STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000293	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA CARE ALEDO	304 S.W. 12TH STREET , ALEDO, Illinois, 61231

(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) COMPLETION DATE
S0000	Initial Comments Annual Licensure Survey	S0000		
S9999	Final Observations Statement of Licensure Violations (1 of 7) 300.650c) Section 300.650 Personnel Policies c) Prior to employing any individual in a position that requires a State license, the facility shall contact the Illinois Department of Financial and Professional Regulation (IDFPR) to verify that the individual's license is active. A copy of the license shall be placed in the individual's personnel file. This requirement was not met as evidenced by: Based on interview and record review the facility failed to ensure licensed nursing staff were verified against the Illinois Department of Financial and Professional Regulation website prior to hiring. This applies to all residents in the facility. The findings include: The facility resident census report provided on 9/30/25 showed 47 residents in the facility. The facility's list of staff showed V10 Licensed Practical Nurse (LPN) was hired 3/1/25; V11 LPN was hired 2/5/25; and V12 Registered Nurse (RN) was hired 9/19/25. On 10/1/25 a copy of V10, V11, and V12's IDFPR license check was requested. On 10/1/25 at 11:50 AM V3 Business Office Manager provided V10, V11, and V12's background checks. The background checks provided did not include IDFPR verifications. On 10/1/25 at 12:25 PM, V3 stated the documents provided for V10, V11, and V12 are the only background	S9999		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 checks available for these staff. V3 was unable to produce an IDFPR background check. On 10/1/25 at 1:37 PM, V3 stated she was not aware the IDFPR website needed to be verified prior to hiring nurses. V3 stated she believed the contracted company the facility uses for background checks would verify all necessary background documents. V3 stated the purpose of the IDFPR check is to ensure nursing licenses are active and in good standing. On 10/1/25 at 1:43 PM, V3 provided a copy of an IDFPR website check dated 10/1/25 and asked the surveyor if it was correct. V3 stated these IDFPR checks had not been done and she would do them now. (C) (2 of 7) 300.696a) 300.696b)1)3) Section 300.696 Infection Prevention and Control a) A facility shall have an infection prevention and control program for the surveillance, investigation, prevention, and control of healthcare-associated infections and other infectious diseases. The program shall be under the management of the facility's infection preventionist who is qualified through education, training, experience, or certification in infection prevention and control. b) Written policies and procedures for surveillance, investigation, prevention, and control of infectious agents and healthcare-associated infections in the facility shall be established and followed, including for the appropriate use of personal protective equipment as provided in the Centers for Disease Control and Prevention's Guideline for Isolation Precautions, Hospital Respiratory Protection Program Toolkit, and the Occupational Safety and Health Administration's Respiratory Protection Guidance. The policies and procedures must be consistent with and include the requirements of the Control of Communicable Diseases Code, and the Control of Sexually Transmissible Infections Code. 1) All staff shall be trained at least annually on basic infection prevention and control practices based on job responsibilities. Training records shall be maintained for three years. For the purposes of this	S9999		

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S9999	Continued from page 2 Section, “staff” means those individuals who work in the facility on a regular (that is, at least once a week) basis, including individuals who may not be physically in the facility for a period of time due to illness, disability, or scheduled time off, but who are expected to return to work. This also includes individuals under contract or arrangement, including hospice and dialysis staff, physical therapists, occupational therapists, mental health professionals, or volunteers, who are in the facility on a regular basis. 3) Facility activities shall be monitored on an ongoing basis by the Infection Preventionist to ensure adherence to all infection prevention and control policies and procedures. This requirement was not met as evidenced by: Based on observation, interview and record review the facility failed to prevent cross-contamination by not ensuring licensed nursing staff administered medications according to professional standards. This failure affects 1 of 4 residents (R7) reviewed for medications in the sample of 8. The findings include: On 10/1/25 from 9:17 to 9:20 AM, V6 (Registered Nurse) prepared R7 morning medications that included: one chewable tablet of aspirin 81mg (milligram), one tablet of baclofen 5mg, one tablet of buspirone 10mg, one tablet of carvedilol tablet 3.125mg, one tablet of metformin 500mg, three tablets of sertraline 50mg to equal 150mg, two tablets of acetaminophen 325mg, one tablet of dapagliflozin propanediol (Farxiga) 10mg, one tablet of furosemide (Lasix) 40mg, one capsule of gabapentin 400mg, one tablet of glipizide 5mg, one tablet of omeprazole 20mg, one tablet of spironolactone 10mg, one tablet of trospium chloride 20 mg, and tiotropium bromide monohydrate inhaler. On 10/1/25 at 9:23 AM, V6 (RN) entered R7’s room to administer his medications. R7 was lying in bed watching television. At 9:25 AM, V6 (RN) handed R7 the inhaler and he self-administered one inhalation. R7 refused to rinse his mouth afterwards. V6 then handed R7 the plastic med cup filled with his pills. R7 brought the cup to his mouth, tilted his head back then proceeded to pour most of the pills into his mouth. R7 then took a drink of cola and swallowed the pills in his mouth. R7 again brought the med cup to his mouth and as he tilted his head back, the remaining pills (approximately 5-7) spilled onto his shirt near his	S9999		

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S9999	Continued from page 3 chest area and onto the bed next to him. V6 picked up the pills from R7's chest area and from the bed, then placed them into R7's hand. R7 took the pills from his hand and placed them in his mouth. He then took a drink of cola and swallowed the pills. V6 then exited the room. R7's face sheet showed a last admission date of 6/2/25 with a past medical history not limited to cirrhosis of liver, type 2 diabetes, sebaceous cyst and pressure ulcer. R7's Administration History Report dated 10/1/25 showed that V6 (RN) had documented administering R7's medications at 9:17 AM through 9:20 AM. Review of active orders as of 10/1/25 showed orders to give one tablet of aspirin 81mg chewable oral tablet by mouth one time a day related to headache with orthostatic component, one tablet of baclofen oral tablet 5mg by mouth three times a day related to hereditary spastic paraplegia, one tablet of buspirone hcl oral tablet 10mg by mouth in the morning for mood and anxiety related to major depressive disorder and give 0.5mg tablet by mouth in the afternoon for anxiety/treatment resistant depression related to depression, one tablet of carvedilol oral tablet 3.125mg by mouth two times a day for variceal prophylaxis, one tablet of metformin hcl oral tablet 500mg by mouth two times a day for diabetes mellitus, sertraline hcl 150mg (Sertraline HCl) by mouth in the morning for mood related to depression, 2 tablets of acetaminophen 325mg by mouth three times a day for pain, one tablet of Farxiga 10 mg (dapagliflozin propanediol) by mouth one time a day for diabetes mellitus, one tablet of furosemide 40mg by mouth two times a day for edema, one capsule of gabapentin 400mg by mouth two times a day related to low back pain, one tablet of glipizide 5mg by mouth two times a day for diabetes mellitus, omeprazole delayed release 20mg by mouth one time a day for indigestion, one tablet of spironolactone 100mg by mouth in the morning for edema, one tablet of trospium chloride 20 mg by mouth every morning and at bedtime related to neuromuscular dysfunction of bladder, and inhale orally one capsule of tiotropium bromide monohydrate inhalation capsule 18mcg (microgram) one time a day for shortness of breath and wheezing. On 10/1/25 at 2:22 PM, V2 (Director of Nursing) said that V6 should have discarded the pills that landed on R7 and his bed, then dispensed new pills to administer to him to prevent cross-contamination due to R7's wound and medical history.	S9999		

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S9999	Continued from page 4 Medication/Narcotic Destruction policy provided by V2 on 10/2/25 with effective date of 04/2025 did not indicate procedure for discarding dropped medications or dispensing of new medications. Infection Precaution Guidelines provided by V2 on 10/2/25 with effective date of 10/2024 indicated it is the facility's policy to, when necessary, prevent the transmission of infection within the facility through the use of isolation precautions…standard precautions will be employed by all personnel for all residents at all times… On 10/1/25 at 2:45 PM, V2 said "there are no other policies pertaining to infection control with medication administration." (C) (3 of 7) 300.1060f) 300.1060g) Section 300.1060 Vaccinations f) A facility shall document in the resident's medical record that he or she was verbally screened for risk factors associated with hepatitis B, hepatitis C, and HIV, and whether or not the resident was immunized against hepatitis B. (Section 2-213(c) of the Act). g) All persons determined to be susceptible to the hepatitis B virus shall be offered immunization within 10 days after admission to any nursing facility. (Section 2-213(c) of the Act) This requirement was not met as evidenced by: Based on interview and record review, the facility failed to ensure residents were screened for risk factors of Hepatitis B, and failed to assess if residents were immunized against Hepatitis B. This applies to 5 of 5 residents (R1, R2, R3, R4, R5) reviewed for immunizations in the sample of 8. The findings include: On 10/1/25, a review of the electronic medical records and immunization history for R1, R2, R3, R4, and R5's showed no documentation that the residents had received verbal assessments for risk factors of Hepatitis B or were asked if they had received the Hepatitis B vaccines.	S9999		

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S9999	Continued from page 5 On 10/1/25 at 2:28 PM, V2 (Director of Nursing/Infection Preventionist) stated that offering the hepatitis vaccine is not a part of their admission process. On 10/2/25 at 11:08 AM, V1 (Administrator) said that she cannot find documentation that R1 - R5 were screened for hepatitis B or offered the vaccine. V1 added that she will have V2 (Director of Nursing) “do an audit of building and screening if needing to be completed.” Hepatitis policy last approved 09/2025 reads in part, there are several types of hepatitis, all of which may have similar symptoms…the Centers for Disease Control (CDC) consider the hepatitis B (HPV) the most important among them in the healthcare industry because of its possible transmission to employees through occupational exposure to blood and body fluids containing blood…Methods of Control included but not limited to vaccination of high risk individuals… (C) (4 of 7) 300.1630a)1)2)3) 300.1630 Administration of Medication a) All medications shall be administered only by personnel who are licensed to administer medications, in accordance with their respective licensing requirements. Licensed practical nurses shall have successfully completed a course in pharmacology or have at least one year's full-time supervised experience in administering medications in a health care setting if their duties include administering medications to residents. 1) Medications shall be administered as soon as possible after doses are prepared at the facility and shall be administered by the same person who prepared the doses for administration, except under single unit dose packaged distribution systems. 2) Each dose administered shall be properly recorded in the clinical record by the person who administered the dose. (See Section 300.1810.) 3) Self-administration of medication shall be permitted only upon the written order of the licensed prescriber. This requirement was not met as evidenced by:	S9999		

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S9999	Continued from page 6 Based on interview and record review the facility failed to properly administer medications after preparation and failed to obtain a physician's order for the self-administration of medications. This failure resulted in medications being found at the bedside for 2 of 4 residents (R1, R6) reviewed for medications in the sample of 8. The findings include: 1. On 09/30/25 at 11:19 AM R1 was lying in bed watching television. A clear plastic medication cup sat on her bedside table that contained one red, oval-shaped pill and a blue and green capsule. R1 said that the pills are her morning pills that all the nurses leave her pills every morning and she takes them when she gets up around 1:00 PM. R1 said one pill is a stool softer and the other is her anti-depressant. R1 then said the nurses only leave pills at the bedside for a few residents that can take their medications by themselves and remember to take them. R1's face sheet showed admission date of 11/1/24 with a past medical history not limited to major depressive disorder, failure to thrive, acute kidney failure, and sepsis. R1's order summary report as of 10/1/25 included duloxetine HCl oral capsule delayed release particles 60mg, give 1 capsule by mouth in the morning related to major depressive disorder with start date of 9/30/25; and docusate sodium oral tablet 100mg, give 100 mg by mouth two times a day for constipation with start date of 5/8/25. No order was found indicating R1 may self-administer medications or have any medications at the bedside. On 9/30/25 at 11:56 AM, when asked about leaving meds at the bedside, V5 (Licensed Practical Nurse) said "oh you saw [R1's] meds on her bedside table from this morning" then said she gave R1 those medications this morning and R1 was supposed to take them. V5 added that nurses "are not supposed to leave medications at the bedside" and she will now have to stay with R1 and make sure that she takes her medications when scheduled. R1's Administration History Report dated 10/1/25 showed that V5 documented administering R1's morning medication's on 9/30/25 at 8:23 AM. 2. On 9/30/25 at 1:36 PM, V5 (Licensed Practical Nurse) was told by another staff member that R6 was requesting "another neb [nebulizer] treatment." At 1:38 PM, V5 entered R6's room and informed R6 that she had already	S9999		

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S9999	Continued from page 7 signed out and poured her “neb treatment” at 1:00 PM. V5 then proceeded to remove a clear plastic nebulizer cup (medicine cup) that was attached to the side of the compressor unit (power source) that was set on R6’s nightstand next to her bed. The nebulizer cup was approximately one third filled with a clear liquid. V5 handed to R6 the nebulizer cup, which had an attached plastic mouthpiece on the upper portion, then turned the compressor on. R6 inserted the mouthpiece into her mouth and began inhaling the aerosolized medication. On 9/30/25 at 1:40 PM, V5 indicated that R6’s “duo neb” (ipratropium-albuterol) treatment was in the nebulizer cup. V5 then said that R6 likes a treatment after smoking and can start the neb treatment herself then turn off the machine after it’s done. V5 added that she checks on R6 after awhile to make sure she “did the treatment”. V5 did not indicate whether R6 has an order to self-administer medications. R6's face sheet showed last admission date of 1/7/25 with a past medical history not limited to chronic obstructive pulmonary disease and dependence on supplemental oxygen. R6's order summary report as of 10/1/25 included ipratropium-albuterol inhalation solution 0.5-2.5 3mg/3ml (milliliter), one vial inhale orally every two hours as needed for shortness of breath related to chronic obstructive pulmonary disease. R6’s Administration History Report dated 10/1/25 showed that V5 documented administering one vial of ipratropium-albuterol inhalation solution on 9/30/25 at 12:55 PM. On 10/1/25 at 2:22 PM, V2 (Director of Nursing) said nurses should not be leaving medications at the bedside, and residents should have an order for meds at the bedside and/or to self-administer medications. V2 added that she will “need to do some in-servicing with the nurses.” Medication Administration Policy provided by V2 with an effective date of 10/2024 reads in part: licensed nurse may prepare, administer and record the administration of medications… medications shall always be prepared, administered, and recorded by the same licensed nurse or certified medication aide (CMA)…documentation of medication administration is recorded on the medication administration record (MAR) or treatment record and includes the date, time and initials of the licensed nurse or CMA who administered the medication…medications must be administered in	S9999		

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S9999	Continued from page 8 accordance with a physician's order, e.g., right resident, right medication, right dosage, right route, and right time…medications may not be pre-poured, only prepare and administer medications for one resident at a time… (C) (5 of 7) 300.2100 Section 300.2100 Food Handling Sanitation Every facility shall comply with the Department's rules entitled "Food Code." (Source: Amended at 49 Ill. Reg. 760, effective December 31, 2024) These requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to adequately store food by not properly labeling and/or dating several food items; and failed to ensure the sanitizing solution was at the manufacture's recommended level. This failure affects all 47 residents who currently reside in the facility. The findings include: The facility resident census report provided on 9/30/25 showed 47 residents in the facility. On 9/30/25 at 11:10 AM, observed in deep freezer near three compartment sink, 20-30 packages of frozen pancakes, two large bags of frozen cookie dough, and a large bag of frozen egg omelets all not labeled or dated with discard date. Also observed a half bag of undated sugar cookies and pancakes both partially open with ice particles on the cookies, the pancakes and throughout the bags. On 9/30/25 at 11:12 AM, observed V4 (Food Service Director) test the sanitizer concentration level within a red sanitation bucket near the three-compartment sink. Test strip appeared light brown in color that indicated sanitizer concentration level of 150 ppm (parts per million). V4 said this level was "within range." Requested from V4 the sanitation policy and the manufacture's recommendations for the required sanitation concentration range. On 9/30/25 at 11:17 AM, observed in a second deep freezer, six-five-pound packages of ground beef all unlabeled and undated. At 11:19 AM, observed in walk-in freezer near deep freezer, a partially opened bag of frozen breadsticks and garlic bread that were both	S9999		

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S9999	Continued from page 9 unlabeled and undated and contained ice particles on the breads and throughout both bags. On 10/1/25 at 10:30 AM, V7 (Regional Dietary Consultant) said the sanitizer concentration level should be between 200-400 per FDA and manufacture recommendations to ensure proper sanitation level. V7 indicated there is no policy for the sanitizer buckets. On 10/1/25 at 11:15 AM, V7 said a “pinhole was found on the sanitizer line that caused the levels to be off.” V7 indicated she submitted a work requisition to replace the line and is the process of in-servicing dietary staff on procedure for adjusting sanitizer levels when needed. V7 then said staff are trained to label all food items with dates to ensure it will be safe to consume. On 10/1/25, V7 said facility uses “quat” sanitizer then provided sanitizing sink chemical log that indicated required “quat” range of 200 – 400 ppm. V7 also provided in-service dated 10/1/25 that discussed when testing quat, it needs to be in the range of 200 – 400 ppm. If not in range, may add more quat or water… On 10/1/25, V1 (Administrator) provided copy of work requisition created 10/1/25 to replace sanitation line due to “pinhole in sanitizing line causing sanitizer levels to be off”. Labeling and Dating Foods policy last effective 09/2023 reads in part, all foods stored will be properly labeled according to the following guidelines…date marked for freezer storage items-frozen food packages removed from original case will be dated with the date the item was received into the facility and will be stored using the “first in, first out” method of rotation…once a package is opened, it will be re-dated with the date the item was opened and shall be used by the safe food storage guidelines or by the manufacturer's expiration date… Equipment Cleaning and Sanitizing policy provided by V7 effective 09/2023 reads in part, food service workers who use equipment will be responsible for washing and sanitizing removable parts after each use…verify sanitizer concentration for each meal period and as necessary as per policy…quaternary ammonia 200 ppm… (C) (6 of 7) 300.3240a) Section 300.3240 Abuse and Neglect	S9999		

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S9999	Continued from page 10 a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) This requirement was not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure verbal abuse of a resident did not occur for 1 of 1 resident (R4) reviewed for abuse in the sample of 8. The findings include: R4's Admission Record, printed by the facility on 10/1/25, showed diagnoses including, but not limited to Sepsis, acute and chronic respiratory failure with hypoxia, type II diabetes mellitus with complication, morbid severe obesity due to excess calories. Chronic obstructive pulmonary disease, acute kidney failure, dysphagia, critical illness myopathy, fibromyalgia, restless legs syndrome, venous insufficiency, chronic, peripheral, acute cystitis with hematuria, generalized anxiety disorder, UTI (urinary tract infection), localized adiposity, lobar pneumonia, GERD, gross hematuria, psoriasis, hydronephrosis with renal and ureteral calculous obstruction, atrial fibrillation and flutter, urine retention, stress incontinence, urge incontinence, major depressive disorder, presence of urogenital implants. chronic kidney disease stage 3, and an open wound of upper right arm. R4's facility assessment dated 7/26/25 showed she was cognitively intact and dependent on staff for toilet hygiene. R4's activities of daily living care plan showed she required two staff assist for bathing/showering, one staff assist for personal hygiene and oral care, two staff assist for toileting, and two staff assist for transfers using a mechanical sling lift. On 10/1/25 at 10:22 AM, R4 said there was an aide that was mean and rude to her. R4 said the aide was (V14 Certified Nursing Assistant-CNA). R4 said V14 took her meal tray and put it on the seat in her room. R4 said when V14 went to walk out of R4's room, she picked up the tray and went to take it out of her room, R4 said she told V14 she had better bring that tray back. R4 said V14 told R4 she had enough time to eat it. R4 said the incident happened on second shift. R4said the CNA was very rude and took the tray out anyway. R4 said she told V14 she better bring it back or she (R4) was going to call someone. R4 said V14 brought her back the peanut butter and the bread. R4 said she told V14 when	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000293	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA CARE ALEDO	304 S.W. 12TH STREET , ALEDO, Illinois, 61231

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S9999	Continued from page 11 she came back in that she thinks she might be wet. R4 said V14 said she had just changed me. R4 said she told V14 that she needed to check to see if she was wet. R4 said V14 told her she was not going to do it again and slammed the door. R4 said she reported the incident to the Social Services person, and someone came in to talk to her about it. R4 said she told them she did not want V14 taking care of her anymore. R4 said V14 has not taken care of her since the incident. On 10/1/25 at 11:25 AM, V2 (Director of Nursing) said R4 complained about V14 on 9/11/25. V2 said there were multiple things in the investigation. V2 said R4 complained about V14 taking her tray and slamming the door. V2 said “Words were exchanged.” V2 said V1 (Administrator) was the one that did the investigation. V2 said V14 was suspended until the investigation was completed. V2 said she and the floor nurse went down and made sure R4 was okay. V2 said R4 was upset. Her food had already been addressed, so she and the floor nurse checked R4 to see if she was soiled. V2 said R4 was not soiled. V2 said because of past things that have happened, V14 was terminated. V2 said it is not acceptable for staff to argue with a resident and slam their door. On 10/1/25 at 1:19 PM, V1 (Administrator) said V14 was the CNA involved in the incident with R4. V1 said it is not acceptable for staff to argue with residents and slam their door. V1 said V14 was terminated due to this incident. V1 added, “It was not the first time we have had issues regarding her grumpy attitude.” On 10/1/25 at 2:37 PM, V5 (Licensed Practical Nurse-LPN) said the incident between R4 and V14 happened on 9/11/25 on second shift, around 3:00-3:30 PM. V5 said she was at the nurse’s desk and heard a door slam. V5 said V14 was walking down the hall mumbling that she was not going to check her again. V5 said she and V2 went down to check R4, and she was dry. V5 said she does not know if V14 has issues outside of work that she is bringing to work or not, but she has had other coworkers complain that V14 gets irritable. V5 said when she and V2 went down to talk to R4, she said she does not want V14 back in her room because she was rude. V5 said R4 told them V14 said she was not checking R4 again. V5 said she was just concerned that R4 might have had bladder spasms and was wet. V5 said R4 already has skin breakdown. V5 said after they finished checking R4 and talking to her, V14 was called to V2’s office and was escorted out of the building by V2. V5 said she heard V14 slam the door, “it was pretty hard.” V5 said “That is not acceptable. It is also not acceptable to refuse to check a resident when they say	S9999		

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S9999	Continued from page 12 they think they had a spasm or were wet." V5 said V14 could have let R4 know that she would inform the nurse. The facility's investigation of the 9/11/25 showed at approximately 2:35 PM R4 was allegedly involved in a verbal altercation with an employee. Employee suspended immediately. Appropriate notifications made. Investigation initiated; 5-day final to come. The investigation file contained written statements from V5 (LPN) and V13 (LPN-no longer employed at facility). V13's statement showed she was standing at the nurses desk. V14 went down to R4's room to answer her call light. V14 was in R4's room a short time, came out saying something out loud. V13 did not hear what she said. V13's statement showed V14 slammed R4's door. V13 asked V14 if she was alright. V14 told V13 R4 says she needs changed again because she is wet and they had just changed her. V13's statement showed she asked V14 if R4 was wet when they changed her and V14 said yes. V13's statement showed V13 informed V14 if a resident is wet and has a catheter, the nurse needs to know. V13's statement showed V14 said she did not know if R4 was wet or not, she did not check because they literally just changed her. On 10/1/25 at 1:30 PM, V14's contact number was called. The number was disconnected. The facility did not have another contact number for V14. On 10/1/25 at 1:31 PM, a message was left on V13's voicemail to please return call. No return call was received. The facility's Corrective Action Form showed V14 was terminated. The form showed on 9/11/25 V14 was witnessed yelling at R4 as she exited her room. The report showed R4 further expressed concerns about V14's overall demeanor, stating when V14 provides care for her it feels like a chore and V14 always seems like she is in a bad mood and takes it out on R4. The form also showed that V14 had received a verbal warning on 7/11/25 for disorderly behavior and for demonstrating a negative attitude toward residents during her shifts. The facility's Abuse Prevention and Reporting-Illinois policy and procedure, with a revision date of October 2022, showed, "This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment… this facility prohibits abuse, neglect, exploitation misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment.	S9999		

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S9999	Continued from page 13 “The policy defined mental abuse as the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. The policy showed Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability. The policy also showed examples of mental and verbal abuse include, but are not limited to harassing a resident, mocking, insulting, ridiculing, yelling or hovering over a resident with the intent to intimidate, threatening residents, including but not limited to depriving a resident of care… (B) (7 of 7) 300.3260l) 300.3260 Resident’s Funds l) Unless otherwise provided by State law, the facility shall upon the death of a resident provide the executor or administrator of the resident's estate with a complete accounting of all the resident's personal property, including any funds of the resident being held by the facility. (Section 2-201(10) of the Act). This requirement was not met as evidenced by: Based on interview and record review, the facility failed to disperse resident funds to a deceased resident’s family for 1 of 1 resident (R8) reviewed for resident funds in the sample of 8. The findings include: R8’s Admission Record, provided by the facility on 10/2/2025 showed she had diagnoses including, but not limited to, dementia, nontraumatic subarachnoid hemorrhage, major depressive disorder, anxiety disorder, macular degeneration, pain, anemia, and hypertension. R8’s progress notes showed she passed away in the facility on 2/4/2025. On 10/1/25 at 2:40 PM, V3 (Business Office Manager-BOM) said when a resident expires with money in their resident funds, she (BOM) will notify the facility’s biller to let them know. V3 said V18 (Biller contact person) was the person she notified when R8 expired. V3 said V18 no longer works at the billing services	S9999		

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S9999	Continued from page 14 company. V3 said R8 expired on 2/5/25. V3 said the funds are still in R8's account. V3 said V16 (R8's daughter and Power of Attorney) had requested the funds in R8's account. V3 said she spoke with V18, and he said R8's family would not be getting the money back due to R8 being on Medicaid. V3 said the money reverts to Medicaid when the resident passes away. V3 said she informed R8's family that they would not be receiving any funds due to R8 being on Medicaid. V3 said she asked if there were any unpaid funeral expenses for R8 when she spoke with her family. V3 said R8 has a balance of $2,437.23 in her resident fund account. V3 provided the Resident Fund Management Service list. The list showed R8 having a balance of $2,437.23. V3 was asked to provide information showing why the funds were not provided to R8's family. How it was determined that the funds are supposed to revert to Medicaid, and any correspondence between her and V18 regarding the matter. V3 was also asked to provide information on if the money is supposed to revert to Medicaid, how that process works and why the money was still in the facility's resident funds account. On 10/2/25 at 10:39 AM, this surveyor sent an email to V3 asking for information on how it was determined that the funds revert to Medicaid instead of R8's family/POA. V3 replied the decision was based on the guidelines for probate. Please see below: (755 ILCS 5/18-10) (from Ch. 110 1/2, par. 18-10) Sec. 18-10. Classification of claims against decedent's estate. All claims against the estate of a decedent are divided into classes in the manner following: 1st: Funeral and burial expenses, expenses of administration, statutory custodial claims, and final fees and costs as determined by the court relating to guardianship, including fees awarded under Section 11a-13.5, 13-3, 13-3.1, 27-1, 27-2, or 27-4. For the purposes of this paragraph, funeral and burial expenses paid by any person, including a surviving spouse, are funeral and burial expenses; and funeral and burial expenses include reasonable amounts paid for a burial space, crypt or niche, a marker on the burial space, care of the burial space, crypt or niche, and interest on these amounts. Interest on these amounts shall accrue beginning 60 days after issuance of letters of office to the representative of the decedent's estate, or if no such letters of office are issued, then beginning 60 days after those amounts are due, up to the rate of 9% per annum as allowed by contract or law. 2nd: The surviving spouses or child's award.	S9999		

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S9999	Continued from page 15 3rd: Debts due the United States. 4th: Reasonable and necessary medical, hospital, and nursing home expenses for the care of the decedent during the year immediately preceding death; and money due employees of the decedent of not more than $800 for each claimant for services rendered within 4 months prior to the decedent's death. 5th: Money and property received or held in trust by decedent which cannot be identified or traced. 6th: Debts due this State and any county, township, city, town, village or school district located within this State. 7th: All other claims. (Source: P.A. 102-72, eff. 1-1-22.) On 10/2/25, V3 emailed the correspondence activity regarding R8's resident funds. The correspondence showed "Small estate affidavit, just an fyi [for your information] when someone is Medicaid and expires, we can only refund to spouse, state, or funeral home." The email sent to this surveyor on 10/2/25 showed on 10/1/25 R8's account has been closed and balance refunded. Spoke with (V17) to verify all funeral expenses have been paid. On 10/2/25 at 3:05 PM, V3 was asked if the funds were dispersed to R8's family. At 3:12 PM, V3 replied "No, for us to distribute to the family, we would need documentation showing that they are the administrator or executor of the resident's estate. If there is no spouse." The facility's policy and procedure titled Resident Funds, with a revision date of 04/2019, showed "This facility manages the personal funds of residents when such request is made by the resident…4. Resident funds are deposited into an interest-bearing resident trust fund account which is different from the facility's banking account." The policy does not address disbursement of resident funds when the resident expires in the facility. On 10/2/25 at 2:29 PM an email was sent to V3 asking if the facility had a policy regarding dispersing resident funds upon death. No policy was provided. (B)	S9999		