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S 000	Initial Comments Annual Licensure Survey Facility Reported Incident on 10/14/25/IL#198120- Section 340.1440a)b)c)d)e	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 3 340.1010a)2)A)ii)vi) 340.1335a) 340.1335c)2)6) Section 340.1010 Incorporated and Referenced Materials a) The following regulations and standards are incorporated in this Part: 2)Federal guidelines: A)The following guidelines of the Center for Infectious Diseases, Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services, may be obtained from the National Technical Information Service (NTIS), U.S. Department of Commerce, 5285 Port Royal Road, Springfield, VA 22161: ii)Guideline for Hand Hygiene in Health-Care Settings, available at: https://www.cdc.gov/infection-control/media/pdfs/Guideline-Hand-Hygiene-P.pdf (October 25, 2002);	S9999		

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vi)2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, available at: https://www.cdc.gov/infection-control/media/pdfs/guideline-isolation-h.pdf?CDC_AAref_Val=https://www.cdc.gov/infectioncontrol/pdf/guidelines/isolation-guidelines-H.pdf (September 2024);

Section 340.1335 Infection Control

a) Each facility shall establish and follow policies and procedures for investigating, controlling, and preventing infections in the facility. The policies and procedures shall be consistent with and include the requirements of the Control of Communicable Diseases Code and Control of Sexually Transmissible Infections Code. Activities shall be monitored to ensure that these policies and procedures are followed.

c) Each facility shall adhere to the following guidelines and toolkits of the Center for Infectious Diseases, Centers for Disease Control and Prevention, U.S. Public Health Service, Department of Health and Human Services, and Agency for Healthcare Research and Quality (see Section 340.1010):

2) Guideline for Hand Hygiene in Health-Care Settings.

6) 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings.

These requirements were not met as evidence by:

Based on observation, interview, and record review the facility failed to complete hand hygiene

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and apply gloves prior to administering a subcutaneous injection for one resident (R10) and apply gowns prior to providing high-contact care for residents with indwelling catheters and wounds for four of six residents (R2, R3, R6, and R8) reviewed for infection control in a sample of 12.

Findings include:

The facility's Medication Administration Policy revised 1/24 documents nurses are to perform hand hygiene before and after every direct resident contact. This policy further documents when administering a subcutaneous injection, the nurse is to first wash their hands then put on gloves if contact with blood or body fluids is likely or your skin or the resident's skin is not intact.

The facility's Standard and Transmission-Based Precautions, dated 3/19/2024, documents "Enhanced Barrier Precautions: Use Enhanced Barrier Precautions with a resident known to be infected or colonized with a targeted MDRO (Multidrug-Resistant Organism). High-contact resident care activities have been shown to provide opportunities for transfer of MDROs to staff hands and clothing. Enhanced Barrier Precautions fall on the spectrum in between Standard Precautions and Contact Precautions. They are more specified than standard Precautions as they require PPE (Personal Protective Equipment) use for high-contact resident-care activities. They are less restrictive than Contact Precautions as PPE is not required for every room entry/activity, residents are not restricted to their rooms, and placement in a private room entry/activity, residents are not restricted to their rooms, and placement in a private room is not required. A. Enhanced Barrier

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Precautions apply to two categories of residents: 1. Residents infected or colonized with a novel or targeted MDRO when Contact Precautions do not apply; and 2. Residents with wounds and/or indwelling medical devices, regardless of MDRO colonization status. D. Wear gown and gloves when performing high-contact resident care activities. 1.High-contact care activities include: assisting with transferring, bathing, dressing, toileting, changing linens, care for wounds or indwelling devices, and providing hygiene such as brushing teeth or hair."

1. On 10/20/2025 at 11:15 AM, V3/RN (Registered Nurse) entered R10's room to administer three units of Novolin R Insulin as physician ordered. V3 did not perform hand hygiene or don gloves prior to the medication administration.

On 10/22/2025 at 11:30 AM, V35 (Nurse Supervisor/RN) confirmed that nursing staff are expected to perform hand hygiene and wear gloves prior to administering injections to residents.

2. R2's computerized Medical Record documents that R2 is an 88-year-old male that admitted to the facility on 12/31/24 with diagnosis of Neuromuscular Dysfunction of Bladder.

R2's MDS (Minimum Data Set) assessment dated 9/17/25 documents that R2 has an indwelling catheter.

R2's Physician Order documents to provide indwelling catheter care every shift.

R2's Care Plan documents that R2 has an indwelling catheter for urinary retention related to

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Neurogenic Bladder. Intervention "Enhanced Barrier Precautions: Wear gown and gloves when changing linens, providing direct personal care to resident." Date Initiated: 4/4/2025.

On 10/20/25 at 11:50 AM, There was a sign posted on R2's door that Enhanced Barrier Precautions were required for R2. There was Personal Protective Equipment available at the door. V9/CNA (Certified Nursing Assistant) entered R2's room to provide catheter care. V9 washed his hands and applied gloves. V9 did not put on a gown. V9 provided incontinent care for R2.

On 10/20/25 at 11:55 AM, V9 was asked if he should wear a gown while doing catheter care. V9 stated "No, we just wear gloves, a gown is not needed."

3. R3's current Physician Orders documents, "10/6/25: Stage two wound to coccyx, cleanse with saline solution, apply tissue debriding ointment to wound bed, cover wound bed with saline moistened gauze, and then cover with sacral foam dressing."

R3's current Care Plan documents, "Date Initiated 2/5/25. revision: 10/3/25: (R3) has a pressure injury related to quadriplegia, chronic pain, hypothyroidism, Type 2 Diabetes Mellitus, and impaired. Goal: Revision on 10/8/25- (R3's) pressure injury stage two of the left ankle will show signs of healing and remain free from infection by/through review date. (R3's) pressure injury stage two of the coccyx will remain free of infection and show signs of healing through next review date. Interventions: Enhanced Barrier Precautions: Wear gowns and gloves when changing linens, providing direct personal care to

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resident."

On 10/21/25 at 9:36 AM R3's door had an Enhanced Barrier Sign posted on the outside of his door with PPE available at the door.V20/Wound Nurse and V21/CNA entered R3's room and prepared to perform wound treatment to R3's coccyx and left ankle. V20 and V21 both washed hands and applied gloves. V21 rolled R3 onto his right side while V20 performed wound treatment to R3's coccyx. V20 then performed wound treatment to R3's left ankle.V20 and V21 did not wear a gown while providing cares/wound cares to R3.

On 10/21/25 at 9:50 AM V20/Wound Nurse verified her, and V21/CNA should have worn a gown during wound care.

4. R6's Order Summary dated 10/22/2025 documents R6 has an indwelling catheter, coccyx abrasion, right hip abrasion, right and left gluteal fold abrasions, right toe abrasion, and right arm skin tear.

R6's Care Plan dated 12/17/2024 documents R6 is on Enhanced Barrier Precautions, staff is to wear gowns and gloves when changing linens and providing direct personal care to R6.

On 10/20/2025 at 10:00 AM, R6 was in bed and unable to answer questions appropriately at this time. R6 was in his room in his bed facing the wall, V30 (Certified Nurse Assistant) was in his room performing hygiene cares and dressing cares. V30 only had gloves on.

On 10/21/2025 at 10:00 AM, V14 (RN/Unit Supervisor) stated R6 was supposed to be in Enhanced Barrier Precautions due to his

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indwelling catheter and wounds. V14 verified V30 should have been wearing a gown during cares.

5. R8's care plan, dated 10/16/25, documents "(R8) has pressure ulcers related to urinary and bowel incontinence, impaired mobility, venous insufficiency, Chronic Kidney Disease, Diabetes Mellitus Two and Anemia." This same care plan also documents "Enhanced Barrier Precautions: Wear gowns and gloves when changing linens, providing direct personal care to resident."

On 10/21/25 at 10:35 AM, R8 was sitting in his room in a reclined wheelchair with his eyes closed. R8's door and entry way contained a sign documenting R8 is in Enhanced Barrier Precautions.

On 10/21/25 at 11:05 AM, V23 and V24 (Licensed Practical Nurses) entered R8's room and completed wound care to R8's right heel pressure ulcer. Throughout the wound care, V23 and V24 did not wear a gown.

On 10/21/25 at 11:13 AM V23 confirmed she only wore gloves during the wound care for R8. V23 stated "I don't wear a gown for (R8's) wound care, only gloves. For residents with catheter care, I don't believe staff gown up either. I just wear gloves. Looking at the sign now, I probably am supposed to wear a gown."

(B)

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340.1440c)
340.1440d)

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S9999	Continued From page 7 340.1440e) Section 340.1440 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 facility administrator. (Section 3-610 of the Act) c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act) e) Employee as perpetrator of abuse. 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) These requirements are not met as evidenced by: Based on Observation, Interview and Record Review, the facility ensure residents were kept free from misappropriation, immediately report an	S9999		

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allegation of theft to the facility's abuse coordinator, state agency and local law enforcement, conduct prompt misappropriation investigations, and prevent the alleged perpetrator from further contact with residents in the facility for two of four residents (R1, R11) reviewed for misappropriation in the sample of 12. This failure resulted in R1's report of misappropriation going un-investigated for 15 days, R1's bank debit card being taken and used (unauthorized) at local retailers and R1's bank account dwindling from $439.31 dollars to $0 dollars in one day.

Findings include:

The Abuse Prevention, Reporting and Investigation Policy, dated 7/2015 documents, "Purpose: To establish a resident sensitive and resident secure environment in which personnel are doing all possible to provide for the physical and emotional safety of residents of (the facility). Staff will follow proper prevention, reporting and investigation procedures as they become aware of incidents or are witness to incidents. Policy: All (facility) employees are committed to being proactive in providing for the well-being of all residents by the recognition and prevention of abuse and training and prevention measures. All alleged reports of patient abuse and neglect will be immediately reported and fully investigated. (The facility) will not tolerate abuse of our residents. New employees will be educated regarding the facility prevention, reporting and investigation of abuse policy. The penalty for resident abuse by employees will be discharged. Definitions: The following definitions are based on federal and state laws, regulations, and interpretive guidelines. Misappropriation of Property (Financial or Material Exploitation): The

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illegal or improper use of resident's funds, property, or assets. Examples include, but are not limited to, cashing a resident's checks, using a resident's credit card, forging a resident's signature, misusing, or stealing resident's money or possessions; coercing or deceiving resident into signing any documents (e.g. (example) contracts or wills); and the improper use of conservatorship, or power of attorney. Signs and symptoms of financial or material exploitation may include but are not limited to: Unexplained disappearance of funds or valuable possessions. A resident's report of financial exploitation. Procedure for Reporting Abuse: Any staff who observe or suspect abuse must report it immediately to their immediate supervisor. The facility Administrator or his designee will notify Illinois Department of Public Health and DVA (Department of Veterans Affairs) Central Office. If there is reasonable cause to believe abuse occurred, an employee accused of resident abuse will be removed from resident contact immediately. Nursing staff will notify residents POA (Power of Attorney) or legal representative and document notification of residents POA or legal representative in the electronic health record. If resident is capable of providing information, the Nursing Supervisor and MSW (Master Social Worker) will interview the resident and document in the electronic health record. The resident will review and sign his/her statement if able. A copy will be forwarded to the Director of Social Services. The MSW will prepare report of mental status assessment and forward to the involved nursing supervisor and Director of Social Services. Upon completion of the resident interview, the MSW will notify the direct care social worker who will assess the resident for any psychosocial problems associated with the alleged abuse and reporting process, such as

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adjustment difficulties and/or fear of retribution. The social worker will alert nursing staff or Nursing Supervisor and/or physician as needed of any problems and document accordingly. The Nursing Supervisor will notify resident's POA or legal representative of the outcome of the investigation and document in the interdisciplinary notes. Procedure for Facility Investigation of Abuse: If State or local law enforcement officials become immediately involved in the investigation of alleged abuse, those officials will be the coordinators of the investigative process. In their absence, facility staff will investigate abuse allegations. When an incident of financial abuse and/or misappropriation of property or material exploitation is reported, the facility's chief of security will be responsible for overseeing the investigation of the incident. The results of all interviews and statements obtained, and conclusions of the investigator will be documented."

1. R1's computerized Medical Record documents that R1 is a 74-year-old male that admitted to the facility on 8/30/23 with diagnoses which included Personal History of Malignant Carcinoid Tumor of Rectum, Type 2 diabetes Mellitus, Heart Failure, and Orthostatic Hypotension. There is no documentation in R1's Medical Record that R1 had any property or Debit Card stolen. R1's medical record does not document any Social Services notes related to theft, or that Social Services has talked to or assisted R1 with his concerns of his stolen property.

R1's MDS (Minimum Data Set) assessment dated 7/18/25 documents a BIMS (Brief Interview for Mental Status) of 15, indicating R1's cognition is intact.

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On 10/20/25 at 11:35 AM, R1 stated that he noticed on 10/6/25 that his Debit Card was missing from his locked security box and R1 reported it to an unidentified nurse on 10/6/25. R1 had no idea who took the Debit Card. The key to the lock box was on an elastic band around R1's wrist. R1 stated that previously the key was kept next to his bed or in the pouch on the side of his wheelchair. R1 stated he had called the bank when he realized the Debit Card was missing and was told that about 350 dollars was spent at a (local major retailer), around 50 dollars at a (local body lotion shop), and the rest at a (local women's clothing store). R1 stated that he did not make any of these purchases and the last time he had used the card was on 10/4/25. R1 also stated that prior to his Debit Card being stolen he was missing about 200 dollars cash from his locked security box. R1 stated he reported the money missing to an unidentified nurse prior to the missing Debit Card. R1 also stated the only personal property he has had taken is the cash and his Debit Card. When R1 reported the cash missing no one asked him any questions about it. R1 stated security and the police did not come speak to him until after his Debit Card was missing. R1 also stated "I'm very upset about my money being taken. They took it all and my balance is now zero. I came here to be taken care of. I didn't expect for this to happen. I called the bank this morning to get a new Debit Card and hopefully I can get my money back."

On 10/20/25 at 1:32 PM, V13/Executive Secretary stated that V7/Certified Nursing Assistant/CNA is on unpaid leave pending judicial outcome.

On 10/20/25 at 1:40 PM, V7/CNA (Certified Nursing Assistant) stated that the facility accused her of stealing R1's Debit Card. V7 stated the

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local police came to the facility on 10/17/25 while V7 was working and arrested V7. V7 stated she was taken to the police station and charged with theft. V7 confirmed the last day she worked at the facility was 10/17/25. V7 also stated that she was surprised when she was arrested because V7 had not been questioned by the facility about the missing card. V7 stated she had worked the weekend (10/12/25), then not again until 10/17/25. V7 stated she was in a resident's room when V31/Nursing Supervisor told V7 to go to the office on the unit. V7 stated there were two police officers in the office and V7 was arrested.

R1's Incident Report written by V15/Nurse Practitioner dated 9/30/25 documents Nature of Incident "Theft." On 9/29/25 at 1:00 PM, (R1) reported to me (V15) that he (R1) has had personal belongings taken from his lock box in his bedroom." Residents Cognitive Status: "Alert." Action Taken: "(Unit) Supervisor (identified as V31/Nursing Supervisor) notified. Actions taken by Supervisor: "E (Electronic)-Mailed Security Chief (V5) 10/2/25 at (5:15 AM)."

On 10/20/25 at 1:52 PM, V5/Chief of Security stated he was told by V15/Nurse Practitioner that R1 had some belongings missing. V5 stated originally, he thought it was clothing, but a week later V5 was told that R1 was missing a Debit Card. V5 stated he called the local police department, and the police went to a (local major retailer) and saw on video that V7/CNA had used R1's Debit Card. V5 stated the police also suspect that V7 used the card at a (local women's clothing store) and a (local body lotion shop). V5 stated that V7 was arrested on 10/17/25 while at the facility working. V5 also stated that he believes it was on Monday (10/13/25) that V5 first heard R1's Debit Card was missing. V5 stated V7

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had worked the weekend (10/10 -10/12/25) and was not scheduled to work again until 10/17/25. V5 stated V7 came to work on 10/17/25 and V6/Police Officer came to the facility and arrested V7. V5 also stated V5's first knowledge of R1 having missing items was when V5 got the incident report (dated 9/30/25) the first week of October through office mail. V5 stated "I hadn't got a chance to talk to (R1) yet. I wasn't aware that there was any money involved because the report said personal items. It was the middle of October when I heard about the Debit Card missing and I immediately called the (local) police and turned it over to them." V5 stated that he did not have any other documentation about R1's missing items other that the 9/30/25 Incident Report and 10/14/25 Missing Property Report.

On 10/21/25 at 9:09 AM, V15/Nurse Practitioner stated that she did not remember any specifics about R1's missing items that V15 had reported. This surveyor told V15 that the first report filled out by V15 about personal property from R1's lock box was dated 9/30/25. V15 stated "Then I would go off that. My main focus is on patient care. I don't remember specifics about the incident. I let V33/Nurse Supervisor know." This surveyor asked what the personal items R1 had missing were and V15 stated "I think it was about money." V15 also stated "Then last week (R1) said he had a missing Debit Card and I let V33/Nursing Supervisor know." V15 stated "Last week I overheard people talking about the incident, but I wasn't involved in any of that. I take care of the resident's medical needs."

On 10/21/25 at 9:58 AM, V1/Administrator stated that he is the Abuse Coordinator and does not know much about R1's incident other than what was reported. V1 stated he does not know when

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he was notified about R1's missing property and stated he thinks it was last week (10/13 or 10/14/25). V1 stated the first thing he heard about R1 was that a Debit Card was missing. V5 stated he heard there was money missing from R1's bank account and confirmed the police were able to identify the staff (V7/CNA) that used the card and then (V7) was arrested. V1 also stated Abuse from staff to resident or resident to resident should be reported within two hours to (the state agency). So, should this have been reported? If we proved it was in fact stolen, then it would be reported."

On 10/21/25 at 10:21 AM, V2/Director of Nursing stated "I heard about (R1's) Debit Card on Monday (10/13/25) but did not report it to (State agency) until 10/17/25, after (V7/CNA) was arrested. I can't report something that has not been proven. I guess that is on me. I did not do any investigation on (R1's) missing Debit Card because it was handed over to the Police Department to see what they found. I did not know about the 9/30/25 report on (R1's) missing property until (V5/Chief of Security) let me know. (V5) already had the report and I have no explanation to why nothing was done. There was no other investigation. I don't know what the first report (9/30/25) was about. It would be my assumption that it would be items of value since it was in a locked security box. (V5) handles those incidents."

On 10/22/25 at 11:04 AM V33/Nursing Supervisor stated that she is on vacation and has no dates in front of her but thinks the first incident on R1 was reported at least a couple of weeks ago. V33 stated, V15/Nurse Practitioner came to V33 after doing resident care rounds and reported that R1 said R1's personal property was taken from his

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locked security box. V33 stated she had V15 fill out an Incident Report and V33 sent the report to V5/Chief of Security. V33 also stated "I did not contact (V1/Administrator/Abuse Coordinator) directly, I told (V2/Director of Nursing)." V33 stated she is not sure if an investigation was done or not because V33 turned the issue over to security. V33 was asked what personal property of R1's was missing. V33 stated "I didn't ask." V33 stated that she suspected it was money or valuables since it was taken from R1's locked security box and the box is not large enough to hold any items like clothing. V33 stated "The box is about the size of a shoe box." V33 also stated that on 10/17/25 around 7:15 AM, V33 was told to find V7/CNA and take V7 to the office on the Unit. V33 stated V7 was in a resident room, taking care of (R12). V33 stated she took V7 to the office where V2/DON, V5/Chief of Security, and the local Police Officers were. V7 was then arrested. V33 confirmed V7 had started her shift at 6:45 AM that day and was time clocked out after 7:15 AM.

On 10/22/25 at 11:23 AM, V2/DON stated that V1/Administrator is the Abuse Coordinator and that an incident about missing money is either investigated by the Unit Supervisor or Security. V2 stated "It depends on the dollar amount who does the investigation. If it is over 100 dollars it is sent to (V5/Chief of Security). Then if (V5) thinks it needs reported to the (Local) Police Department (V5) will contact them."

R1's Missing Property Report dated 10/14/25 documents Individual Initiating Report: V15/Nurse Practitioner. Missing Property Information "Personal Items and a Debit Card." Estimated Date of Loss: 10/4/25, Estimated Value of Items: 450 dollars. Explain how Value was

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Substantiated: "I (V15) was notified that (R1) realized that he was also missing his Debit Card." Describe the Situation: "(R1) realized he was missing his debit card after he reported personal items missing. (R1) also checked with his bank and the card had been used at a (local major retailer) and some other places." Person Completing Report: V5/Chief of Security dated 10/14/25. Individual Designated to Follow-Up V5/Chief of Security. Actions Taken: "I (V5) talked to (R1) and once (R1) explained that his Debit Card was also missing, and it had been used on 10/6/25 at (local major retailer) and (R1) thinks another place. I called (local Police Department) to have a report completed for this." Signed by V5/Chief of Security dated 10/14/25. Police Report Filed: Yes, Report # (number) 25-24530. Outcome of Action(s): "(V6/Local Police Officer) came to (Unit at facility) and talk to (R1). Once (V6) had the information from (R1), (V6) went to the (local major retailer). (V6) was able to view video at (local major retailer) and it was determined that (V7/CNA) was the individual that used (R1's) Debit Card. (V6) is waiting for confirmation from (local women's clothing store) and (local body lotion store), if (V7) also used the Debit Card there. (V6) arrested (V7) for Financial Abuse of the Elderly." Signed by V5/Security Chief dated 10/17/25.

R1's Initial Incident Report dated 10/17/25 sent to (the State agency) documents "On 10/14/25, (the facility) Chief of Security (V5) spoke with (R1) regarding documentation (V5) received regarding (R1's) missing Debit Card. (R1) is alert and oriented and informed (V5) that (R1's) Debit Card was used at (local major retailer) and (R1) thinks another place. (local) Police Department was notified regarding this incident, (V6/Police Officer) was notified regarding this incident, (V6)

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conducted his investigation after speaking with (R1), (V6) was able to view video at (Local Major Retailer) and it was determined that it was a (facility Certified Nursing Assistant) that used (R1's) Debit Card. (V6) is waiting for confirmation from (local women's clothing store) and (local body lotion shop) if suspect used (R1's) Debit Card there as well. On 10/17/25, (V6) arrested employee (V7) in question for Financial Abuse of the Elderly." Case number 25-24530.

The Police Report 25-24530 dated 10/20/25, documents that V7/Certified Nursing Assistant stole R1's Debit Card ending in 9454 and $439.31 (dollars) was stolen from R1's bank account. This report documents "Offense Description: Financial Exploitation of Elderly, Possession of Another's Credit/Debit Card, and Theft Under $500." This same report documents V6 (local Police Officer) was able to obtain video surveillance footage of V7 using R1's debit card at a local major retailer. This same report documents "(V7) was lodged in the local county jail for charges of Financial Exploitation of the Elderly, Possession of another's credit debit card, theft under $500, and retail theft. (V7) was employed by (the facility) and was in a position of trust and was supposed to be taking care of the residents."

R1's Bank Statement dated 10/21/25 at 4:55 PM, documents the following unauthorized purchases from R1's bank account on 10/6/25: (local body lotion shop) $47.04, (local women's clothing store) $58.30, and (local major retailer) $333.97, leaving R1 with a bank balance of zero dollars.

V7/CNA's Timecard dated 10/17/25 documents V7 clocked in at 6:40 AM and clocked out at 7:20 AM.

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2. R11's computerized Medical Record documents that R11 is an 84-year-old male that admitted to the facility on 7/25/243 with diagnoses which included Atherosclerotic Heart Disease, Essential (Primary) hypertension, and Chronic Kidney Disease (Stage 3). R11's Medical Record does not document that R11 has had any money missing. This same record does not document Social Services has talked to or assisted R11 with his concerns of his missing money.

R11's MDS (Minimum Data Set) assessment dated 7/23/25 documents a BIMS (Brief Interview for Mental Status) of 15, indicating cognition intact.

On 10/20/25 at 11:25 AM, V10/Charge Nurse stated that he had heard about the theft of R1's Debit Card on 10/14/24 when the police came to the facility. V10 also stated that he heard that R11 (R1's Roommate), reported R11 was missing 100 dollars.

On 10/20/25 at 1:52 PM, V5/Chief of Security stated that he had heard about R11 reporting that he had 100 dollars taken about the same time as R1 was missing his Debit Card. V5 stated that V5 told V6/Police Officer to add R11's incident in with R1's report of missing items. V5 also stated that there was no investigation into R11's money missing but V5 is sure it is connected to R1's incident.

On 10/21/25 at 9:58 AM, V1/Administrator that he is the Abuse Coordinator. V1 stated that he had not been told that R11 was missing any money. "I'm not aware that an investigation was done for (R11). As the Administrator I should have been notified."

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On 10/21/25 at 10:21 AM, V2/DON stated that she has no documentation that there was an investigation into R11's missing money and confirmed there was not a report sent to the (State agency), and R11's POA (Power of Attorney V16) was not notified of the incident.

On 10/21/25 at 11:34 AM, V11/Housekeeper stated last week while she was cleaning R11's room R11 said he was missing 100 dollars. V11 stated that R11 said he had already reported to security about the missing money.

On 10/21/25 at 1:10 PM, V16/R11's Power of Attorney stated that she got a call from V17/R11's Family Member on 10/14/25 that R11 had around 100 dollars stolen. V16 also stated "I was never notified by the facility about (R11's) money being taken. The only way I knew was that I got a call from a family member. I would have liked to have been notified by the facility and told what was going on there."

On 10/21/25 at 1:29 PM. V17/R11's Family Member stated that she was visiting R11 on 10/14/25 at 12:30 PM when a Police Officer and facility Security Officer were interviewing R1 about R1's Debit Card being stolen. V17 stated they were talking to a bank representative for verification of how much was taken. V17 then stated "After the police officer left, I asked (R11) if he had checked his money. (R11) checked his lock box and found his money was missing. (R11) always keeps around 100 dollars to 150 dollars folded with a black hair tie around it. It was all gone. The Security Officer wrote down the information and then I don't know if anything was done."

R11's medical record and the facility's local police

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department report from R1's October 2025 theft incident, do no indicate that R11's money was ever located, investigated or reported to the state agency after the facility was notified of R11's allegation.

(B)

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340.1950 a)

Section 340.1950 Food Preparation and Service

a) Every facility shall comply with the Department's rules entitled "Food Service Sanitation" (77 Ill. Adm. Code 750).

This requirement was NOT met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure dishes reach the required hot water sanitation surface temperature of 180 degrees, during the rinse cycle of the automatic dishwasher. This failure has the potential to affect all 233 residents residing in the facility.

Findings include:

The facility's Warewashing Temperature Checks policy, dated 12/2024, documents "To ensure all automatic warewashing equipment with the Dietary department maintains proper temperature as required but the Illinois Department of Public Health Food Service Sanitation Code of 2008. Assigned Dietary staff will check and log the temperature of automatic warewashing equipment and inform supervisor of any

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S9999	Continued From page 21 equipment that is not within appropriate guidelines." The facility's Dish Machine Temperature Log (undated) documents, Required Temperatures: final rinse/sanitize 180 degrees. On 10/21/25 at 11:30 AM, the facility's automatic dish machine was viewed while in use and contained an outside digital thermometer for water temperature results. V27 (Dietary Manager) stated "The dish machine final rinse should reach 180 degrees for sanitation. Staff check the temperature on the dish cycle three times a day by looking at the gauge on the outside. Nothing is run through the machine to check surface temperature accuracy. We just look at the thermometer on the outside." V27 confirmed there is not a daily check done to ensure the outer thermometer is accurate for sanitation. The facility's Daily Census Report, dated 10/19/25 and provided by V2 (Interim Director of Nursing), documents 233 residents currently reside in the facility. (C)	S9999		