

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000232		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/13/2025	
NAME OF PROVIDER OR SUPPLIER ALIYA OF GLENWOOD				STREET ADDRESS, CITY, STATE, ZIP CODE 19330 SOUTH COTTAGE GROVE , GLENWOOD, Illinois, 60425			
(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 Complaint Investigation: 25912154/2690413 300.610a) 300.615a) 300.615j) 300.625a) 300.625b) 300.1210b) 300.1210c) 300.1210d)6)			S0000			12/23/2025
S9999	Final Observations Statement of Licensure Violations: (1 of 2) 300.610a) 300.615a) 300.615j) 300.625a) 300.625b) 300.1210b) 300.1210c) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be			S9999			12/23/2025

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information a) For the purpose of this Section only, a nursing facility is any bed licensed as a skilled nursing or intermediate care facility bed, or a location certified to participate in the Medicare program under Title XVIII of the Social Security Act or Medicaid program under Title XIX of the Social Security Act. j) The facility shall be responsible for taking all steps necessary to ensure the safety of residents while the results of a name-based background check or a fingerprint-based background check are pending; while the results of a request for waiver of a fingerprint-based check are pending; and/or while the Identified Offender Report and Recommendation is pending. Section 300.625 Identified Offenders a) The facility shall review the results of the criminal history background checks immediately upon receipt of these checks. b) The facility shall be responsible for taking all steps necessary to ensure the safety of residents while the results of a name-based background check or a fingerprint-based check are pending; while the results of a request for a waiver of a fingerprint-based check are pending; and/or while the Identified Offender Report and Recommendation is pending. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and		S9999				

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S9999	Continued from page 2 personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow their abuse policy and failed to protect one resident (R1) from repeated verbal and psychological abuse by R2. This failure affected one (R1) of three residents reviewed for abuse. These failures resulted in R1 experiencing ongoing fear and anxiety related to being R2's roommate. The facility also failed to take the necessary steps to ensure the safety of one resident (R1) while the results of one resident's (R2) background check and finger-print checks results were pending. This failure affected one resident (R1) of three residents (R1, R2, and R3) reviewed for verbal abuse. R2's face sheet documents and admission date of 10/30/2025 and diagnoses that include but are not limited to asthma, type 2 diabetes mellitus, and chronic kidney disease. R2's BIMS (brief interview mental status), dated 11/05/25 is 12 which indicates R2's cognition is moderately impaired. On 12/12/2025 at 9:31am, R2 said, "We (R1 and R2) had a disagreement a few days ago. They (facility staff) keep putting me in rooms that make me sick. The residents are way sicker than me. I'm not sick like all of them (other residents). I should have a private room or semi-private. Yeah, it was Saturday or Sunday (12/06/25 or 12/07/25) when our (R1 and R2) arguing got a little out of hand. His (R1) cough, his (R1) skin, and his (R1) hair is just nasty. I have to eat, and his nastiness is just no good for me. He's a disgusting fat pig. He needs to stay on his side of the room. I mean when he starts hacking, yeah, I called R1 nasty a** out. I don't call him names all the time, but it's happened a few. No, that's a lie. I never said that I would shoot anyone in the head. I came in with the BB gun. I had it ever since I was admitted here. Never took it (BB gun) out. They (facility staff) took my bag with the gun, and I called the police. I (R2) have a police report." R2 said, "I've been in this room with R1 and R3 for about 3 weeks. R2's CHIRP (Criminal History Information Response Process), dated 10/30/25, documents, in part, "Result:		S9999				

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S9999	Continued from page 3 In Process." R2's care plan, dated 11/10/25, documents, in part, "(R2) have a history of criminal behavior. (R2) have demonstrated stability during the admission screening process and does not appear to present at risk. I (R2) fit the criteria for an "identified offender," with interventions, that document, in part, "Appropriate supervision and observation." R2's "(Name of Company) Live Scan Fingerprinting and Identity Services," dated 11/06/25, documents, in part, that R2 was fingerprinted on 11/06/25. However, review of R2's electronic medical record (EMR) and interviews with facility staff revealed that R2's fingerprint results were not available and could not be located. R1's face sheet documents diagnoses that include but are not limited to chronic obstructive pulmonary disease, type 1 diabetes mellitus, and major depressive disorder. R1's BIMS (brief interview mental status), dated 11/26/2025, is 15 which indicates R1 is cognitively intact. On 12/12/2025 at 9:35am, R1 said, "I (R1) never said anything about anyone saying that they were going to shoot me (R1) in the head. That's probably the one thing R2 hasn't said to me (R1). He (R2) did say that he's gonna slap me into next year and choke me to death. He (R2) moved in about 2 weeks ago. Nothing but problems. He doesn't like me. I (R1) think he's a "germaphobe." I'm (R1) sick, I'm hospice, and I'm dying. There's nothing I (R1) can do. He (R2) wheeled past my bed the other day and kicked my bed so hard that my bed moved about 1 or 2 inches, and the bed was locked. The fight between us (R1 and R2) was real bad last Sunday (12/07/25). I (R1) went to turn up the air conditioner that is by his (R2) bed, cause it was hot as he** and he lost it. He was sitting in the doorway and started screaming, "Don't go on my (R2) side of the room. Turn the air conditioner down. You fuc**** smell. He's (R2) not wrong, I am nasty because I'm dying and can't help it. I (R1) shower every day. I'm just sick. " Oh yeah, V3 (Licensed Practical Nurse/LPN) and V4 (Nurse's Aide) know all about R2 going crazy on me (R1). V3 settled down R2. R2 is a scary guy. I can only take so much of him telling me I'm a "fat faggot mother fuc****r... all the flies are in the room cause me (R1)." He has a valid reason, but I'm sick and dying. I'm 70 years old. I don't need to be yelled at every day. I'm scared to death. Once he (R2) said that he (R2) was going to choke me to death. I'm (R1) scared to		S9999				

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S9999	Continued from page 4 death. I'm (R1) constantly on edge because of him and I (R1) don't feel safe with him here. I'm scared of this guy (R2). I'm (R1) 70 years old and couldn't function myself out of a paper bag. Look." R1 pulls out of R1's sock, a facility menu, dated 12/08/2025 (day after verbal altercation), that R1 wrote on documents, in part, "CHOKIN TO DEATH; LIVING IN CHRONIC FEAR; R2." R1 said, " I (R1) wrote on this and put it in my sock just in case R2 kills me (R1), so they know R2 did it. He's (R2) crazy." R1's active physician order, ordered date 2/10/2022, documents, in part, "Admit to Hospice Services for DX (diagnosis) of Respiratory Failure." R1's "Abuse/Neglect Screening," dated 5/22/2024, is 5 which indicates R1 is at high risk for "potential future problems/ symptoms related to mistreatment." R1's care plan, dated 6/26/2025, documents, in part, "(R1) have been assessed for Risk of Abuse and Neglect, and I (R1) am at risk for abuse and Neglect," with interventions that documents, in part, "Report any verbalization of abuse or neglect to administrator immediately; Immediately act and conduct abuse investigation if the resident reports any abuse or neglect; Take appropriate action(s) based upon the findings of investigation regarding abuse or neglect that is conducted; Ensure safety, if resident reports feeling unsafe." R3's face sheet documents diagnoses that include but are not limited to hypothyroidism and anxiety disorder. R3's BIMS (brief interview mental status), dated 10/16/2025, is 15 which indicates R3 is cognitively intact. On 10/12/25 at 9:52am, R3 said, "I (R3) don't know what their (R1 and R2) deal is. They (R1 and R2) are at each other all the time ever since he (R2) has been in this room. I (R3) just stay outta of it. He (R1) just lays there and R2 just starts with him (R1). Yeah, I (R3) try to tune it out though. He's (R2) called him (R1) a fat fuc**** pig, a sick fat fu**, and he (R2) told him (R1) to shut the fu** up or he'd (R2) choke him (R1) to death. It (arguing with R1 and R2) was real bad last weekend. The CNA (certified nurse's assistant) came in and said knocked the crap off. I (R3) don't know her (CNA) name. It was last weekend. I (R3) don't know if it was Saturday or Sunday (12/06/25 or 12/07/25). The days run together. Look, just keep me (R3) out of it and get R2 outta here. He's (R2) been at R1 since he (R2) came. I (R3) never seen R2 kick R1's bed. No, I		S9999				

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S9999	Continued from page 5 (R3) never heard R2 say he (R2) was going to shoot R1 in the head." On 12/12/25 at 10:45am, V3 (Licensed Practical Nurse/LPN) stated that on 12/07/25 was V3's last day worked that week and reported that, while passing medications outside R1's and R2's room, V3 overheard the residents discussing an odor. V3 stated that V3 entered the room because of concerns about an odor being discussed by R1 and R2 and reported that, once inside the room, V3 learned the residents were discussing that one resident leaving the lid off a urinal was causing the odor. However, when asked to clarify whether the urinal was full or emitting a foul odor, V3 stated there was "nothing was in the urinal or else I (V3) would have emptied it." V3 further denied hearing any yelling, arguing, fighting, or inappropriate language between R1 and R2 and characterized the interaction between R1 and R2 as "fine." Despite denying the presence of an odor, denying any inappropriate behavior, and describing the interaction as normal, V3 stated V3 entered the room specifically to determine what smell the residents were discussing. On 12/12/2025 at 10:53am, V4 (Nurse's Aide) stated that the only interaction V4 recalled between R1 and R2 occurred "last weekend, Sunday (12/07/25)," while V4 was picking up trays. V4 described the interaction as a "normal conversation," but could not remember any details about what R1 and R2 were discussing. When asked about yelling, name-calling, arguing, or inappropriate language, V4 repeatedly responded "no" and offered no additional information. On 12/13/25 at 10:16am, while in R1's room with V1 (Administrator), R1 said, "He (R2) was scary. He's (R2) worse than Dr. Jekyll and Mr. Hyde. Every movement I (R1) made; I (R1) was afraid. I (R1) feel better now that he's (R2) not here. I'm (R1) not on pins and needles anymore. Thank you." On 12/13/25 at 10:19am, V1 (Administrator) stated that R2's initial CHIRP (Criminal History Information Response Process) was initially marked as "held" and "in process." V1 stated that the facility never received the results. V1 further stated that the facility does not have the results of R2's CHIRP or fingerprints. V1 stated that the Admission Director has been following up on the CHIRP. V1 also stated that the fingerprints were submitted by the previous Social Services Director, who no longer works at the facility. On 12/13/25 at 10:21am, V7 (Social Services Consultant)		S9999				

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S9999	Continued from page 6 stated that the facility does not have an official CHIRP result for R2, and that the Admissions Director (V6) is responsible for managing CHIRP results. V7 stated that if a CHIRP is marked as "held," there is potential for multiple hits on the resident's background, and that the Admissions Director (V6) checks once a week for 30 days, rerunning the CHIRP if results are not returned within that timeframe. V7 stated that the facility does not have R2's fingerprint results, and did not have authorization to order them, and that the previous Social Services Director had submitted the fingerprints. V7 explained that CHIRP results are managed by the Admissions Director (V6), fingerprints by Social Services, and that the purpose of the background checks is to ensure "regulatory compliance, assess the resident's risk level, and determine appropriateness for placement in a skilled nursing facility. On 12/13/25 at 10:46am, V6 (Admission Director) stated that sometimes the facility receives CHIRP (Criminal History Information Response Process) results immediately, while other times a delayed hit occurs. V6 stated that when a CHIRP is delayed, they check every day to see if the results have been returned. V6 stated that the facility received an "in process" result for R2 in the mail. V6 stated that sometimes CHIRP results do not come back at all and eventually expire. V6 stated that they checked R2's CHIRP status yesterday and found it had expired, so they ran another CHIRP for R2, which is currently marked as "held" again. V6 stated that this situation usually occurs when residents have hits from out-of-state sources. On 12/13/25 at 10:56am, V1 (Administrator) stated that V1 was never aware of any physical or mental/verbal abuse between R1 and R2. Evidence shows that the facility's failure to prevent, identify, and respond to verbal and mental abuse allowed R1 to experience ongoing fear, emotional distress, and a loss of safety in R1's home environment. Record review of facility policy titled, "Abuse Policy and Prevention Program," dated 10/2022, documents, in part, "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 therefore 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	S9999					

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S9999	Continued from page 7 resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. This will be done by: conducting pre-employment screening of employees and pre-admission screening of residents; orienting and training employees on how to deal with stress and difficult situations, and how to recognize and report occurrences of abuse neglect, exploitation, and misappropriation of property; establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment, identifying occurrences and patterns of potential mistreatment; identifying concerns of residents' allegations of deprivation of goods and services by staff; immediately protecting residents involved in identified reports of possible abuse, neglect, exploitation, mistreatment, and misappropriation of property; implementing systems to promptly and aggressively investigate all reports and allegations of abuse, neglect, exploitation, misappropriation of property and mistreatment, and making the necessary changes to prevent future occurrences. his facility is committed to protecting our residents from abuse, neglect, exploitation, misappropriation of property and mistreatment by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals. Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means (210 ILCS 45/1-103). Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident (42 CFR 483.5). This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain and/or maintain physical, mental, and psychosocial well-being. This assumes that all instances of abuse of residents, even those in a coma, cause physical harm or pain or mental anguish (42 CFR 483.12 Interpretive Guidelines). Verbal Abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance, regardless of an individuals' age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to, threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never to be able to see his/her family again (42 CFR 483.12 Interpretive		S9999				

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S9999	Continued from page 8 Guidelines). Mental Abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation (42 CFR 483.12 Interpretive Guidelines)." Record review of facility policy titled, "Baseline Care Plan," dated 1/2023, documents, in part, "The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care. The baseline care plan will include at a minimum the following necessary information to properly care for a resident. C. Supervision needs. D. Behavioral interventions. F. Social services. Person-centered care means that the facility focuses on the resident as the center of control and supports each resident in making his or her own choices. Person-centered care includes making an effort to understand how each resident communicates, verbally and nonverbally, identifying what is important to each resident with regard to daily routines and preferred activities, and having an understanding of the resident's life before coming to reside in the facility. The baseline care plan must reflect the resident's stated goals and objectives and include interventions that address his or her current needs. It must be based on admission orders and, information about the resident available from the transferring provider, and discussion with the resident and resident's representative, if applicable. Because the baseline care plan documents the interim approaches for meeting the resident's immediate needs, it should also reflect changes to approaches, as necessary, resulting from significant changes in condition or needs, occurring prior to the development of the comprehensive care plan. The facility will provide the resident and their representative with a summary of the baseline care plan that includes at a minimum the following: e. Any updated information based on the details of the comprehensive care plan, as necessary. If significant changes are made to the baseline care plan prior to completion of the comprehensive care plan, an updated summary will be provided to resident and resident's representative." Facility presented document titled, "RESIDENTS' RIGHTS' For People In Long-Term Care facilities," revised date 11/18, documents, in part, "Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life... Your facility must provide equal access to quality care regardless of diagnosis. You must not be abused, neglected, or exploited by anyone - financially, physically, verbally, mentally, or sexually. Your facility must provide services to keep your physical and mental health, at their highest practical levels.		S9999				

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S9999	Continued from page 9 Your facility must be safe, clean, comfortable, and homelike. You may participate in developing a person-centered care plan which states all the services your facility will provide to you and everything you are expected to do. This plan must include your personal and cultural choices. Your facility must make reasonable arrangements to meet your needs and choices. You should receive the services and/or items included in the plan of care..." (B) (2 of 2) 300.1210d)6) Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide a safe environment for residents residing in the facility and failed to perform a resident inventory check for one of three residents (R2) upon admission. This failure resulted in a weapon found in R2's possession due to facility not performing an inventory check. Findings include: Facility census, dated 12/12/2025, documents 137 residing in the facility. R2's face sheet documents admission to facility 10/30/2025 with diagnoses that include but are not limited to include but are not limited to asthma, type 2 diabetes mellitus, and chronic kidney disease. R2's BIMS (brief interview mental status), dated 11/05/25 is 12 which indicates R2's cognition is moderately impaired.			S9999			

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S9999	Continued from page 10 R2's progress note, dated 12/10/2025, documents, in part, "The resident (R2) returned from hospital and was immediately complaining of his missing black bag. The writer was busy with another resident while he (R2) was out in the hall yelling for nurses to return his bag. I explained to the resident that I was unaware of any missing items and that I will figure out what happened. The Resident called 911 for theft and police came out. The resident (R2) is heard yelling and blaming the shift nurses for theft. The officer managed to calm him down and the resident (R2) went into room. please follow up with social services about this behavior and situation." R2's "Behavioral Assessment, dated 12/10/25, documents, in part, "(R2) was observed with an unknown substance, smoking materials and contraband in his possession. SS (Social Services) conducted a 1:1 conversation educating the resident (R2) regarding the prohibition of contraband and unknown substance in the nursing facility. (R2) understood the education and the IDT (interdisciplinary team) has been made aware. R2's care plan, dated 11/10/25, documents, in part, "(R2) have a history of criminal behavior. (R2) have demonstrated stability during the admission screening process and does not appear to present at risk. I fit the criteria for an "identified offender," with interventions, that document, in part, "Appropriate supervision and observation." On 12/12/2025 at 9:31am, R2 said (in part), I (R2) never said that I would shoot anyone in the head. I came in with the BB gun. I had it ever since I was admitted here. Never took it (BB gun) out. They (facility staff) took my bag with the weapon, and I (R2) called the police. I (R2) have a police report." On 12/12/25 at 10:39am, V9 (Infection Preventionist) said, "The other day, maybe Tuesday (12/09/25), I (V9) was called to his (R2) room because R2's ankle was bleeding profusely. I (V9) couldn't get the bleeding to stop and told R2 I (V9) needed to send him out (hospital). R2 refused. I (V9) educated R2, and he agreed. R2 was adamant about telling me (V9) to make sure no one touches his (R2) things. R2 said it multiple times. It was kinda suspicious, so when I (V9) went to get his (R2) things, I (V9) smelled smoke. I (V9) wanted to make sure R2 wasn't smoking so I (V9) searched his things and found the BB gun. The BB gun was in R2's room. I (V9) locked it up in the office and reported it to the administrator. We (facility staff) then "swept" the entire building (checking for			S9999			

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S9999	Continued from page 11 contraband)." On 12/13/2025 at 10:19am, V1 stated, R2 did not have it (referring weapon) on admission and an inventory list was done. V1 further stated, she was unsure if R2 went out on pass, but he had to go to the hospital a few times. Surveyor asked if staff document when residents go out on pass. V1 stated, if he went out on pass it would have been documented in the progress notes. On 12/13/25 at 10:21am, V7 (Social Services Consultant) said, "I'm the acting Social Services Director. I (V7) did have R2's contraband (BB gun). I (V7) attempted to find a working number for R2's sister to give it to her, even checked the hospital record, but was unable to get a working number for R2's sister. I (V7) gave the BB gun to the administrator." On 12/13/25 at 10:41am, V5 (Social Services Coordinator) said, "I (V5) seen it (R2's BB gun). V7 (Social Services Consultant) discarded it (R2's BB gun). V9 (Infection Preventionist) originally had the gun and then gave it to V7. R2's BB gun was in an envelope, locked away, and was told V7 discarded it. That is all I (V5) know." On 12/13/25 at 10:56am, V1 (Administrator) said, R2's BB gun was discovered when R2 was preparing to go to the hospital. The IP (Infection Preventionist/V9) nurse noticed a smell of smoke and asked to see what was in R2's bag. Upon looking inside the bag, V9 found the BB gun. V9 contacted me, and I instructed V9 to take the item and secure it. V9 placed the BB gun in an envelope, took it to Social Services, and locked it in their office. There is no family contact information available for R2. As of yesterday, and to the best of my knowledge, the Social Services Consultant disposed of the BB gun. V1 said that the facility does not do routine checks of residents' belongings. V1 stated that the facility only checks resident's belongings if there's a suspicion. V1 did not report the BB gun to the Department because V1 did not consider it to be an "actual weapon." V1 stated that no one else was aware of the BB gun, and it was not displayed, shown, or used in any manner. V1 said that the BB gun was not listed as part of R2's inventory on admission, and R2 did not have it at the time of admission. V1 affirmed that resident's inventory is to be updated as needed. V1 said that R2 has privileges to leave the facility but is unaware whether R2 has left the facility recently. V1 stated that V1 would need to check to confirm. V1 stated that residents are not checked when they leave the facility and return for contraband. V1 said that a full "sweep" of the building was conducted the		S9999				

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S9999	Continued from page 12 following morning, and no additional contraband was found. During survey, surveyor requested R2's inventory list, however V1 was unable to produce inventory list for R2 nor provide documentation that R2 went out on pass. Record review of facility's policy titled, "Contraband Policy," dated 5/2025, documents, in part, "Policy: This organization reserves the right to conduct inspections if there is reason to suspect/believe that a resident has contraband items/materials in his/her possession. This includes egregious actions such as secretly (and illegally) recording other persons. These items include, but are not limited to, alcohol, illicit [street or over-the counter] drugs, weapons [including any sharp objects/ammunition], and smoking materials [if the individual has assessed as dangerous and irresponsible with smoking related items]. The individual may also be appropriately checked to look for suspected lost or stolen property, if reasonable suspicion exists. No over-the-counter medications may be kept by the resident. These items must be turned over to facility personnel upon arrival at the facility. The organization will try to balance individual rights against the safety needs of peers, visitors and staff members in making decisions about further investigation of contraband. In situations where illegal activity appears to have taken place appropriate authorities will be notified. Again, safety and security are of the utmost concern. Hoarding is considered unsafe and dangerous and will not be allowed in this facility. The following items are not allowed in resident rooms at any time and are not allowed on the resident's person unless permission has been granted from administration and supervision is being provided: Firearms and ammunition of any type." Record review of facility policy titled, "Personal Effects," dated 5/2025, documents, in part, "Purpose: The purpose of inventory is to limit the risk of loss of residents' personal effects and to protect the facility from liability for loss personal effects. Standards: 1. The inventory shall be completed upon admission and signed by the resident or resident's responsible party. 2. The inventory shall be updated when items are brought to the facility for the resident or when things are removed from the facility by the resident or resident's responsible party; resident/family to notify facility staff of changes to inventory to facilitate updates to the recorded inventory." Facility presented document titled, "RESIDENTS' RIGHTS'		S9999				

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S9999	Continued from page 13 For People In Long-Term Care facilities," revised date 11/18, documents, in part, "Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life... Your facility must provide equal access to quality care regardless of diagnosis. You must not be abused, neglected, or exploited by anyone - financially, physically, verbally, mentally, or sexually. Your facility must provide services to keep your physical and mental health, at their highest practical levels. Your facility must be safe, clean, comfortable, and homelike. You may participate in developing a person-centered care plan which states all the services your facility will provide to you and everything you are expected to do. This plan must include your personal and cultural choices. Your facility must make reasonable arrangements to meet your needs and choices. You should receive the services and/or items included in the plan of care..." (B)			S9999			