STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0046672	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF ENERGY	**210 EAST COLLEGE PO BOX 519, ENERGY, Illinois, 62933**

(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 Investigations 25510933/2664396 25511526/2678910 25511920/2686154	S0000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 300.610a) 300.1210a) 300.1210b) 300.3210a)1) 300.3240a) 300.3240b) 300.3240d) 300.3240g) 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 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.	S9999		

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

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S9999	Continued from page 1 Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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 personal care needs of the resident. Section 300.3210 General a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by State or federal law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of the resident's status as a resident of a facility. 1) Residents shall have the right to be treated with courtesy and respect by employees or persons providing medical services or care and shall have their human and civil rights maintained in all aspects of medical care as defined in the State Operations Manual for Long-Term Care Facilities. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility	S9999		

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S9999	Continued from page 2 administrator. (Section 3-610(a) of the Act) d) When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act) g) A facility shall comply with all requirements for reporting abuse and neglect pursuant to the Abused and Neglected Long Term Care Facility Residents Reporting Act. These requirements were not met as evidenced by: Based on interview, observation, and record review, the facility failed to prevent the verbal and physical abuse of a resident from staff for 1 of 7 residents (R7) reviewed for abuse in the sample of 44. This failure resulted in psycho/social harm to R7 having feelings of irritation, anger, and continued complaints of pain to her right shoulder. The findings include: R7's face sheet, dated 12/22/25 documents an admission date of 04/29/2021 with diagnoses in part of unspecified dementia, psychotic disturbance, mood disturbance, anxiety, primary arthritis, spondylosis with myelopathy or radiculopathy, malignant neoplasm of unspecified site of left breast, history of falling, and Vitamin D deficiency. R7's MDS (Minimum Data Set) dated 10/23/2025 documents in Section C a BIMS (Brief Interview for Mental Status) of 8 which indicates moderately impaired cognition. Section GG documents chair/bed to chair transfer as partial/moderate assistance. R7's Care Plan, edited 09/30/25 documents a problem of R7 is grieving due to recent loss of her son approaches for this problem include: Approach R7 in a calm manner and provide emotional support as needed. Another problem of Falls R7 is high risk for falls. R7 at risk for falling r/t (related to) history of falls visual acuity impairments, decreased safety awareness, impulsiveness with attempts to stand or self-transfers without assistance from staff leaning forward in chair with attempts to pick up objects. On 09/17/24 I slid out of my wheelchair in the hallway. I did not hit my head, and I do not have any obvious injury. On 1/22/25	S9999		

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S9999	Continued from page 3 I was observed sitting on the floor beside my bed. I have no apparent injury. On 03/27/25 I rolled out of bed when sleeping. I had shoulder pain, but it went away. On 07/29/25 I slid off of a pillow that was in the seat of my w/c (wheelchair). No injury. On 11/02/25 I was attempting to move from my w/c to the bed and slid to the floor. Approaches for this problem include: Keep assistive devices at bedside. Another problem area of R7 is considered at risk for abuse/neglect (per assessment) due to dx (diagnosis) of dementia/chronic pain/resistance of care/exit seeking approaches for this problem area include: address all complaints/concerns promptly with grievances policy and procedure, intervene if observing any peer-on peer conflict to avoid potential abusive situation. A facility document titled Long-Term Care Facility and IID-Serious Injury Incident report documents under general information: Incident Date 01/05/2025 with a time of incident of 0630 and a report date of 01/05/25. Resident #1 involved in Incident: R7 listed as victim. Staff #1 involved in the incident: V13 position CNA (Certified Nursing Assistant) , retained no, suspended yes, terminated no. Witness Name V16 (former Assistant Director of Nursing) and V49 (CNA). Detailed Incident Summary (Who, What, When, Where, Why) Resident #1 (R7) is a 95 y.o (year old) Fw/PMH (Female with a Past Medical History): dementia, CAD (Coronary Artery Disease), HTN (Hypertension), anxiety, insomnia, depression. Per the facility protocol, an investigation was conducted in response to an allegation of abuse involving resident #1 (R7). Per interview conducted with witness #2 (R49), resident approached witness #2 and staff during a conversation. Witness #1 (V16) stated that resident #1 stated she “needed to be careful with that man” staff asked resident not to interrupt and took resident #1 (R7) to room. Per staff member resident #1 (R7) referred to him as “a druggie, loser, and a fool” He did ask her to stop and took her to her room. While in the room staff member states that resident slapped him and scratched his face. Resident #1 then through a water pitcher at staff member striking him in the back of the head. Staff member left the room with no further incident. Staff member stated that he went outside to take a break following the incident. Staff member states that he did rush his care with resident #1, but he was never aggressive with the resident #1. Staff member states that he was frustrated with the resident’s behavior. Multiple staff members did hear about the incident second hand. The PCP (Primary Care Physician, Administrator, ADON (Assistant Director of Nursing) and family were notified of the incident. An interview was conducted with the resident with ADON present. A skin assessment was completed with	S9999		

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S9999	Continued from page 4 no findings by the ADON. Law enforcement notified of incident and investigation is ongoing with no current concerns. Facility investigation unsubstantiated with no findings of abuse. Resident #1 had no recollection of event on follow up interview. Dated 02/28/25 by V1 (Administrator) at 12:00PM. On 11/25/25 at 2:34 PM, R7 who was alert to person and place stated one day V1's (Administrator) son V13 (CNA) took her into her room and shut the door then grabbed her around her arms and chest from behind and squeezed her until it hurt then took her wheelchair away. R7 stated she told V1 and V1 took care of it. R7 stated she mentioned a couple times "I ought to call the police" but never did. R7 stated V13 never came back, she thinks he left town. On 12/17/25 at 3:45 PM, R7 who was alert to person and place stated she did have a man hurt her one time a while back and she doesn't know why he did it. R7 stated the man was V1's son V13. R7 stated V1's son took her into the room in her wheelchair and got behind her and wrapped his arms around her and squeezed really hard until it hurt. R7 stated she felt like he broke her arms. R7 stated she doesn't remember what he said to her or why he did it, but she remembers he hurt her and to this day her right shoulder hurts. R7 stated after V13 let go of her arms he took her wheelchair away. R7 stated she doesn't remember how she got her wheelchair back. R7 stated that it scared her, and she didn’t know what to do. At that time observed R7 trying to show she couldn't reach across her body with her right arm and when she moved her right arm across her body to her left, she grabbed her right shoulder and said "ouch, it hurts when I do that. On 12/2/25 at 2:26 PM, V20 (CNA) stated R7 says V1's son V13 tells her all the time that V1's son V13 hurt her arms. V20 stated that R7 will roll to V1's office door at times and tell him his son hurt her. On 12/11/25 at 1:08 PM, V13 (former CNA) stated R7 called him a drug addict and multiple other things and he got tired of being called that. V13 stated, "I didn't do anything to hurt that woman, I shut the door and I apologized." V13 stated he took R7 back to her room because it was late and maybe she was acting up because she was tired. V13 stated he took her into her room to get her ready for bed then R7 came out again so he took her back into her room and then she threw water at me and smacked me in the face and chest, "you know like what old ladies do." V13 stated he walked out of the room when R7 started hitting him but he doesn't remember if she was in her bed, in her wheelchair, or	S9999		

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S9999	Continued from page 5 if he was in the middle of transferring her into her bed. V13 stated at one point he got down to eye level with R7 and was trying to talk to her. V13 stated he might have raised his voice at her in frustration during this but then he left the room in frustration and took the wheelchair. V13 stated he doesn't remember who gave R7 the wheelchair back. V13 stated, "I never harmed that woman, I was just over exaggerated on the story in the morning." V13 stated at the end of the day that woman was down on the other hallway upset most of the night. V13 said that some people know how to handle her better than he does. V13 stated he tried to help R7 go to bed, and she got up immediately and she was very frustrated with him and it was unclear to him why. V13 stated he is one person to 20 residents, so he didn't want his clothes wet to take care of all the other residents. V13 stated, "the other staff were appeasing her and giving her crap that I can't give her." V13 stated he already told her she couldn't have a soda, and the others gave it to her on the other hall. V13 stated R7 will go to the other parts of the building and find someone that will give her soda to make her happy. V13 stated he doesn't have the money to buy residents soda, and the residents can't expect the same treatment from every CNA. V13 stated he didn't have any conversation with R7 after the incident. V13 stated there were call ins and they were short 2 CNA's (Certified Nurse Assistants) so he was very busy and doesn't remember if she came back to her room that night. V13 stated he doesn't remember who called him and asked him what happened. V13 stated he resigned from his position after all of this happened. On 12/13/25 at 3:19PM, V14 (Licensed Practical Nurse/LPN) stated he was on A wing passing meds the night of the incident with V13 and R7 and he was (in hall) because he had just come out from there passing meds. V14 stated while he was going in and out of rooms, he noticed one-time R7's door was closed then next time she was out of the room then the next time her door was closed again then he saw R7's wheelchair in the hallway and her door was closed. V14 stated R7 doesn't usually have her door closed so it worried him. V14 stated he went to R7's room to check on her and she was visibly upset and saying V13 put her in her bed and took her wheelchair away from her and she wanted to get up. V14 told R7 he would be right back and get her taken care of, he was taking his med cart back up to where it belongs and while he was taking his cart he started thinking that taking a wheelchair away was considered a restraint and he got worried so he went and got V31 (Registered Nurse) to ask for help with the situation. V14 stated he asked V31 if taking R7's wheelchair away was a restraint and V31 stated yes,	S9999		

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S9999	Continued from page 6 that last time someone took her wheelchair away she fell and had to get staples. V14 stated he and V31 ran back to R7's room and when they walked in R7 was still visibly upset and was reaching for V31 to console her. V14 stated then R7 refused her medications with him because she was so upset but she ended up taking them for V31. V14 stated R7 is independent with getting herself from the wheelchair to the bed and back to her wheelchair. V14 stated V13 told him that R7 called him a druggy saying he will never make anything of himself and V14 told him it doesn't matter what a resident says to you, you cannot take away their wheelchair and shut them in their room. V14 stated he didn't report the incident because he didn't know he was supposed to. V14 stated V1 (Administrator) called him and asked what happened. V14 stated no one else from the facility contacted him regarding this incident. V14 stated the police never contacted him regarding this incident. V14 stated he doesn't remember talking to anyone from Illinois Department of Public Health prior to right now. V14 stated this incident bothered him for a long time because he just felt like it wasn't right and wondered what could have happened to R7 if no one was there. On 12/4/25 at 2:29 PM, V49 (CNA) stated she recalls the incident with R7 and V13 but she doesn't remember the exact day and doesn't remember what time of the shift it was, but it was during a midnight shift. V49 stated she and V13 were having a conversation at the nurse's station and R7 interrupted them and V13 told R7 to mind her own business, they were trying to have a conversation. V49 said that R7 then told her that V13 is a no good use of a man and then called him a drug addict. V49 said that V13 got angry and grabbed R7's wheelchair and pushed her to her room and shut the door. V49 said she was at the nurses station and could hear R7 and V13 yelling at each other but doesn't remember what was said. V49 said she heard R7 yelling give me my wheelchair back, please get me out of bed, and help. V49 said then V13 took R7's wheelchair out of the room and left it in the hall and slammed her door closed all while R7 was still yelling. V49 said that V13 came back to the nurses station and told her that he threw R7 into bed and that R7 threw a water bottle at him and he threw it back at R7 then left the room. V49 stated she told V13 to not mess with R7 anymore or touch her that she was going to take care of her. V49 said that R7 was taken to the Suites unit (but she couldn't remember who took her) and R7 was put in a bed in an empty room to sleep the rest of the night. V49 said another CNA was working the suites and took care of R7 the rest of the night. V49 did not report it because she thought someone else did because V1	S9999		

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S9999	Continued from page 7 (Administrator) called her the next day to ask her what happened. V49 stated she told V1 the same thing she told this surveyor. On 12/4/25 at 2:57 PM, V22 (CNA) stated she took report from V13 on Saturday 2/22/25 in the morning and V13 told her that he and R7 weren't getting along during the night, and he said he tried to put R7 in bed and she would not let go of her wheelchair, so he dumped her into bed. V22 stated that during report on 2/23/25 V13 told her that he and R7 weren't getting along again so he took her wheelchair away from her and he told V22 that if she called him a druggie again, he would throw water in her face and make R7 eat a bar of soap. V22 stated that R7 mentions often that V13 grabbed her arms and was rough with her and hurt her. V22 stated when there are reports of abuse to administration, actions are never taken, and they treat the reporter different after that. On 12/8/25 at 12:28 PM, V12 (LPN) stated she left the facility in late August of 2025 due to feeling like administration would sweep things under the rug and that V2 (Director of Nursing) was verbally abusive to residents and staff. V12 stated she arrived to work at 6am the morning after the alleged abuse of R7 by V13 (CNA). V12 stated she was getting report from V14 (LPN) and V14 told her that V13 took R7's wheelchair and put it in the hallway and V12 stated yes, it was a restraint, you can't take away R7's only means of transportation. V12 stated while she was getting report from V14 in the hallway on A wing, V13 walked by, and she told V13 she heard he took away R7's wheelchair during the night and she told V13 that he can't do that because that is considered a restraint. V12 said that then V13 said to V14 if she calls me a druggie again one more time I'm going to shove a bar of soap down her throat and throw water in her face. V12 told V13 that he can't do that because that is abuse and V12 stated she asked V13 why is he bullying a 96 year old that has dementia and she probably doesn't even know what she is saying then V13 stated he doesn't care. V12 stated after V13 walked away V22 (CNA) came up to her and told her that V13 told her he was trying to put R7 in bed last night because she was having behaviors and she wouldn't let go of her wheelchair so he dumped her out of the wheelchair into her bed. V12 stated she immediately called V1 (Administrator) to report potential abuse and she was afraid he wouldn't do anything about it because it was his son so she told him if he didn't do anything about it she was going to call the police. V12 stated after a couple of hours V1 still hadn't shown up so she went to V16 (Former Assistant Director of Nursing/ADON) and told her what	S9999		

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S9999	Continued from page 8 happened and that V1 still hadn't come in to handle it so V16 stated she would get a hold of V1. V12 stated V1 didn't show up to the facility until he arrived with the police around 3:30 PM that day. V12 stated V16 was on shift that day during day shift and she was the ADON at the time. V12 stated she doesn't know who called the police. V12 stated she left because she spoke up about things that weren't right multiple times and she felt like the administration swept it under the rug. V12 stated when she arrived to work that morning at 6:00 AM R7 was still on the rehab unit and would not come back to her unit because she was so upset. V12 stated she was finally able to get her to come back around 2PM or 3PM that day. V12 stated she did a body assessment after the police and V1 arrived at the facility. V12 said that the police officer and V1 were present as they looked at R7's arms and under her arms where R7 said she was hurting. V12 stated she did not see any markings. V12 stated anytime Illinois Department of Public Health came into the facility V2 (DON) would tell staff to keep their mouths shut about the alleged abuse of R7 by V13. On 12/8/25 at 3:51 PM, V16 (Former ADON) stated she no longer works for the facility but she was the ADON at the time of the incident between R7 and V13. V16 stated she came in like normal for her shift around 8 or 8:30 AM and when she arrived the nurse on duty V12 came up to her and told her about an incident that occurred during the night shift. V16 said that V12 stated it was reported to her that V13 took R7's wheelchair away from her and V13 also told her that if R7 called him names again he was going to shove a bar of soap down R7's throat. V16 stated she took a written statement from V12 and V22 about the incident. V16 stated V12 notified V1 (Administrator) of the incident. V16 stated V1 didn't get to the facility until late that day and she stated she kept calling V1 and texting him about what to do with the incident. V16 stated when V1 came to the facility he took over the investigation from her, and she is not aware of what happened after that. V16 doesn't remember if she did the body assessment to R7 or not. V16 stated she wasn't there when V1 talked to R7 about the situation. V16 stated R7 told her a boy grabbed hold of her and hurt her. On 12/03/25 at 2:49PM, V31 (RN) said that he was working the night that the incident occurred with V13 and R7. V31 said that he was working a different hall and that V14 (LPN) came and got him. V31 said that V13 had taken R7 out of her wheelchair and put her in her bed and had the door shut and the wheelchair on the outside of R7's room. V31 said that R7 was in her room yelling and that he and V14 went in and got R7 back up	S9999		

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S9999	Continued from page 9 out of bed and moved her to a different hall because V13 was still working on her hall. V31 said that R7 will usually transfer herself if she has her wheelchair next to her, but V13 moved her wheelchair away from her. On 12/08/25 at 11:28AM, V1 (Administrator) said that he doesn't think that V16 (Former ADON) was working the night that V13 and R7 had the alleged altercation. V1 said that he was not told about the incident between V13 and R7 until the next morning. V1 said that he talked to the officer and that he really doesn't know a lot about the abuse allegation that the police were doing their investigation into it. V1 said that he investigated the allegation of abuse between V13 and R7 and it was not substantiated. V1 said he had to investigate this with an unbiased mind because it was his son. V1 said that date of 1/5/25 was wrong on the reportable/incident report that he forgot to change the date to 02/23/25. On 12/18/25 at 9:10AM, V2 (Director of Nursing) stated if a resident wanted their wheelchair to get out of bed and they were in bed and the wheelchair was taken away from them she would consider it abuse or seclusion and she stated that isn't right. Statements provided from the facility regarding the investigation present as follows: V22's (CNA) statement with no date documents, "Saturday during report V13 mentioned him and R7 weren't getting along and attempted to put R7 in bed. R7 wouldn't let go of wheelchair so V13 stated he dumped her out of the wheelchair into bed. On Sunday 02/23/25 during report V13 mentioned that R7 and him weren't getting along again and he took her wheelchair and said to me and the nurse next time R7 is mean to him or calls him a "Druggie" he will throw water in her face or make her eat a bar of soap." A statement dated 02/23/25 with no staff name documents, "Today when I arrived to work at 6AM got report. V14 asked me if "taking a wheelchair is restraints, right?" then told me V13 was being hateful to R7 and put her in bed and took her wheelchair from her. V22 then told me that she forgot to let me know but V13 said in report that he picked R7 up in the wheelchair and dumped her in the bed. R7 is stating that he kept pinching her on her arms and twisting the skin. I told V13 he cannot treat residents like that nor take the wheelchair from them. V13 told me "I apologized for taking her wheelchair but next time she calls me a druggie I'm gonna throw water in her face or	S9999		

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S9999	Continued from page 10 shove a bar of soap down her throat." V14, V22 and V31 were there for this happening. A statement that says interview with V31 (RN) heard about incident 2nd hand, V31 gave ger medication and took her to C-wing. R7 was upset at that time. Not an eyewitness to any proceeding events prior to taking R7 to C-wing. A statement that says interview with R7 dated 02/25/25 no clear recollection of events at time of interview. A statement that says interview with R7 no date documents. "Beat the tar out of me. Stated individual beat her all over. States she screamed and hollered but no one came. Put arms around her and squeezed her. Stated he pinched her under right arm specifically. He hit her on shins as well." A typed statement by V13 dated 02/26/25 which documents R7 has a history of wandering the building. Normally there are no restrictions. (The facility) is currently under precautions due to respiratory illnesses. I try to encourage R7 to stay on her hallway due to infection risks. R7 does suffer from Alzheimer's dementia and does become agitated with restrictions despite repeated attempts to redirect her. R7 is a risk for falls and has poor safety awareness. At the time of this incident, I was talking with the other CNA on the hall. R7 came up to us and started calling me a "druggy, loser, and fool." I asked R7 to stop and took her to her room. I asked R7 at that time to please stop calling me names. R7 proceeded to slap and scratch my face. I transferred R7 to her bed. As I was leaving the room, R7 threw a water pitcher at me that hit the back of my head. I quickly left the room with the wheelchair. I placed the wheelchair right outside the room. I told V49 (CNA) that I was going outside to have a cigarette. I was told after returning that the wheelchair was returned to R7 and that she went to another hallway where she remained for the rest of the night. I was frustrated when I gave the report the next morning, but I never was aggressive with R7 in any manner. My care may have been rushed but it was never aggressive. As I gave report, I did not use proper words. It was obvious that I was frustrated with the resident's behavior. A statement by V14 dated 02/24/25 documents, V13 put R7 in room and closed door x 3, returned with w/c after 3rd time, went into room with meds and R7 stated that CNA took w/c away. You talked to V31 and decided that w/c needed to be returned. V31 took resident to c-wing, did not see any interaction between V13 and R7, per V14	S9999		

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S9999	Continued from page 11 V31 was not on the hall at the time of the incident. V14 returned wheelchair immediately, R7 spent rest of night on the suites. An incident report from the local police department documents: Incident Assault, reported 02/23/25 at 4:16PM. Officer arrived at 02/23/25 at 3:34PM. Report of incident Assault: On 02/23/25 I (local officer) responded to (the facility) for a complaint of possible Elderly Abuse. Upon arrival I was met by two nurses that were witnesses to the complaint. I first spoke to V12. V12 stated that she is one of the head nurses at the business and was made aware of an incident that possibly took place the evening of 02/22/25 involving a male CNA and a resident. V12 stated when she arrived at work that a CNA V13 had taken a wheelchair from R7 which her means of getting around the facility. V12 then said that V22 (CNA) another nurse and complainant to this incident, advised her that V13 was telling her during report this morning that he picked R7 up in her wheelchair the night prior and dumped her into her bed. V12 said she confronted V13 about his behavior towards R7 to which he replied “I apologized for taking her wheelchair, but next time she calls me a druggie I’m gonna throw water in her face and shove a bar of soap down her throat.” V12 advised that R7 is stating that V13 was pinching her arms and twisting her skin during these events as well. V12 stated her and V22 then both went to their Administrator V1 and filed statements and formal complaints against V13 for his conduct. I did not speak to V22 specifically regarding the events due to her working with patient, but she provided her written statement about her involvement with V13. V12 and V22 both provided their written statements and are attached to (Local Police Department) complaint forms in file. I would like to note at this time that V13 is the son of V1, the administrator for the facility. I would also like to note that I was advised that R7 has serve dementia. I spoke with V1, V1 advised that he was made aware of the situation involving his son and resident the morning of 02/23/25 and soon came into work to start his investigation. V1 stated that his son V13 has been suspended from work pending the investigation into the allegations. He advised that he and nurses at the facility have observed R7 for injuries and did not notice any redness or bruising consistent with the allegations. I never visually saw or spoke with R7 while at the facility due to her medical state. V1 stated that a full investigation would be completed on the facilities behalf and reports would be available to investigation as requested. V1 stated that he would be in contact with R7’s POA to advise them of the allegations. V1 also provided his bosses information if investigators were to need to	S9999		

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S9999	Continued from page 12 contact her. The facility policy titled “Abuse Prevention” with a revision date of 07/2015 documents in part, “This facility desires to prevent abuse, neglect, or misappropriation of property by establishing a resident sensitive and resident secure environment…” (B) 2 of 2 300.610a) 300.1210a) 300.1210b) 300.1210d)1)2) 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 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 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and	S9999		

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S9999	Continued from page 13 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 personal care needs of the resident. 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician. These requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to administer/apply pain medications as ordered for 1 of 3 residents (R19) reviewed for pain management in a sample of 44. This failure resulted in R19 experiencing pain with the treatment application to R19's leg wounds. The findings include: R19's Face Sheet documents an admission date of 9/26/25 with diagnoses including: cellulitis of right lower limb, weakness, depression, and other specified hearing loss bilateral. R19's Minimum Data Set (MDS) dated 10/2/2025 documents a Brief Interview for Mental Status (BIMS) score of 07, indicating R19 has severe cognitive impairment. Section J, Health Conditions, documents that R19 experiences pain or hurting "frequently." R19's Care Plan documents that R19 has impaired skin integrity related to venous insufficiency and R19 has pain/risk for pain with a start date of 9/26/25 with documented interventions including administer medications, monitor and record effectiveness, and report adverse side effects. R19's Wound Evaluation and Management Summary Report dated 12/10/25 documents that R19 has the following wounds: Venous wound of the right leg with a wound size of 13.6 cm (Centimeters) length x 16.8 cm width x 0.3cm depth , skin tear of the right dorsal foot wound size of 1.3 cm in length x 1.4 cm width x 0.5 cm in depth,	S9999		

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S9999	Continued from page 14 arterial wound of the right ankle with a wound size of 2.7 cm length x 2.7 cm in width x 0.4 cm in depth, non-pressure wound of the right medial foot with a wound size of 1.3 cm length x 2.4 cm in width x 0.3 cm in depth, and skin tear to the right, posterior ankle with a wound size of 12 cm in length x 5 cm in width x 0.3 cm in depth. R19's Physician Order Report dated 11/15/2025-12/15/2025 documents and order for Lidocaine cream 4% topical, apply to right lower extremity wounds prior to wound care/treatment change once a day with a start date of 11/17/25 and an end dated labeled "open ended", an order for pain assessment every shift with a start date of 10/06/25 with an end date labeled "open ended", and an order for hydrocodone-acetaminophen tablet 5-325mg amt (Amount) 1 tablet twice a day PRN (as needed) with a start date of 09/26/25 and an end date labeled "open ended." R19's Pain-MDS focused assessment dated 12/02/25 documents: Pain received schedule pain med regimen: No; Pain management: Received PRN (as needed) pain meds or offered and declined: Yes; Received non-medication interventions: Yes; Should pain assessment interview be conducted: Yes; Res (resident) have you had pain or hurting at any time in the last 5 days? Yes; Res (resident) How much of the time have you experienced pain or hurting over the last 5 days? Occasionally; Res (resident) Over the past 5 days, how much of the time has pain made it hard for you to sleep at night? Rarely or not at all; Res (resident) Over the past 5 days, how often have you limited your participation in rehabilitation therapy sessions due to pain? Rarely or not at all; Resident Over the past 5 days, how often have you limited your day-to-day activities? Occasionally; and Resident please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine: 4. R19's Medication Administration Record (MAR) for December 2025 documents: Hydrocodone-Acetaminophen 5-325mg 1 tablet PRN (As Needed) twice a day. Administered on 12/02/25 at 8:45PM for pain, 12/04/25 at 12:28AM for pain, 12/04/25 at 9:40AM for pain, 12/05/25 at 10:52PM for pain, 12/08/25 12:44AM for pain, 12/08/25 10:29PM for pain, 12/09/25 10:31AM for pain, 12/09/25 11:11PM for pain, 12/10/25 10:31AM for pain, 12/10/25 7:40PM pain 4/10 RLE (Right Lower Extremity), 12/12/25 12:50AM for pain 7/10 for RLE, 12/12/25 7:34PM for pain, 12/13/25 7:33PM for pain, 12/15/25 12:54Am for pain, 12/17/25 at 9:47AM for pain 12/21/25 at 12:32AM for pain, 12/21/25 11:40PM for pain	S9999		

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S9999	Continued from page 15 4/10 RLE. The same MAR documents the order for Lidocaine cream 4% topical apply to right lower extremity wounds prior to wound care/treatment change from 6:30PM to 6:30AM was administered on the following dates: 12/01/25, 12/02/25, 12/03/25, 12/04/25, 12/05/26, 12/06/25, 12/07/25, 12/08/25, 12/09/25, 12/10/25, 12/11/25, 12/12/25, 12/13/25, 12/14/25, 12/15/25, 12/16/25, 12/17/25, 12/18/25, 12/19/25, 12/20/25, and 12/21/25. On 12/08/25 at 11:41 PM, V37 (License Practical Nurse) was observed providing wound treatment on R19 wounds of the right leg and foot. Observed old dressing which was saturated with large amounts of yellowish-green drainage to entire dressing. Topical lidocaine was not observed to be applied during this observation. R19 was observed multiple times throughout the procedure grimacing, grabbing her leg, and saying ouch. Wounds extend to most of R19 lower right leg from front to the back with what appears to be a depth of around 0.25 to 0.5 cm in depth. The area to the back of the right leg around the ankle/heel area looks to have a large amount of slough and possible muscle exposure. On 12/08/25 at 1:30 PM, R19 stated that there have been times when she has not gotten her treatment done to her right leg. R19 stated the nurses won't do it for a couple of days. R19 stated they have told her they have ran out of the medicine they put on her wounds on her right leg before. On 12/17/25 at 1:31PM, R19 stated that she doesn't know if they put the lidocaine on her leg during her treatment or not. R19 said that they just start working on her right leg and she doesn’t' t know what all they are doing to her just that they are doing the treatment. R19 said that it always hurts when she gets her treatment done. R19 said that she usually will get a pain pill before her treatment if she requests it. R19 said that she is usually asleep when they come in to do her treatment, so she doesn't get a chance to request the pain pill prior to the treatment. On 12/17/25 at 1:40PM, V40 (Licensed Practical Nurse/LPN) stated that she looked in the treatment cart and she was unable to find any lidocaine gel for R19. V40 said that she found lidocaine gel for other resident, because each lidocaine gel is prescribed to each resident. V40 said that she looked in the medication cart as well and only found a lidocaine gel tube with no resident name on it and didn’t know who’s gel it was. On 12/03/25 at 2:19 PM, V21 (LPN) stated they run out	S9999		

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S9999	Continued from page 16 of wound supplies like prescription creams and medication for wounds at times, and she will have to push off the wound care at nighttime until the next shift. On 12/18/25 at 9:10AM, V2 (Director of Nursing) stated if lidocaine is ordered for pain control to be applied prior to wound treatments it should be applied. V2 stated a residents lidocaine cream will have their name on it and come from their pharmacy, On 12/19/25 at 9:45AM, V48 (Physician) stated that he would expect any medication or treatment that is ordered to be administered as ordered. V48 said if R19 had an order for lidocaine gel to be applied to her right leg before doing the treatment then he would expect it to be applied. V48 said that the lidocaine gel being applied before the treatment performed was probably to help with pain from the treatment as a topical pain medication. The facility policy titled “Pain Prevention and Treatment” with an effective date of October 2017 documents Policy: To assess for, reduce the incidence of the severity of pain to help resident attain or maintain his or her highest practicable level of well-being and to prevent or manage pain to the extent possible. The facility will develop and implement a plan, using pharmacological and non-pharmacological interventions to manage pain and/or try to prevent the pain consistent with the resident’s goals. Definitions: Pain-an unpleasant “sensory and emotional experience that can be acute, recurrent, or persistent.” (B)	S9999		