but could not recall the date. Z1 denied ever telling establishment staff that R1 often seats herself on the floor to watch television and stated, "Why would an elderly person who has had a stroke sit on the floor? It would be difficult for her to get up. My sister never just decided to randomly sit on the floor. They called and told me that she had fallen, but never told me that she just sat on the floor. She's never done that." On 09/17/25 at 02:40 PM, E1 (Executive Director) verified that R1's declining condition was not addressed by E2, confirmed that details of R1's declining condition was not documented in R1's medical record, and verified that R1's service plan was not revised to accurately reflect the care R1 required at the establishment. E1 stated she was not made aware that R1 had ever fallen at the establishment and stated, "I am just sick about all of this."	A6000		

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A6000	Continued From page 15 R1's (local hospital) medical record documents the following: "09/03/25 Triage Note: Patient arrives to triage with her sister. Sister reports she picked her up from respite care yesterday and she is lethargic, not eating, and has lower extremity edema. Patient is supposed to be on a diuretic but was not taking her medications at respite care. History of Present Illness: 78 year-old female presents to the emergency department with altered mental status and generalized weakness. Patient has a history of aphasia per sister who is primary caretaker. The sister was out of town for the past 2 weeks and the patient was at respite care at (establishment) at that time. Sister picker her up yesterday and brought her in today due to marked altered mental status and generalized weakness. Typically the patient can ambulate independently with a walker and is no longer able to stand independently. ED (emergency department) Diagnosis: UTI (urinary tract infection) (Primary); Altered Mental Status; CHF (congestive heart failure)." These records also document, "Admitting Provider Impression: Acute on chronic systolic Congestive Heart failure, Acute Kidney Injury most likely cardiorenal syndrome from CHF exacerbation, Metabolic Acidosis most likely due to acute kidney injury, UTI, Altered Mental Status most likely Metabolic encephalopathy from UTI, Lactic Acidosis." R1's medical records also document, "(R1) is found to have E. coli UTI and she was continued on intravenous Rocephin during her stay. Overnight events occurred. Earlier this morning, just after midnight, patient reportedly became bradycardic and went into Pulseless Electrical Activity arrest. Resuscitation was not attempted as the patient was Do Not Resuscitate. Sister, who is healthcare POA (power of attorney) was notified."	A6000		

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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: 10) Documentation of any significant change in a resident's behavior or physical, cognitive, or functional condition that would trigger an assessment or evaluation, and action taken by employees to address the resident's changing needs; Based on interview and record review, the facility failed to maintain accurate documentation of a resident's change in condition throughout the duration of residency for one resident (R1). Findings include: R1's medical record documents R1 admitted to the establishment on 08/16/25, and discharged on 09/02/25. R1's medical record has no Progress Notes or documentation of a change in condition for the time frame of her entire recent stay at the establishment (08/16/25 - 09/02/25). On 09/16/25 at 09:10 AM, E2 (Wellness Director) stated the following regarding R1, "(Z1, R1's sister) told us that R1 was independent and completed all of her ADLs (activities of daily	A7000		

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living) independently. We soon discovered otherwise. (R1) was too much care for Assisted Living. Her family was out of town several states away, so we did care for her until they returned to pick her up. I believe her family wanted her to permanently move in, but when (Z1) picked her up, she was told that we could not meet (R1's) needs. (R1) had stayed for respite care in the past, maybe a year or so ago, and it was very noticeable that she had declined since then. She requires much more care now."

On 09/16/25 at 10:30 AM, Z1 (R1's sister) stated the following: "I dropped my sister off at (establishment) for a respite care stay because I was going to be out of town for several days. When I dropped her off, she was fine and could do things for herself. We took all of her medications with her to (establishment), which she could take herself. She had been recently diagnosed with a UTI (urinary tract infection) at urgent care, and she had been prescribed antibiotics, which she had been taking. I made sure to tell them this. When I picked her up (on 09/02/25), she was in pretty bad shape. Her clothes were dirty and had dried food on them. She had soiled her pants (incontinent of bowel and bladder), and she was confused. I ended up taking her to the emergency room the following day, and she was admitted to (local hospital). She remained hospitalized for several days, and on 09/07/25, I got a call in the middle of the night from a hospital staff member who had told me my sister had passed away. I was told they had found her in bed unresponsive. On the day I had picked her up from (establishment), the staff told me that my sister could not return there because she was not appropriate for the building. They told me she had Dementia. My sister has never been diagnosed or told she has Dementia. She was

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A7000	Continued From page 18	A7000		

alert and oriented, and able to do most things independently. When she was hospitalized, the doctor explained to me that my sister had a UTI (urinary tract infection), and he said that it can cause confusion, especially in older people. This makes me believe the staff at (establishment) had mistaken her confusion from the infection for Dementia. They had called me several times during her stay and said she was feeling under the weather. They also called me to say she had fallen. Another day I got a call and was told that she hadn't been taking her medications for a few days, so they were going to start administering them to her. It sounds like they just watched her decline. I just wish they would've sent her to the hospital when she started going downhill."

On 09/16/25 at 11:45 AM, E2 (Wellness Director) denied that R1 had fallen at the facility and stated a staff member, whom she could not recall, had informed her that R1 was found sitting on the floor. E2 stated, "I called and spoke with (Z1, R1's sister) and she told me that (R1) liked sitting on the floor and often sat on the floor at home." E2 stated she could not provide a fall investigation on R1 because, "She did not fall while she was at (establishment)."

On 09/16/25 at 12:50 PM, E2 verified that R1's medical record has no Progress Notes documented regarding R1's condition during her recent stay at the establishment. E2 provided copies of the establishment's 24-hour Communication Log, and explained care staff note any issues or concerns on this log as a form of communication to the care staff working future shifts. E2 stated these records are not part of the resident's medical record, but she is providing copies, "to show how much the care staff had to monitor (R1)." E2 stated R1 is referred to as #7

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A7000	Continued From page 19 on these logs for confidentiality purposes. This log documents the following information on the following dates: On 08/18/25, "#7 in house. Confused to take meds (medications);" On 08/20/25, "Keep an eye on #7. She has pills but is not taking them herself. Remind her;" On 08/21/25, "Showers (given to) #7;" On 08/22/25, "Keep an eye on #7. Needs supervision. She is confused. Checked on #5, #6, #7 every hour;" On 08/25/25, "If you could please keep an eye on #7. Checked on #5, #6 and #7 every hour due to confusion;" On 08/28/25, "Keep eye on #6, #7, #5 please due to confusion;" On 08/29/25, "Did one hour check on #5, #6 and #7;" On 08/30/25, "Make sure you watch #7 take her pills;" On 08/31/25, "Did one hour checks on #5,#6 and #7;" On 09/02/25, "#7 showered and going home today!" E2 also provided a typed statement and explained she had just typed up a summary of what she could recall during R1's stay which documents, "Spoke with (Z1, R1's sister) on 08/21/25 regarding antibiotic noted in (R1's) room by staff member. (Z1) stated (R1) has seen the doctor a few days before coming to (establishment) and had been given the medication for a UTI (urinary tract infection). I informed (Z1) that resident had not been taking her medications at this time and we had found them loose under her bed, as well as other containers in her suitcase and on her kitchen counter. I expressed to her that I was not comfortable with her taking her own medication at this time and that we will provide reminders as well as putting medications in secured cabinet in her room. (Z1) agreed with the plan. I discussed with (Z1) that resident sits down in front of recliner. She stated this is something she has been doing at home as well, and that she just prefers to sit on the floor while watching television."	A7000		

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A7000	Continued From page 20 On 09/16/25 at 02:40 PM, E3 (Care Partner) stated she often cared for R1 during her recent respite care stay at the facility. E3 stated, "She was here one other time, and was not in the shape she was in now. It seemed like she continued to decline the longer she was here. I think she should have been sent out to be seen. I discovered she hadn't been taking her medications a few days after she had come, and I took all of her medications to (E2, Wellness Director). (R1) was confused and needed assistance with just about all of her cares. I was told that she had a UTI (urinary tract infection) once we were aware that she hadn't been taking her medications. I provided her assistance with toileting, and her urine had a very strong odor. She definitely mimicked the behavior of someone who has a UTI." E3 stated she was unaware that R1 had ever fallen at the facility, and never found her sitting on the floor watching television. On 09/16/25 at 03:00 PM, E4 (Care Partner) stated she cared for R1 often during her recent respite care stay at the establishment. E4 stated, "(R1) was a nice lady. She couldn't say much because she'd had a stroke. She could communicate by pointing or using gestures. She shouldn't have even been here because she couldn't do anything for herself. She wouldn't come out of her room for meals. We would take her meals to her, but she didn't always eat. She could walk and would go to the bathroom the first few days while she was here, but seemed to need more and more assistance with each day that passed. It was like she was having a progressive decline right in front of us. She needed assistance with dressing, bathing, and grooming, and she wasn't taking her medications. She was pretty confused and just appeared to be pretty out	A7000		

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A7000	Continued From page 21	A7000		

of it. Sometimes, new residents need some time to adjust to their new surroundings, but (R1) seemed to be getting worse. I notified (E2, Wellness Director) of my concerns with (R1) several times." E4 stated she was not aware that R1 had fallen at the establishment and denied ever seeing her seated on the floor watching television. E4 stated, "We left her door open so we could keep a close eye on her."

On 09/17/25 at 01:40 PM, E5 (Certified Nursing Assistant) stated she had frequently cared for R1 during her respite care stay at the establishment. E5 stated, "(R1) would just sit in her chair. She would call and ask for help getting up. I believe it was a Friday toward the end of her stay around 09:00 AM, I went in her room to give her medications to her and found her on the floor in front of her bed with her arms stuck underneath her. She was face down on the floor. I radioed (E2, Wellness Director) and told her how I had found (R1), and she told me that she sits on the ground. (E6, Business Office Manager) came and helped me get her up. (E2) told me not to fill out an incident report because she was told that (R1) sits on the floor. When we got her up, I asked her if she was hurt and she nodded her head 'no.' You could tell that she had fallen. She was face down on the floor. She was very confused and was getting worse the longer she was there. We told (E2) every day that (R1) wasn't right and she didn't address any of the concerns. (R1) was not appropriate to be in the building because she could not take care of herself. She needed quite a bit of assistance with dressing, bathing, her medications, meals, hygiene and toileting. She would just sit in her chair and wet her pants." E5 denied ever finding R1 seated on the floor watching television and stated, "I only found her on the floor after she had fallen on that Friday."

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A7000	Continued From page 22 On 09/17/25 at 11:25 AM, E1 (Executive Director) stated she is the individual that conducted an initial assessment on R1 on 08/06/25. E1 stated, "(R1) was alert and oriented and could perform her ADLs (activities of daily living) independently. She was able to communicate her needs. She nodded her head to questions and could verbalize the words 'yes' and 'no' to answer. (R1) came to the building on 08/16/25 and left on 09/02/25. I saw a big change from when I assessed her on 08/06/25. It was noticed during her stay." E1 stated she could not provided any documentation from R1's medical record detailing the changes in her condition that occurred during her stay at the establishment. On 09/17/25 at 11:45 AM, E2 (Wellness Director) stated she created the following focus on R1's Service Plan: "Has memory loss/cognitive impairment." E2 verified that R1 did not have a diagnosis of memory loss or cognitive impairment and stated she created this focus because, "(R1) wasn't following direction. She had a big change in the middle of her stay. She was found on sitting on the floor. I am aware of one instance of this. She was sitting on the floor in front of her recliner." E2 stated she could not recall the staff member that reported this incident to her. E2 verified that R1's Service Plan was inaccurate and was not revised to correctly reflect R1's need for assistance and did not address R1's risk for falls. On 09/17/25 at 02:00 PM, E6 (Business Office Manager) stated she assisted (E5, Certified Nursing Assistant) to get R1 off of the floor after she had fallen during her stay at the establishment. E6 stated, "It was a Friday, because (E5) is the only one who is scheduled to	A7000		

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A7000	Continued From page 23	A7000		

work on Fridays. (E5) called for help on the radio. When I entered R1's room, (R1) was lying on her side and it appeared she had fallen. She was near her suitcase, so I assumed she had fell when she was getting dressed. (E5, Certified nursing Assistant) and I grabbed under her arms and booster her up. We asked her if she was hurt or had any pain and she shook her head no." E6 stated she did not complete any type of incident report regarding this matter, "The person who found the resident would be the person that completes an incident report."

On 09/17/25 at 03:15 PM, Z1 (R1's sister) stated she was informed that R1 had fallen at the facility, but could not recall the date. Z1 denied ever telling establishment staff that R1 often seats herself on the floor and stated, "Why would an elderly person who has had a stroke sit on the floor? It would be difficult for her to get up. My sister never just decided to randomly sit on the floor. They called and told me that she had fallen, but never told me that she just sat on the floor. She's never done that."

On 09/17/25 at 02:40 PM, E1 (Executive Director) confirmed that details of R1's declining condition was not documented in R1's medical record, and verified that R1's service plan was not revised to accurately reflect the care R1 required at the establishment. E1 stated she was not made aware that R1 had ever fallen at the establishment and stated, "I am just sick about all of this."