STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE		
					C	
		IL6008023			03/2	5/2024
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S ST HIGHWA	STATE, ZIP CODE		
RIVERSI	DE FOUNDATION		SHIRE, IL 60			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
Z 000	COMMENTS		Z 000			
	Revisit to Annual Ho	ealth Survey				
	Complaint Investiga	ation 2411019/IL169531				
Z9999	FINDINGS		Z9999			
	Statement of Licens	sure Violations:				
	350.620 a) 350.700 a)					
	Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually.					
	a) The facility shall reports of each inci- resident that is not to resident's condition descriptive summan affecting a resident	cidents and Accidents maintain a file of all written dent and accident affecting a the expected outcome of a or disease process. A ry of each incident or accident shall also be recorded in the urse's notes of that resident.				
	These requirements	s are not met as evidenced by:				
	interview, the facility	on, record review, and y failed to implement their d neglect when they failed to				

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

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		A. BUILDING:		C		
		IL6008023	B. WING		1	25/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
RIVERSI	DE FOUNDATION		ST HIGHWA SHIRE, IL 60			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
Z9999	protect 2 of 2 client injuries; failed to en physical abuse invocient (R1) found na and 1 of 1 incident client (R2) were the Findings include: 1)R1's face sheet of male whose diagnor intellectual Disability Disorder with poor On 03/08/24 at 2:2'R1 told him he was day before he brous Surveyor asked Z1 the facility about this (E2, Quality Assuranot really sure who someone at the face was short of breath physical therapy. To occupational therapy breath. We went to have him evaluated removed his shirt to saw a lot of bruises on his left upper balleg near his shin ar	s (R1 and R2) from sustaining usure 1 of 1 allegation of olving 1 of 1 client (R1), 1 of 1 aked in his room on 11/01/23 of multiple injuries on 1 of 1 broughly investigated describes R1 as a 76 year old describes R1 as a 76 year old describes R1 as a 76 year old describes R1 as a 76 year old	Z9999			
	was cough and abo during his admissic due to unspecified respiratory failure a	ds indicate his chief complaint dominal pain. His diagnoses on were: Acute bronchiolitis organism, Acute hypoxemic and left Pneumothorax. Under epartment Course (of				

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STATE FORM 6899 EFIG11 If continuation sheet 2 of 11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		A. BUILDING:	A. BUILDING:		
	IL6008023	B. WING			C 2 5/2024
NAME OF PROVIDER OR SUPP	LIER STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
RIVERSIDE FOLINDATION		EST HIGHWA' ISHIRE, IL 60			
PREFIX (EACH DEFIC	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
bedside who in informed him the facility. Patient incident. Patient incident. Patient nipple area and R1's hospital on Under ED (Emtreatment)) da "Patient's fan results and platedside who in informed him the facility. Patient incident. Patien	n page 2 ncludes; "Guardian is at the forms that 2 days ago, patient had at someone beat him up at the had abdominal bruising from that t does have bruising around left abdominal area." cords indicate R1 was just sent to 01/31/24 for shortness of breath. Ergency Department Course (of sed 01/31/24, it includes; filly informed about diagnostic in for admission. Brother is at the forms that 2 days ago, patient had that someone beat him up at the had abdominal bruising from that the does have bruising around left abdominal area." 11:40am, Z3 (hospital Registered anager) stated, "(R1) had multiple orso and back. His right ankle was downth bruising up to his shin when to the ER (Emergency Room) on dided, "(R1's) guardian also told as bruises on his back, but I didn't Gurveyor asked Z3 to describe the Z3 answered, "(R1) had multiple chest area on both right and left under his left breast was a few efter. The bruises were kind of the were not in a pattern and did not ere from a fall." Surveyor asked the bruises. Z3 replied, "The were less than a week old." respondence from E2 to surveyor, at 10:45am, E2 wrote "I was told tim (R1) before going to the				

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STATE FORM 6899 EFIG11 If continuation sheet 3 of 11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.	A. BUILDING:		
		IL6008023			1	5/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RIVERSI	DE FOUNDATION		ST HIGHWA SHIRE, IL 60			
(V4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE
Z9999	Continued From pa	ge 3	Z9999			
	questioned him about told me no to all root state who hit him. It including two nurse bruise on his stomat belt. Both nurses a stomach couldn't had I reviewed camera a building where (R1) evidence of anyone asked E2 that if the on his stomach before is documentate even in the nurses a correspondence to 11:12am, E2 stated report and investigate remember what day	on was that hit him. I but all his roommates and (R1) ommates. (R1) was unable to When I questioned staff, s, everyone told me that the ach was caused by his gait tated that the bruise on (R1's) ave been caused by a person. footage, for all areas of the was located, and found no harming (R1)." Surveyor facility was aware of bruising ore he went to the hospital, if tion about it on R1's record, or notes. In E2's email surveyor, dated 03/11/24 at , "There is no official incident ation completed. I don't y I was told, either on 01/30/24 before he left for the hospital				
	The facility's incident reports and investigations from 10/23 through 03/24 showed there is no incident report regarding R1's 01/24 injuries before 02/02/24.					
	under incident desc Assurance Director (R1) was admitted to pneumonia and Pne observed a large br / hip area and seve back / shoulder blace	nt report, dated 02/06/24, cription indicates; "(E2, Quality) went to the hospital to visit. to the hospital; for left lung eumothorax on 01/31/24. (E2) ruise on (R1's) left upper thigh ral small bruises on his upper de area when visiting (R1)."				
	completed by E2 or Under following info	ormation was gathered it se on (R1's) left hip / thigh was				

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STATE FORM 6899 EFIG11 If continuation sheet 4 of 11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY	
			A. BUILDING:			,
	IL6008023 B. WING			03/2	25/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
RIVERSI	DE FOUNDATION		ST HIGHWA SHIRE, IL 60			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
Z9999	round and measure diameter. The bruis were round shape inch to 1 inch. Ther scattered on left up Under conclusion it this investigation is when (R1) received thigh and left upper Under corrective ac change will be arra from the rehabilitation the rehabilitation (Developmental Inself (Developmental Inself (Shift supervise (facility attendant), Person-DSP), E6 (Inself (DSP), E10 (DSP	ed about 10 inches in ses on (R1's) left upper back measuring approximately 1/2 re were approximately 5 to 6 oper back / shoulder area" It includes; "The conclusion to inconclusive as to how and the bruises on his left hip / reback / shoulder blade area." etion it includes; "A roominge for R1 before his return ion facility." Instructor) and E15 structor), E11 (PM supervisor), or/ On the job Trainer), E19 E5(Direct Support DSP), E7 (DSP), E8 (DSP), E9 E13 (DSP), E14 (DSP), E15 E17 (DSP) and E18 (DSP) on 03/05/24 and 03/06/24, and e a little unsteady on his feet, een him fall. I's injury report from October th 2024. The only injuries of sustained were noted on 0/23. The injuries are as orted R1 has a scrape along 25cm. ise on right side of back, d left side of back indicate the cause of these fown origins. R1 on 03/07/24 at 10:26am,	Z9999			
		hair in the hallway close to the rveyor observed two red				

Illinois Department of Public Health

STATE FORM 6899 EFIG11 If continuation sheet 5 of 11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		IL6008023	B. WING			C 25/2024
	PROVIDER OR SUPPLIER DE FOUNDATION	14588 WE	ST HIGHWA			
		LINCOLN	SHIRE, IL 60	0069		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
Z9999	Continued From pa	ge 5	Z9999			
29999	scratch marks on to to interview R1, but question, R1 would you open that door? door, which is his could possibly get a both October and J and E2 answered, "have been client to On 03/07/24 at 1:45 (R1), it must have be towards him and care	op of R1's head. Surveyor tried every time surveyor asked a only answer, "Hey lady, can?" Pointing to room (number) urrent bedroom. and E2 were interviewed on m. Surveyor asked how R1 all these bruises on him on anuary 31st incidents. Both E1' The possible cause could	Z9999			
	facility conducted a and why wasn't thei injuries in his record 11:12am. E2 stated completed, I don't rowas told January 30 he left for the hospi Prior to being disch facility on 02/20/24, other peers (R4, R5 room since 08/15/2 room on 02/10/24.2 (R4 and R5) have be R4 is a 26 year old include Severe Interest Microcephaly and Sendividual Program	formal investigation report, re no documentation on R1's d. E2 replied on 03/11/24 at d, "No official investigation was emember what day either I or January 31, 2024, before tal." arged from the rehabilitation R1 was in a quad room with 3 and R6). R1 was in this quad 3, and was moved to another 2 of R1's previous quadmates behavior program plans. client whose diagnoses llectual Disability, seizure Disorder. His Plan, dated 08/29/23, includes				
	(R4) is pushing resi	Social Services reported that dents that are in wheelchairs or that he has exhibited in the				

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STATE FORM 6899 EFIG11 If continuation sheet 6 of 11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		IL6008023	B. WING		03/2	25/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RIVERS	DE FOUNDATION		ST HIGHWA SHIRE, IL 60			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
Z9999	past" R4's behavion 09/13/23, indicates aggression toward R4's behavior data reviewed. R4 displat aggression, and more pushing other client R4 ran and scratched R5 is 31 years old Schizophrenia and behavior intervention indicated the follow hallucinations, with inappropriate bathrous physical aggression his behavior data from indicated that he has aggression against 2) R1's face sheet male whose diagnor Intellectual Disabilit Disorder with poor in R1's incident, dated reviewed. Under de "(R1) found sitting on the was hungry." The facility's investing interview with R1. Surveyor interviewed Director) on 03/06/2 asked at the time of wheelchair? E2 and for awhile, but he with the significant of the was hungry.	or intervention plan, dated the following target behaviors: others and public disrobing. since 09/23 until 03/24 was used 10 incidents of physical ost of these are described as as hard, and 1 incident where ed R1 on his head. whose diagnoses includes Mild Intellectual Disability. His on plan, dated 11/20/23, ing target behaviors: auditory	Z9999			

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STATE FORM 6899 EFIG11 If continuation sheet 7 of 11

Illinois Department of Public Health						
STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		11 6008022	B. WING		02/2	
		IL6008023	B. WING		03/2	5/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
14588 W		14588 WF	ST HIGHWA	Y 22		
RIVERSI	DE FOUNDATION		SHIRE, IL 60			
	0.0000000000000000000000000000000000000					
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
				DEFICIENCY)		
70000	Cantinuad Francisa	7	Z9999			
Z9999	Continued From pa	ige /	Z9999			
	disrobe, at that time	e he might have taken his				
		ady for bed." Surveyor asked				
		vere near him when he was				
		ed, " I don't know if any clothes				
		on't remember. (R1) was sitting				
		between his bed and his				
		then asked E2 if any of R1's				
	_	the room at that time. E2				
	answered, "I don't t	hink so." Then E2 added, " I				
	am not sure if they	are in there. If (R1) was in				
	wheelchair, staff wo	ould have brought him in and if				
	he was using walke	er, he would have just walked				
	in by himself . " E2	then added, "Now that I think				
	about it, (R5) might	have been in his bed with the				
	covers over him, fro	om what I remember about my				
	conversation with (I	E23), he's our nurse."				
	Surveyor asked if R	R5 had any sexual				
	inappropriate behav	viors towards others. E2				
	answered,"I have s	een him masturbate, but I				
	haven't seen him be	eing inappropriate with another				
	individual." Surveyo	or then asked if there is				
	documentation to s	how who were in the room				
	with R1 when he wa	as found naked. E2 answered,				
	"No there is no doc	umentation regarding that."				
		ated 02/15/24, states under				
	incident description	; "(E13, Direct Support Person				
	/ Developmental Tra	ainer) observed a dark purple				
		t inner thigh and scrotum. The				
		and dark purple. R2 is unable				
	to state when or ho	w the bruises occurred."				
	•	were reviewed. An entry dated				
		"Family complaint multiple				
	· ·	nest, back, and legs. Nurse				
		nest, back and legs. Quarter				
		se noted under left nipple. NO				
	recent or multiple bruises noted to chest, back or					

STATE FORM 6899 If continuation sheet 8 of 11 EFIG11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6008023	B. WING		C 03/25/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI		STATE, ZIP CODE	1	
RIVERSI	DE FOUNDATION		ST HIGHWA SHIRE, IL 60			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	.D BE	(X5) COMPLETE DATE
Z9999	legs." The facility's summ completed by E2 (0 02/21/24 was revier includes; "The cond founded for resident occurred toward (R On 03/07/24 at 10: surveyor observed in his hands and waroom (number). R2's injury reports f March 2024 were refind any other injury R2's nurses notes, 01/31/24 includes; bruising noted to chassessed skin to chassessed skin to chasessed skin to chasessed skin to chase yellow old bruis recent or multiple blegs." Email corresponder facility staff dated 0 "(Z2, guardian) reponder with bruises, agrees that this is hother resident's rookicking him to get of the properties of th	ary of injury of unknown origin Quality Assurance Director) on wed. Under conclusion it clusion to this investigation is at physical aggression to have 2) on 02/14/24." 18am, while in the hallway, R2 holding a tablet computer as checking the door knob for from October 2023 through eviewed. Surveyor could not a report for R2. Upon review of surveyor noted an entry dated "Family complaint multiple nest, back, and legs. Nurse nest, back and legs. Quarter se noted under left nipple. No ruises noted to chest, back or nace from E1, Administrator, to 1/30/2024 at 5:30pm includes; orted to us that (R2) is coming We believe and (Z2) also nappening when he goes into ms and they may be hitting or	Z9999			

Illinois Department of Public Health

STATE FORM 6899 EFIG11 If continuation sheet 9 of 11

Illinois D	epartment of Public	Health				
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		IL6008023	B. WING		03/2	5/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
14588 WE			ST HIGHWA			
RIVERSI	DE FOUNDATION	LINCOLNS	SHIRE, IL 60	0069		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
Z9999	Continued From pa	ge 9	Z9999			
	consistent one-on-one can learn to stay that's fine with us see it as protective. turns out to be a root to another room (eithey will be perman We look forward to the investigation is kind of protection for happening since Rafactor. The injuries whoever is doing the fight back and feels like to hurt him."	one-monitoring for (R2) until of out of other resident's rooms, I don't see that as restrictive, I Or, if the person hurting him commate, one will be relocated ther (R2) or the offender) and ently separated. hearing what you find out. If inconclusive, we expect some or R2 to prevent this from 2's safety is the most important have gotten steadily worse so is seems to know R2 won't a free to do whatever he feels				
	stated, "(R2's) scrothe had a bruise on the bruise on (R2's) the sole of (R5's) fli (R2) went into (roor came out of the roo added, "I think this happened." Survey bruising reported or did not investigate to	on 03/06/24 at 10:12am. E2 tum was swollen and purple, the left thigh, impression on leg matches the bottom of p flop. Per my investigation, m number) at 8:28.06pm and om at 8:50.38pm." E2 then is when the incident or asked E2 how about R2's n 01/30 by Z2. E2 answered, "I hat, I was not aware of it."				
	03/06/24 at 10:12ar R2 get all those bru	m. Surveyor asked how did the lises that Z2 described as se. Both stated "We believe it				
	on 03/07/24 at 11:4	nce Director, was interviewed 5am. E2 stated, "I don't have (R2's) injuries of January. I				

The facility's incident reports were reviewed and

STATE FORM 6899 If continuation sheet 10 of 11 EFIG11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING:		SURVEY PLETED		
		IL6008023	B. WING			C 25/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RIVERSIDE FOLINDATION			ST HIGHWA SHIRE, IL 60			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION OF CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
Z9999	surveyor did not find injuries. The facility's abuse 01/16/23 defines neagency's, or facility' medical care, personal action of an ior mental condition.	and neglect policy revised eglect as; "An employee's, s failure to provide adequate onal care or maintenance, and nce, causes an individual pain, distress, results in either an otive behavior or the ndividual's physical condition, or places an individual's substantial risk of possible	Z9999			

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