STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057877	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARRY HEALTHCARE & SR LIVING	**1313 PRATT STREET , BARRY, Illinois, 62312**

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S0000	Initial Comments Annual Licensure Survey	S0000		01/26/2026
S9999	Final Observations Statement of Licensure Violations: 1 of 3 300.610a) 300.1210a) 300.1210b) 300.1210d)6) 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	S9999		01/26/2026

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

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S9999	Continued from page 1 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. 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. These requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to implement and document new fall interventions after a fall for 1 (R50) of 4 residents who was assessed to be high fall risk upon admission to the facility. This failure resulted in R50 falling, sustaining a hematoma to her head and 2 rib fractures, and subsequently being transferred to the emergency room for treatment. Findings include: R50's Undated Face Sheet documents R50 was initially admitted to the facility on 12/27/2024 with diagnosis of dementia and osteoarthritis. R50's Care Plan, dated 12/29/2024 and revised 11/24/2025 documents the resident is a high risk for falls R/T (related to) history of falls. The resident will not sustain serious injury through the review date. The resident will be free of falls through the review date. R50's Quarterly Minimum Data Set (MDS) dated 8/14/2025 documents R50 was cognitively impaired, had a history of falls and uses a wheelchair.	S9999		

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S9999	Continued from page 2 R50's Fall Risk Data Collection, dated 8/15/2025 documents she was high risk for falls. R50's Progress Note, dated 8/23/2025 9:11 PM, documents CNA (Certified Nurse Aide) informed writer that she heard the resident yelling while in another patient's room. Writer went to assess the situation and found R50 lying in the middle of the floor. Her feet facing the door, while entrapped in the bottom of the isolation bin. Her head facing the bathroom door. Her wheelchair was sitting next to her legs, on the right side, unlocked. A basin full of water sat by her head. Water spilled all over the floor. She is wearing regular socks. No shoes. Call light is on the bed, not in use. Writer asked resident how she ended up entangled in the isolation bin on the floor. Resident stated she was trying to get in her car and thinks she may have fell. Writer assessed the resident and found redness to the back. No complaints of pain or discomfort to the back area. Resident had complaints of pain to the BLE (bilateral lower extremities.) 7+. writer assessed the area and found that she only had complaints of pain to the areas where edema is present. Scheduled narcotic given and effective. Neuro (neurological) checks initiated. ROM (Range of Motion) completed on all extremities with no difficulty to upper extremities and little difficulty to lower extremities. Dr (doctor) office notified. DON (Director of Nurses) notified as well. R50's Care Plan, dated 8/23/2025 an intervention documented ensure non-skid socks are on. R50's Health Status Note, dated 10/1/2025 at 5:11 AM documents, resident had an unwitnessed fall around 4:30 AM. She has a new skin tear on her L (left) elbow which was cleaned and dressed. She denies hitting her head. Resident has no other new marks or injuries. R50's Care Plan, dated 10/1/2025 an intervention documented remind resident to wear non-skid footwear and remind staff to make sure she has them on when needed. R50's Health Status Note, dated 10/3/2025 at 11:17 PM, documents CNA notified writer that when she was walking down the hall, she heard a faint "help me". She opened bedroom doors and found resident sitting on the floor. Writer immediately went to assess the situation and found resident sitting on the floor in front of her dresser. The two bottom drawers were on the floor. Her wheelchair was in the corner, unlocked. Her walker was next to the bed. She had on regular socks and a depend. Blood was behind her on the floor. Writer asked	S9999		

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S9999	Continued from page 3 resident how did she end up on the floor. Resident told writer to worry about someone else. She knows what she is doing. Skin tear to left hand cleanse and dry dressing applied. Has a hematoma to the left side of the forehead. Complaints of hitting head when fallen. Complaints of head and bilateral knee/hip pain. 8/10. ROM (Range of Motion) completed on all extremities. Mild difficulty to lower extremities. Eyes slow to react from neuro check. Speech began to slur. CNA's lifted from ground into wheelchair. Placed in pajamas. Ambulance called and arrived at 2300 (11:00 pm) to transport to hospital. Message faxed to doctor. R50's Serious Injury Incident and Communicable Disease Report, dated 10/3/2025 documents R50 fell on 10/3/2025 at 11:00 PM CNA notified nurse that when she was walking down the hall she heard a faint, "help me." She opened bedroom doors and found resident sitting on the floor. Nurse immediately went to assess the situation and found resident sitting on the floor in front on her dresser. The two bottom drawers were on the floor. Her wheelchair was in the corner, unlocked. Her walker was next to the bed. She had on regular socks and a depend. Blood was behind her on the floor. Nurse asked resident how did she end up on the floor. Resident told nurse to "worry about someone else. She knows what she is doing." Skin tear to left hand cleanse and dry dressing applied. Has a hematoma to the left side of the forehead. Complaints of hitting head when fallen. Complaints of head and bilateral knee/hip pain. 8/10. Ice pack applied to head and neuros started. ROM completed on all extremities. Mild difficulty to lower extremities. Eyes slow to react from neuro check. Speech began to slur. Ambulance arrived at 11:00 PM to transport resident to the hospital. MD (physician) and POA (Power of Attorney) contacted. ER (Emergency Room) at hospital per RN (registered nurse) called with report with 2 fx (fracture) ribs one on each side. Incentive spirometry use as often as possible per doctor at ER. Resident returned to facility at 2:01 AM Resident still non-complaint with asking for assistance after re-educated about call light and needing assist. R50's Emergency Department (ED) Clinical Care Summary, dated 10/3/2025 and 10/4/2025 documents chief complaint: fall. The resident had extensive tests done, including CT head and chest and a left shoulder x ray. R50 sustained right 10th a left 2nd rib fractures was documented. Discharge diagnoses includes rib fractures. On 1/15/2025 at 11:05 AM R50 was sitting up in her wheelchair in her room. R50 was awake and stated, "Everyone keeps asking me all about that fall when I hit my head and broke my ribs and I don't want to talk	S9999		

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S9999	Continued from page 4 about it anymore, I don't remember what happened and I don't care to remember." There was a call don't fall sign above R50's bed and in her bathroom as well. On 1/15/2026 at 10:56 AM V2, Director of Nurses (DON) stated when a resident falls staff call the on-call staff which is her, V3 ADON (Assistant Director of Nurses) or V1, Administrator which is an LPN (Licensed Practical Nurse) and they ask what exactly occurred regarding the fall and what injuries, if any were sustained. V2 stated when a resident falls, she tells staff an immediate intervention then she reassesses the intervention when she works again to ensure the intervention is appropriate. V2 stated after a fall the intervention should be a new intervention and not an intervention that was already documented on the resident's care plan. The point of the intervention post fall is to prevent future falls. V2 stated R50 was admitted from an assisted living facility, and she has always been noncompliant with waiting for staff to assist her prior to getting up. V2 stated when staff added the intervention for nonskid socks to R50's care plan on 8/23/2025 she expected staff to ensure R50 had nonskid socks on at all times then she fell again on 10/3/2025 V2 stated she read R50 didn't have the nonskid socks on and she was transferred to the emergency room because staff assessed her and she had hit her head. V2 stated R50 had a hematoma on her head and the emergency room called and reported R50 sustained two fractured ribs as well. On 1/16/026 at 10:30 AM V9, Nurse Practitioner (NP) stated when a resident is assessed to be a high fall risk, she expects that to be addressed in the resident's care plan along with interventions to prevent falls. When a resident falls staff are expected to implement and document the new intervention on the resident's care plan. She expects staff to assess if that intervention is effective and if not to change it. V9 stated she expected staff to follow the facility's fall policy and to put implement a different/progressive intervention between falls on the resident's care plan. The facility's Fall Policy Revised 3/18, documents if falling recurs despite initial interventions staff will implement additional or different interventions. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature of or category of falling, until falling is reduced or stopped. In conjunction with the attending physician, staff will identify and implement relevant interventions to try to minimize serious consequences of falling. If the resident	S9999		

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S9999	Continued from page 5 continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified. (B) 2 of 3 300.610a) 300.1210b) 300.1210d)3) 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 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. 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. These requirements were not met as evidenced by:	S9999		

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S9999	Continued from page 6 Based on observation, interview and record review, the facility failed to assess one newly admitted resident 1 of 1 resident (R69) reviewed for pain management in the sample of 30. The facility also failed to administer PRN (as needed) pain medication and to get report from the previous facility. This failure resulted in a nonverbal resident (R69) yelling/screaming out for over 18 hours without being assessed for pain. A reasonable person who was yelling/screaming for hours would feel intense and overwhelming sensations of pain causing emotional distress. Findings include: R69's Previous Facility Documentation states she arrived at the facility with documented diagnosis including chronic pain and Lupus (an inflammatory disorder.) Physician's orders from previous facility included PRN (when needed) pain medication. R69's Unsigned and Handwritten Baseline Care Plan, dated 1/15/2026 documents R69 is dependent with bed mobility, locomotion, bathing, toileting, transfers, dressing and eating. No documentation that resident is yelling/screaming, cognition and communication of verbal or nonverbal not documented. R69's Undated Face Sheet, documents she was initially admitted to the facility on 1/15/2026 with diagnoses including Lupus, anxiety and insomnia, no chronic pain diagnosis documented on R69's face sheet. R69's Health Status Note dated 1/15/2026 at 2:00 PM V10, Licensed Practical Nurse (LPN) documented resident admitted from previous nursing home in a van via geri chair. Resident yelling out. Resident very restless, grabbing at groin area. No pain assessment documented. On 1/16/2026 from approximately 2:00 PM to 2:45 PM Illinois Department of Public Health (IDPH) surveyors heard R69 yelling continually as she lay in bed. R69's Physician's Order Sheet (POS), dated 1/15/2026 documents Tylenol 650 milligrams (mg) PRN for mild pain and Ativan 1 mg PRN for severe anxiety. No scheduled pain medication was ordered. R69's Medication Administration Record (MAR) dated 1/15/2026 no documentation PRN Tylenol was administered. At 8:25 PM V12, LPN documented Ativan 1 mg was administered and documented "E" for effective. No documentation of an assessment. No documentation of a pain assessment every shift documented either.	S9999		

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S9999	Continued from page 7 R69's Progress Notes, dated 1/15/2026 no documentation of assessment for R69 when V12 administered Ativan 1 mg PRN at 8:25 PM R69's Electronic Medical Record dated 1/16/2026 at 9:15 AM no documentation of a pain assessment or admission nurse assessment documented or baseline care plan documented. R69's MAR documents R10 administered PRN Tylenol on 1/16/2026 at 8:20 AM. The pain was documented a 6 and was documented ineffective. R69's POS dated 1/16/2026 at 10:44 AM staff documented pain assessment every shift for admission protocol. No documentation prior to this time of an admission pain assessment. R69's Pain Evaluation with Interview, dated 1/16/2026 at 12:54 PM documents the resident is rarely or never understood. Staff assessment for pain: non-verbal sounds (e.g. crying, whining, gasping, moaning or groaning.) Frequency with which resident complains or shows evidence of pain or possible pain: indicators of pain 1 to 2 days. What makes the pain better: Fibromyalgia. What makes the pain worse: moving around a lot. Received scheduled pain medication regimen: No. Received PRN pain medications or was offered and declined: Yes. Describe administration patterns, any side effects and effectiveness: PRN Tylenol. Received non-medication intervention for pain? Yes. Describe interventions and effectiveness: Positioning. No comments documented. On 1/16/2026 at 9:00 AM through 10:20 AM R69 was observed laying in bed yelling/screaming out. R69 didn't respond to surveyor's questions and was not verbal at that time. On 1/16/2026 at 11:25 AM V14, CNA (Certified Nurse Aide) and V15, CNA transferred R69 from bed to geri chair with a Hoyer lift. R69 yelled/screamed during the transfer. On 1/16/2026 at 11:29 AM V14, CNA stated she was assigned to R69 today and she started at 6:00 AM and when she got to the facility R69 was yelling/screaming and the nurse (name unknown) told her, "That's just what she does." R14 stated R69 was a new resident and she didn't know anything about her but she seemed to be in pain and stated R69 is nonverbal and doesn't respond to questions. On 1/16/2026 at 11:31 AM V15, CNA stated she worked on	S9999		

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S9999	Continued from page 8 1/15/2026 and was here when R69 was admitted to the facility, and she was yelling/screaming upon admission. V15 stated she left the facility at approximately 2:00 PM and so she didn't know much about R69. V15 stated she got to work today at 6:05 AM and the night shift CNA (name unknown) gave her report that R69 was awake yelling/screaming all night long other than for an hour. V15 stated R69 was nonverbal and doesn't respond to questions. On 1/16/2026 at 12:15 PM R69 was observed up in a geri chair in the dining room yelling/screaming out while staff attempted to feed her lunch. On 1/17/2026 at 10:45 AM V10, LPN stated she admitted R69 on 1/15/2026. R69 arrived to the facility at approximately 2:00 PM and she was restless and yelling upon admission. V10 stated R69 was admitted from another nursing home but she didn't get nurse report from the previous nursing home because no one from that facility called her back so she didn't know if R69 being restless and yelling out was normal for her or if she had a change in condition. V10 stated she assessed R69's skin and completed some of the admission paperwork but she had a lot going on with other resident's so when the night shift nurse (V12, LPN) at approximately 6:00 PM so gave report that R69 had been yelling out since she was admitted to the facility at 2:00 PM that day and that the nurse admission assessment wasn't completed including the baseline care plan and she expected V12 to work on it during the night shift. V10 stated when she left the facility on 1/15/2026 at approximately 7:00 PM R69 was laying in bed yelling out continuously. V10 stated she understood R69 had a diagnosis of chronic pain and Lupus but she didn't administer PRN pain medication and V10 stated she didn't know why she didn't. V10 stated the admission pain assessment is part of the admission nursing assessment so it hadn't been done yet. V10 stated when she got to work on 1/16/2026 at approximately 6:00 AM she heard R69 yelling out and the night shift nurse, V12 gave her report that R69 started yelling at approximately 5:30 AM. V10 stated she assessed R69 while she administered her morning medications on 1/16/2026 at 8:15 AM and she administered PRN Tylenol at 8:20 AM for possible pain and she reassessed R69 at 9:20 AM and stated the PRN Tylenol was ineffective. V10 stated she dropped the ball and she should have assessed and documented a nonverbal pain assessment when R69 was admitted to the facility and should have administered PRN Tylenol after the assessment as well and she should have notified the provider to let them know the resident was admitted to the facility and was yelling out.	S9999		

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S9999	Continued from page 9 On 1/16/2026 at 12:32 PM V12, LPN stated she worked 12 hours night shift on 1/15/2026 into 1/16/2026 and she arrived to the facility at 5:58 PM. V12 stated she immediately heard a resident yelling out from the 300 hall. V12 asked the day shift nurse, V10 who was yelling and why and V10 gave her report that R69 arrived a few hours ago and that she continuously yells. V12 stated V10 told her she started R69's admission nurse assessment but that it wasn't complete, so V12 planned on completing it at some point that shift. V12 stated that night was crazy meaning a lot of residents needed a nurse and she was running all over the facility so she didn't complete R69's admission nurse assessment or her baseline care plan. V12 stated she administered bedtime medications to R69 and she recalled R69 continued to yell out. V12 stated she assessed a pain assessment on R69 which consisted of her placing her hand on R69's shoulder and asked if she was in pain. R69 stated R69 was nonverbal and didn't respond to her questions and continued to yell out. V12 stated looking back she didn't document that she assessed R69 for pain and she didn't do a nonverbal comprehensive pain assessment either. V12 stated she didn't have time to review R69's previous facility's medical records and she didn't know R69's diagnoses. V12 stated if she knew R69 had diagnoses of chronic pain and Lupus and she would have administered the PRN pain medication to see if it was effective. V12 stated she thought R69 was anxious, so she administered a PRN anti-anxiety medication to her instead of pain medication. V12 stated she was running around the entire facility that shift and from what she could recall she thought R69 slept from approximately 10:30 PM to 5:30 AM but she could be wrong because she was working with residents on other halls that shift and wasn't on 300 hall all night. V12 stated she didn't have time to complete R69's admission nursing assessment that shift and she let V10 know that when she arrived to the facility on 1/16/2026 at 6:00 AM. On 1/16/2026 at 1:10 PM V2, DON (Director of Nursing) stated she was concerned R69 was in pain due to her yelling and screaming out so she reached out to R69's provider via fax on 1/15/2026 at approximately 2:30 PM and documented R69 has Lupus, and the resident was in pain and requested something stronger for pain. V2 stated she didn't receive a response back from that fax that she's aware of and didn't know anything about a new order for Celebrex for R69. V2 stated she spoke to V11 (Nurse Practitioner 2) and she stated she would come and assess R69 sometime today, but she didn't say when and she didn't mention the Celebrex new order either. V2 stated when a resident is nonverbal, she	S9999		

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S9999	Continued from page 10 expects staff to do a nonverbal comprehensive pain assessment which includes assessing if the resident is yelling out, facial grimacing and/or guarding. V2 stated when a resident is in pain you can usually visually tell. V2 expected staff to review R69's medical record for diagnoses of pain and expected the admitting nurse to assess R69 for pain and to administer the Tylenol PRN if it was needed and to document the pain assessment in R69's progress notes and should have documented the provider was faxed regarding a stronger pain medication. V2 stated she didn't know if R69 slept the night of 1/15/2026 into 1/16/2026. V2 stated the admission pain assessment is part of the nursing admission assessment and the admitting nurse should have documented the pain assessment upon admission and if it's not done the next shift nurse should have the nursing admission assessment completed but staff have 24 hours to complete the admission assessment. V2 stated when R69 was admitted to the facility she expected the admitting nurse to assess her including for pain and document that assessment in R69's progress notes. V2 stated it is standards of nursing practice to call and get nurse report from the facility the resident is being admitted from because then staff understand the resident's baseline. Staff didn't get ahold of the previous facility regarding R69. Staff reported to her they called three times, but no one called back. V2 stated she expected staff to report to her if they couldn't get report for a resident being newly admitted because it's important to have a baseline on the resident. On 1/16/2026 at 12:43 V14, CNA clarified that she got report from a night shift CNA (name unknown) and that she told her the R69 only slept 1 hour during the night and she yelled out the rest of the night. On 1/16/2026 at 4:00 PM V13, CNA stated she worked night shift on 1/15/2026 into 1/16/2026 and when she arrived to the facility at approximately 6:00 PM she heard R69 hollering out but she and another CNA V16, CNA swapped assignments and she didn't work with R69 that night but she spoke to V16 in the morning on 1/16/2026 before she left the facility at approximately 5:45 AM and V13 recalled V16 told her that R69 yelled all night long. On 1/16/2026 at 12:17 PM V11 (Nurse Practitioner 2) stated when a resident is admitted to the facility, she expects a nurse to assess the resident within 2-4 hours of admission and to document the assessment, including a pain assessment and to notify her as soon as possible if the facility has concerns. When a resident is nonverbal and yelling/screaming out the nurse should	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057877	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued from page 11 have assessed her for pain and then reviewed R69's medical record to see if she has a pain diagnosis and if she has pain medication prescribed. V11 stated she expected staff to administer the PRN pain medication and then to reassess her an hour later to see if the pain medication administered was effective, if the pain medications wasn't effective, she expected staff to notify her as soon as possible to let her know what the resident's status is so she can make a professional decision on how to proceed. V11 stated she received a fax from the facility on 1/15/2026 at 2:43 PM that documented R69 has Lupus and they requested something stronger for pain. V11 stated she responded to the fax before she left the office on 1/15/2026 and gave an order to start R69 on Celebrex 50 milligrams (mg) a day for the treatment of Lupus because it's a anti inflammatory and that should help with the Lupus pain. V11 stated she expected staff to call the previous facility and get nurse report on the resident prior to the resident's arrival so they know what her baseline is as that is standard practice. The Facility Pain Policy, revised 10/2022 states "The purposes of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. Pain management is defined as the process of alleviating the resident's pain based on his or her clinical condition and establishes treatment goals. Assess the resident at admission and during ongoing assessments to help identify the resident who is experiencing pain or for whom pain may be anticipated." The Facility Admission Assessment and Follow Up: The Role of the Nurse Policy, revised 9/2012 documents the purpose of this procedure is to gather information about the resident's physical, emotional, cognitive and psychosocial condition upon admission for the purposes of managing the resident, initiating the care plan and completing required assessment instructions. Conduct supplement assessment including pain assessment. Reporting: notify the supervisor and the attending physician of immediate needs that the resident may have. Report other information in accordance with the facility policy and professional standards of practice. (B) 3 of 3 300.610a) 300.615e)	S9999		

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S9999	Continued from page 12 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 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act) These requirements were not met as evidenced by: Based on record review and interview, the facility failed to obtain Background Checks within 24 hours on newly admitted residents for 5 (R33, R31, R65, R17, and R12) of 5 residents reviewed for Background Checks in the sample. This requirement was not met as evidenced by: Facility policy dated April 2021 states “Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident’s symptoms.” R33's Face sheet documents an admission date of 12/19/2025 and background check performed on 1/13/2026. R31's Face sheet documents an admission date of	S9999		

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S9999	Continued from page 13 12/17/2025 and background check performed on 1/13/2026. R65's Face sheet documents an admission date of 1/7/2026 and background check performed on 1/13/2026. R17's Face sheet documents an admission date of 1/15/2019 and background check performed on 4/23/2019. R12's Face sheet documents an admission date of 1/11/2022 and background check performed on 5/18/2023. On 1/16/2025 at 9:50AM V1, Administrator, stated “Our Social Services person does the background checks. I am aware some of them are behind.” On 1/16/2025 at 10:00AM V4, Social Services Director, SSD, stated “If I know we are going to get a new admit I will try to do the background check, but if the facility credit card does not have money on it then I cannot do it. The background checks are $10 and sometimes there is not $10 on the credit card.” The Facility’s Long Term Care Facility Application for Medicare and Medicaid (CMS 671) dated 1/13/26 documents there are 56 residents living in the Facility. (C)	S9999		