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A 000	Initial Comment Complaint Investigation IL199970 295.3000a) 295.4020f) 295.6000a)5)13) 295.6010a) Facility Reported Incident IL199798, IL19904 and IL199459 295.4010a)	A 000		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: Type 1 Violation Section 295.3000 Personnel Requirements, Qualifications and Training a) The establishment shall have staff sufficient in number with qualifications, adequate skills, education and experience to meet the 24 hour scheduled and unscheduled needs of residents and who participate in ongoing training to serve the resident population. (Section 35(a)(3) of the Act) Based on interview and record review, the facility failed to honor a resident's wishes of life sustaining treatment for one resident (R4). This failure resulted in staff performing CPR (Cardiopulmonary Resuscitation) on a resident (R4) with a DNR (Do Not Resuscitate) advanced directive. This failure creates a substantial probability of severe harm to a resident or residents.	A3000		

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A3000	Continued From page 1 Findings include: R4 was admitted to the Memory Care unit on 9/3/25 with a diagnosis of Alzheimer's , Atrial Fibrillation, Congestive Heart Failure, Overactive Bladder, and Cardiac Pacemaker. R4's medical record documents R4 has a POLST (Practioner Order for Life Sustaining Treatment) form that documetns "NO CPR: Do No: Attempt Resuscitation (DNAR)" and signed by R4 and a physician. R4's service plan documents "Advanced Directives/Code Status: (R4) wishes for end of life/resuscitation measures will be honored. (R4) requests a DNR status and a physician order has been obtained from her physician." R4's progress notes dated 1/16/2026 at 6:11 AM "Upon shift change at 06:11am, caregiver 1 (E8, Caregiver) was doing rounds to get residents up for the day. Upon caregiver 1 entering resident's room, resident was observed lying face down on the floor in her bathroom unresponsive. Immediately, caregiver 1 called Hospice to alert them of fall and get direction on what step to take next. Caregiver 1 states that hospice nurse said she will send an alert to the on call nurse and will have the on-call nurse call caregiver 1 back. At 06:19am, caregiver called assistant director or nursing as there was no floor nurse on duty at the time. Assistant director of nursing advised caregiver 1 to call 911 if the hospice nurse wasn't coming right away. Around 06:20, caregiver 1 made the call to 911 while still in resident's room. At that time, caregiver 1 called for help from caregiver 2 (E14, Caregiver). When caregiver 2 entered resident's room, she checked resident's pulse while caregiver 1 remained on the line with	A3000		

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A3000	Continued From page 2 911. Caregiver 2 reported she checked resident's carotid pulse and wasn't sure if it was resident's pulse or her own pulse. A few moments later, caregiver 3 entered the resident's room. She took the phone from caregiver 1 so that caregiver 1 could run and get the AED (Automated External Defibrillators) which was advised by the dispatcher. At that time, caregiver2 and caregiver 3 flipped resident to her back to start CPR. Caregiver 2 started compressions and continued compressions until caregiver 1 returned with the AED. Two rounds of 30 compressions were done by caregiver 2. At that time, AED pads were applied, however AED alerted "shock not advised". While AED was being used, EMT's arrived and took over. They asked if resident was a DNR, and once DNR was obtained, compressions were stopped. EMT's hooked resident up to EKG, and alerted caregivers that no heartbeat was noted on the EKG. Hospice nurse called back around 06:30am and caregivers alerted them there was no heart-beat. Hospice nurse stated she would be in shortly. Caregiver reports EMT's called coroner. Around 06:50am, staff nurse had arrived to community - shortly after, EMT's assisted resident off the floor and into her bed. Nurse then cleaned the blood off resident's face. Hospice nurse showed up around 07:00am and staff nurse and hospice nurse called daughter to alert her of resident's passing. Family stated they were not planning on coming to the community at that time. Coroner showed up around 09:00am." On 2/14/26 at 2:00 PM, E2, Director of Nursing stated that R4 should not have recieved CPR and that the staff should have checked the DNR list prior to performing CPR. On 2/14/26 at 8:17 AM, E14, Caregiver, was	A3000		

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A3000	Continued From page 3	A3000		

asked to give her account of the incident that happened on 1/16/26 with R4. E14 stated "I was working over on the Assisted Living side when I got paged and was asked to help with (R4). When I got over there, I went into R4's room and saw her lying face down on the floor. She was laying in the bathroom entryway facing out of the bathroom. (E8, Caregiver) was on the phone with the 911 dispatcher and they asked if she was breathing or had a pulse. Her lips were blue and she wasn't breathing. I checked and I think I felt a pulse, but I wasn't sure if I was feeling my own pulse since I was so nervous. Dispatch asked if she was a DNR and (E8) and I didn't know. Dispatch then advised us to start chest compression and told (E8) to go grab an AED until a DNR status could be confirmed. I rolled (R4) over and started chest compressions. (E8) arrived with the AED and we applied the patches to (R4), but it said shock not advised. At that time the EMTs arrived and asked if (R4) was DNR. (E8) and I said we didn't know. The EMTs said we needed to find out. That's when (E8) ran down to the RA (Resident Assistant) office to find out. We keep a list of who's a DNR at the RA (Resident Assistant) desk. (E8) came back and said (R4) was a DNR. That's when we stopped chest compressions and the EMTs took over. They hooked an EKG up to her (R4) and said there was no heartbeat." E14 was asked the amount of time it took from the time she started chest compressions to when R4 was identified to be a DNR. It seemed like a really long time. It took (E8) a while to find the DNR list. I would probably say I was doing chest compression for about 5-10 minutes." E14 was asked is she noted any injuries to R4. E14 stated "The only thing I say was dried blood on her face and mouth. The blood was coming from her nose and mouth. When I rolled her over, her face was weird

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A3000	Continued From page 4 looking. Like it was all smashed in were she had been laying on it. Her nose was pushed over. I don't think it was broke, it was just pushed over."	A3000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 1 Violation Section 295.4010 Service Plan a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the Act) The establishment shall respect and accept the resident's choices regarding the service plan. Based on interview and record review, the facility failed to implement fall interventions approprite for a memory care resident (R2). This failure resulted in R2 falling and sustaining rib fractures. This failure creates a substantial probability of severe harm or death to a resident or residents. Findings include: R2's progress note dated 10/4/25 documents "A resident who was walking the halls came to the nurse's station to report that as he walked by a resident's room, he noticed he was on the floor. When this nurse entered the room, she observed the resident lying on his floor on his back. Vitals: BP 126/58 Pulse 58 Temp. 97.9 F O2 sats 97%	A4010		

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A4010	Continued From page 5	A4010		

on RA and pain 4/10. Resident reports that he was "putting a shoe on when he hit his head over there and then over here and ended up on the floor". This nurse noticed his left elbow was bloody, but he did have a previous skin tear, and this fall caused the skin tear to reopen and get bigger. Nurse called 911. Resident was left in place until EMS arrival. Resident sent to the emergency room for further evaluation and treatment via ambulance."

R2's Progress note dated 11/6/25 documents "Staff went to resident room and observed him on the floor in bathroom. Staff came immediately to get nurse to assist. (R2) reports he stepped off the rug in front of his shower and he was only wearing socks, and he slipped and fell. R2 denied having injuries. No bleeding injuries found with skin check. Vitals: 136/78, P.70, T. 97.8, R. 20, O2 98%. Staff and this nurse assisted resident up from the floor and sat him on the toilet. Skin check done and vitals taken."

R2's progress note dated 11/8/25 documents "Staff went into room and observed resident on the floor in his bathroom. Resident stated he "fell back" and hit his back on the silver handrail on the wall. Resident was found to have a bleeding injuries on the left side of his back, and it was also bruised around the area. (R2) denied hitting his head. Resident had his walker with him. Vitals:140/72, P.60, R.16, O2 97%, T.98.4, pain: 6. Staff notified POA, and he was taken to (Local Hospital) ER."

R2's progress note dated 11/10/25 documents "(Local Hospital) ER medical director called to report that the radiologist has just read the residents x-ray report and discovered that he had fractured ribs. Waiting for (Hospital) to send over

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A4010	Continued From page 6 updated progress notes." R2's Service plan documents "(R2) has had an actual fall. Interventions: - (R2)' caregivers will evaluate the environment at the time and location of his fall and attempt to identify any factors that may have contributed to the fall, such as uneven surfaces, bed not in lowest position, poor lighting or glare present, his not wearing footwear with non-skid soles, his not using/wearing assistive device (sensory- glasses, hearing aid; function - walker, cane, etc.), frequently used items not within his reach, etc. and report findings to supervisor (10/4/25) - Immediately after a fall, (R2)'s caregivers will evaluate him for changes in range of motion and notify the nurse, before moving him (11/6/25). - (R2)'s caregivers will obtain and record his vital signs after a fall event and as ordered by his Doctor. They will notify the nurse of results (11/8/25) On 2/14/26 at 10:14 AM, E2 was asked if R2's service plan interventions for his 10/4/25, 11/6/25 and 11/8/25 falls were appropriate. E2 stated "The way the service plans are done is that the program gives us a set of fall intervention options and that's what we select. The fall interventions for (R2) are more what to do after the fall and not what to do to minimize the fall." E2 confirmed the service plan interventions were not appropriate fall interventions for R2.	A4010		
A4020	Section 295.4020 Mandatory Services This Regulation is not met as evidenced by: Type 2 Violation	A4020		

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A4020	Continued From page 7 Section 295.4020 Mandatory Services Each establishment shall provide or arrange for the following mandatory services: f) Assistance with activities of daily living as required by each resident. (Section 10 of the Act) Based on interview and record review, the facility failed to knowingly provide incontinence care to three residents (R5, R6 and R7). This failure has the substantial probability to cause moisture associated skin breakdown and creates a substantial probability of harm to a resident or residents. Findings include: R5 was admitted to the memory care unit on 3/30/24 with a diagnosis of Hypothyroidism, Atrial Fibrillation, Alzheimer's, and Urge Incontinence. R5's service plan documents "Toileting: Date Initiated: (R5) will maintain her current ability to manage her toileting needs. (R4) is dependent on her caregivers for all continence management needs, needs assist every 2 hours. R6 was admitted to the memory care unit on 1/4/24 with a diagnosis of Dementia, Anxiety, and Urinary Incontinence. R6's service plan documents "Toileting: (R6) will maintain her current ability to manage her toileting needs. Toileting - Physical Assist. (R6) needs physical assistance with her toileting tasks; timed toileting program; incontinent care. She is able to participate in some toileting activities."	A4020		

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A4020	Continued From page 8 R7 was admitted to the memory care unit on 3/12/25 with a diagnosis of Dementia, Urinary Tract Infection and Anxiety. R7's service plan documents "Toileting: (R7) will remain free from skin breakdown due to incontinence and brief use. Toileting - Physical Assist. (R6) needs physical assistance with her toileting tasks; timed toileting program; incontinent care. She is able to participate in some toileting activities." On 2/13/26 at 9:15 AM, E8, Caregiver, stated that the facility had an issue with some night shift caregivers assigned to memory care going over to the Assisted Living (AL) side and stated "I used to work nights with (E5 and E6) in memory care. They would go over to AL and leave me by myself. They would be gone for a couple of hours at a time and didn't do their rounds or incontince care. I reported it to (E1, E2 and E10)." On 2/13/26 at 9:18 am, E9, Caregiver, stated there have been ongoing issues with E3, E4, E5 and E6 (Caregivers) leaving the memory care unit and going over to AL. E9 stated" When a caregiver is assigned to the memory care unit, they're supposed to stay on memory care and not go over to AL. There have been times first shift came in to do morning cares and get ups and the residents (incontinence briefs) were completely saturated (with urine). We could tell night shift wasn't doing incontinence care. I know (E13, caregiver) talked to (E2, Director of Nursing and E11, Assistant Director of Nursing) about it. Management did a re-education on completing incontinence care and doing rounds with them." E9 was asked if she knew of any residents that did not receive incontinence care at night. E9 stated "I know (R5 and R6) are two residents that	A4020		

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I've seen with over saturated (incontinence briefs). They can't go the entire night without being changed."

On 2/13/26 at 9:26 am, E10, Memory Care Director, confirmed the caregivers on night shift were re-educated on ensuring incontinence care was being completed. E10 stated "I can't confirm that the incontinence wasn't being done because it was being reported by the day shift caregivers. I wasn't here to see it for myself so I can't confirm if it was being done or not. I know (E2, and E11) did some verbal counseling with (E4, E5 and E6)."

On 2/13/26 at 9:55 AM, E1, Executive Director, was asked about the staff leaving the memory care unit and going to AL and staff not providing incontinence care or doing rounds. E1 stated "We've had some issues with 3rd shift. We had a nurse (E12, LPN), that was hired to manage the night shift, but she no longer works here. (E12) told me that she can't manage the girls (nights shift caregivers). She couldn't watch over them and they weren't doing their job. I have talked to (E5) about not going over to the AL side when assigned to the memory care unit. (E2) did an in-service with the night shift staff about doing incontinence care and rounds. I don't have a lot of details about it, you'll have to talk to (E2) when she get here."

On 2/13/26 at 10:20 AM, E12, LPN stated "I was hired to control the night shift caregivers because there's really no nursing duties to perform on nights. I told (E1) that I can't get them to do their rounds. (E3) was good about doing her rounds, but (E4, E5 and E6) wouldn't do their rounds or incontinence care. They would come in at 10pm, report off with the 2-10pm shift and then sit in the

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living room eating, socializing and being on their devices until 4:30 AM, 4:30 is when they would start doing 3rd shift cares before morning shift came in, but that was only half the time. Most of the time they wouldn't do cares. They would sit there and not move all night. I told them it's a requirement that they do rounds and provide cares, but they said they didn't want to wake the residents. When they weren't sitting in the living room, they would go over to Assisted Living for hours at a time. Anywhere from 2-3 hours. The problem was that they'd been working on nights without supervision for years so they didn't want to change when I got hired. I had a heart attack on 9/22 and was out for 6 weeks. When I came back, I didn't have the health or energy to fight them anymore. As much as I tried, they just wouldn't do their rounds. I pleaded with them, cried over it with them and even bought them pizza, but nothing worked. (E3) was the only one that would do her checks and morning cares. They're supposed to round at 10pm, 12am, 2am and 4 am for toileting and lay eyes on every resident. Other than (E3) the others just wouldn't do rounds. They literally sat in the living room or disappeared to AL every night. Especially (E5 and E6). (E5) would go over to AL around 11PM and I wouldn't see her again until 2 am. When I left employment, I told (E1) that I couldn't control those girls. Nothing I did worked. They just won't do their work. They wouldn't do rounds, cares, safety checks, nothing. There were complaints about them not doing incontinence care. I believe it because I literally saw them with my own eyes doing absolutely nothing. (E13) showed me a photo she took of a (R5) and (R6)'s (incontinence brief) when she did her 6:00 am rounds. They were so saturated with urine, the crystals in the (incontinence brief) were beaded. You could see the discoloration and crystallization from the

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urine. She (E13) also showed me a photo of urine ring on (R5)'s sheets. R5 soaked through her (incontinence brief) to the bedding. The caregivers changed her, then threw a pad over the sheets without changing them."

On 2/13/26 at 2:00 PM, E2, Director of Nursing stated "(E6) was terminated because the night of (R4)'s fall, we found out she never did rounds and was over on the AL side until 2:00 am." E2 was asked about the incontinence care issues and E2 stated "We had several educations with the nights shift caregivers about not completing incontinence care." E2 was asked if she saw (E13)'s photo and E2 stated "I saw several. You could tell the briefs were over saturated from not being changed." E2 also stated E12 reported to her that the caregivers were not doing rounds, sitting in the living room all night and going over to the AL side for hours at a time. E2 Also confirmed E12 told her that she could not control the caregivers or get them to do anything. Verified knowing she begged, pleaded, cried and even bought them pizza, but they still wouldn't listen or do their rounds. E2 confirmed safety checks are to be completed every 2 hours with eyes laid on each resident. E2 was asked if R5 and R6 could go through the night without having incontinence care completed. E2 stated "They definitely need incontinence care done at night."

On 2/14/26 at 8:50 AM, E13, Caregiver, was asked about incontinence care not being completed on residents during 3rd shift. E13 stated "It's not being done. 3rd shift is supposed to be doing toileting and incontinence care every 2 hours starting at 10pm, then 12am, 2am and 4am and then day shift comes in at 6:00 am. When I come in at 6:00 am, the first thing I do is rounds. I check on every resident. There have

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A4020	Continued From page 12	A4020		

been many times I could tell 3rd shift never did incontinence care on the resident's. (R5, R6 and R7) are ones that definitely have to be changed at night, but it's not getting done. They're on a 2 hour check for toileting and incontinence care. Actually (R5) is no longer a 2 hour check because they just put a catheter in on Thursday. I come in in the morning and (R5, R6 and R7)'s (incontinence briefs) were so saturated, they were beaded." E13 was asked what she meant by beaded. E13 stated "Here I'll show you (pulling up her phone and showing a photo of a urine soaked incontinence brief). This is (R6)'s incontinence brief when I did my 6 am rounds. You see how the crystals in the (Incontinence brief) look like beads. That only happens when it's over saturated. Just this morning I came in at 6:00am, did my rounds and (R6)'s (incontinence brief) was completely soaked again. They never changed her last night." E13 was asked if she had reported the concerns to nursing management. E13 stated "I've told them several times. I even showed (E2) the photos. Here's another photo I took of (R5) before she had the catheter put in." The photo is of what appears to be a sheet with urine ring covering the middle of a bed. E13 stated "When I did my 6:00 am check on (R5), she had an incontinence pad under her on top of the sheet. I changed her and took out the pad. That's when I saw the urine ring. It had already dried. The caregiver changed (R5) but didn't bother to change the wet bedding so she just laid an incontinence pad down. I'll give you another example of what they do, or I should say don't do around here. When we do our rounds and find a resident has had a bowel movement, the expectation is that 3rd shift cleans them up before they leave. Not that long ago I came in and found that (R7) had a bowel movement. So I told (E15 3rd shift caregiver) that she needed to

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A4020	Continued From page 13 change (R7) before she leaves. (E15) went into (R7)'s room, was only in there a few minutes, came out and left. That made me suspicious and I thought to myself, "there's no way she had enough time to clean her up" so I went into (R7)'s room to check. (E15) changed the (incontinence brief) without cleaning (R7). There was BM all over her and the (incontinence brief) was only pulled up to the top of her thighs. It wasn't even covering her private area of butt. There was also dried BM on her. I got all cleaned up and dressed. I reported it to (E2). It's an ongoing issue here. 3rd shift is not doing incontinence care at night. Even after being re-educated to do so."	A4020		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 1 Violation Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 5) The right to receive the services specified in the service plan, to review and renegotiate the service plan at any time; and to be informed of the cost of the changes; 13) The right to be free of abuse or neglect or	A6000		

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A6000	Continued From page 14 financial exploitation or to refuse to perform labor; Based on interview and record review, the facility failed to prevent resident neglect by not performing safety checks and providing incontinence care on memeory care residents This failure resulted in R4 being found unresponsive on the floor and later pronounced dead. These failures create a substantial probability of severe harm or death to a resident or residents. This applies to four residnets (R4, R5, R6 and R7) reviewed for neglect. Findings Include: R4 was admitted to the Memory Care unit on 9/3/25 with a diagnosis of Alzheimer's , Atrial Fibrillation, Congestive Heart Failure, Overactive Bladder, and Cardiac Pacemaker. R4's service plan documents "Supervision Needs: (R4) will be provided supervision at her needed level to keep her safe. Extensive: (R4) requires regular supervision in the home and cannot leave home unattended; unaware of unsafe areas." R4's progress notes dated 1/16/2026 at 6:11 AM "Upon shift change at 06:11am, caregiver 1 (E8, Caregiver) was doing rounds to get residents up for the day. Upon caregiver 1 entering resident's room, resident was observed lying face down on the floor in her bathroom unresponsive. Immediately, caregiver 1 called Rock River Hospice to alert them of fall and get direction on what step to take next. Caregiver 1 states that hospice nurse said she will send an alert to the on call nurse and will have the on-call nurse call	A6000		

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A6000	Continued From page 15	A6000		

caregiver 1 back. At 06:19am, caregiver called assistant director or nursing as there was no floor nurse on duty at the time. Assistant director of nursing advised caregiver 1 to call 911 if the hospice nurse wasn't coming right away. Around 06:20, caregiver 1 made the call to 911 while still in resident's room. At that time, caregiver 1 called for help from caregiver 2 (E14, Caregiver). When caregiver 2 entered resident's room, she checked resident's pulse while caregiver 1 remained on the line with 911. Caregiver 2 reported she checked resident's carotid pulse and wasn't sure if it was resident's pulse or her own pulse. A few moments later, caregiver 3 entered the resident's room. She took the phone from caregiver 1 so that caregiver 1 could run and get the AED (Automated External Defibrillators) which was advised by the dispatcher. At that time, caregiver2 and caregiver 3 flipped resident to her back to start CPR. Caregiver 2 started compressions and continued compressions until caregiver 1 returned with the AED. Two rounds of 30 compressions were done by caregiver 2. At that time, AED pads were applied, however AED alerted "shock not advised". While AED was being used, EMT's arrived and took over. They asked if resident was a DNR, and once DNR was obtained, compressions were stopped. EMT's hooked resident up to EKG, and alerted caregivers that no heartbeat was noted on the EKG. Hospice nurse called back around 06:30am and caregivers alerted them there was no heart-beat. Hospice nurse stated she would be in shortly. Caregiver reports EMT's called coroner. Around 06:50am, staff nurse had arrived to community - shortly after, EMT's assisted resident off the floor and into her bed. Nurse then cleaned the blood off resident's face. Hospice nurse showed up around 07:00am and staff nurse and hospice nurse called daughter to alert

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A6000	Continued From page 16	A6000		

her of resident's passing. Family stated they were not planning on coming to the community at that time. Coroner showed up around 09:00am."

R5 was admitted to the memory care unit on 3/30/24 with a diagnosis of Hypothyroidism, Atrial Fibrillation, Alzheimer's, and Urge Incontinence.

R5's service plan documents "Toileting: Date Initiated: (R5) will maintain her current ability to manage her toileting needs. (R4) is dependent on her caregivers for all continence management needs, needs assist every 2 hours.

R6 was admitted to the memory care unit on 1/4/24 with a diagnosis of Dementia, Anxiety, and Urinary Incontinence.

R6's service plan documents "Toileting: (R6) will maintain her current ability to manage her toileting needs. Toileting - Physical Assist. (R6) needs physical assistance with her toileting tasks; timed toileting program; incontinent care. She is able to participate in some toileting activities."

R7 was admitted to the memory care unit on 3/12/25 with a diagnosis of Dementia, Urinary Tract Infection and Anxiety.

R7's service plan documents "Toileting: (R7) will remain free from skin breakdown due to incontinence and brief use. Toileting - Physical Assist. (R6) needs physical assistance with her toileting tasks; timed toileting program; incontinent care. She is able to participate in some toileting activities."

On 2/13/26 at 9:00 AM, E7, Caregiver, stated "I have heard issues on nights of caregivers leaving the Memory Care unit and going over to AL

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(Assisted Living). I know there was an issue involving (R4) where staff left the memory care unit and went to AL and not checking on (R4)."

On 2/13/26 at 9:15 AM, E8, Caregiver, stated that the facility had an issue with some night shift caregivers assigned to memory care going over to the Assisted Living (AL) side and stated "I used to work nights with (E5 and E6) in memory care. They would go over to AL and leave me by myself. They would be gone for a couple of hours at a time and didn't do their rounds. I reported it to (E1, E2 and E10)." E8 was asked about R4 being found on the floor by day shift. E8 stated "I was the one that found (R4) on the floor. I came in, started doing my 6:00 am rounds, opening doors and checking on the residents. I opened (R4)'s door at 6:11 am and found her lying face down on the floor. She was unresponsive and had dried blood on her face. I don't know how long she had been lying there." E8 was asked if R4 was on a frequent check schedule and if she knew the last time someone checked on her. E8 stated "We do safety checks and have to lay eyes on every resident at least every two hours. We also have toileting checks every 2 hours on a lot of the residents, so I do my checks at least hourly when on Memory Care Unit."

On 2/13/26 at 9:18 am, E9, Caregiver, stated there have been ongoing issues with E3, E4, E5 and E6 (Caregivers) leaving the memory care unit and going over to AL. E9 stated" I know (R4) passed away while (E6) was over on AL. When a caregiver is assigned to the memory care unit, they're supposed to stay on memory care and not go over to AL. There have been times first shift came in to do morning cares and get ups and the residents (incontinence briefs) were completely saturated (with urine). We could tell night shift

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wasn't doing incontinence care. I know (E13, caregiver) talked to (E2, Director of Nursing and E11, Assistant Director of Nursing) about it. Management did a re-education on completing incontinence care and doing rounds with them." E9 was asked if she knew of any residents that did not receive incontinence care at night. E9 stated "I know (R5 and R6) are two residents that I've seen with over saturated (incontinence briefs). They can't go the entire night without being changed."

On 2/13/26 at 9:26 am, E10, Memory Care Director stated "(E6) was fired over R4's fall, but I don't have the details on what happened." E10 confirmed the caregivers on night shift were re-educated on ensuring incontinence care was being completed. E10 stated "I can't confirm that the incontinence wasn't being done because it was being reported by the day sift caregivers. I wasn't here to see it for myself so I can't confirm if it was being done or not. I know (E2, and E11) did some verbal counseling with (E4, E5 and E6)."

On 2/13/26 at 9:55 AM, E1, Executive Director, was asked about the staff leaving the memory care unit and going to AL, R4's fall and staff not providing incontinence care or doing rounds. E1 stated "We've had some issues with 3rd shift. We had a nurse (E12, LPN), that was hired to manage the night shift, but she no longer works here. (E12) told me that she can't manage the girls (nights shift caregivers). She couldn't watch over them and they weren't doing their job. The morning (R4) fell, (E6) said she last checked on (R4) around 5:30 AM, but (E3) had a different story and said (E6) didn't do her rounds. (E6) left (E3) on the memory care unit by herself and went to AL. I have talked to (E5) about not going over

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A6000	Continued From page 19	A6000		

to the AL side when assigned to the memory care unit. (E2) did an in-service with the night shift staff about doing incontinence care and rounds. I don't have a lot of details about it, you'll have to talk to (E2) when she get here."

On 2/13/26 at 10:20 AM, E12, LPN stated "I was hired to control the night shift caregivers because there's really no nursing duties to perform on nights. I told (E1) that I can't get them to do their rounds. (E3) was good about doing her rounds, but (E4, E5 and E6) wouldn't do their rounds or incontinence care. They would come in at 10pm, report off with the 2-10pm shift and then sit in the living room eating, socializing and being on their devices until 4:30 AM, 4:30 is when they would start doing 3rd shift cares before morning shift came in, but that was only half the time. Most of the time they wouldn't do cares. They would sit there and not move all night. I told them it's a requirement that they do rounds and provide cares, but they said they didn't want to wake the residents. When they weren't sitting in the living room, they would go over to Assisted Living for hours at a time. Anywhere from 2-3 hours. The problem was that they'd been working on nights without supervision for years so they didn't want to change when I got hired. I had a heart attack on 9/22 and was out for 6 weeks. When I came back, I didn't have the health or energy to fight them anymore. When I found out about (R4), I told myself I should have been harder on those girls. I blame myself for what happened to (R4). I know they didn't check on her all night. (R4) never came out of her room at night so it was our responsibility to check on her. It's the girls' fault. They should have checked on (R4). As much as I tried, they just wouldn't do their rounds. I pleaded with them, cried over it with them and even bought them pizza, but nothing worked. (E3) was

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A6000	Continued From page 20	A6000		

the only one that would do her checks and morning cares. They're supposed to round at 10pm, 12am, 2am and 4 am for toileting and lay eyes on every resident. Other than (E3) the others just wouldn't do rounds. They literally sat in the living room or disappeared to AL every night. Especially (E5 and E6). (E5) would go over to AL around 11PM and I wouldn't see her again until 2 am. When I left employment, I told (E1) that I couldn't control those girls. Nothing I did worked. They just won't do their work. They wouldn't do rounds, cares, safety checks, nothing. There were complaints about them not doing incontinence care. I believe it because I literally saw them with my own eyes doing absolutely nothing. (E13) showed me a photo she took of a (R5) and (R6)'s (incontinence brief) when she did her 6:00 am rounds. They were so saturated with urine, the crystals in the (incontinence brief) were beaded. You could see the discoloration and crystallization from the urine. She (E13) also showed me a photo of urine ring on (R5)'s sheets. R5 soaked through her (incontinence brief) to the bedding. The caregivers changed her, then threw a pad over the sheets without changing them."

On 2/13/26 at 2:00 PM, E2, Director of Nursing stated "(E6) was terminated because the night of (R4)'s fall, we found out she never did rounds and was over on the AL side until 2:00 am." E2 was asked about R4's 5:30 check. E2 stated "She (E6) didn't check on her (R4). During our investigation we confirmed that (E6) never checked on (R4) the entire night." E2 was asked about the incontinence care issues and E2 stated "We had several educations with the nights shift caregivers about not completing incontinence care." E2 was asked if she saw (E13)'s photo and E2 stated "I saw several. You could tell the briefs

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A6000	Continued From page 21	A6000		

were over saturated from not being changed." E2 also stated E12 reported to her that the caregivers were not doing rounds, sitting in the living room all night and going over to the AL side for hours at a time. E2 Also confirmed E12 told her that she could not control the caregivers or get them to do anything. Verified knowing she begged, pleaded, cried and even bought them pizza, but they still wouldn't listen or do their rounds. E2 confirmed safety checks are to be completed every 2 hours with eyes laid on each resident. E2 was asked if R5 and R6 could go through the night without having incontinence care completed. E2 stated "They definitely need incontinence care done at night."

On 2/14/26 at 8:50 AM, E13, Caregiver, was asked about incontinence care not being completed on residents during 3rd shift. E13 stated "It's not being done. 3rd shift is supposed to be doing toileting and incontinence care every 2 hours starting at 10pm, then 12am, 2am and 4am and then day shift comes in at 6:00 am. When I come in at 6:00 am, the first thing I do is rounds. I check on every resident. There have been many times I could tell 3rd shift never did incontinence care on the resident's. (R5, R6 and R7) are ones that definitely have to be changed at night, but it's not getting done. They're on a 2 hour check for toileting and incontinence care. Actually (R5) is no longer a 2 hour check because they just put a catheter in on Thursday. I come in in the morning and (R5, R6 and R7)'s (incontinence briefs) were so saturated, they were beaded." E13 was asked what she meant by beaded. E13 stated "Here I'll show you (pulling up her phone and showing a photo of a urine soaked incontinence brief). This is (R6)'s incontinence brief when I did my 6 am rounds. You see how the crystals in the (Incontinence

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brief) look like beads. That only happens when it's over saturated. Just this morning I came in at 6:00am, did my rounds and (R6)'s (incontinence brief) was completely soaked again. They never changed her last night." E13 was asked if she had reported the concerns to nursing management. E13 stated "I've told them several times. I even showed (E2) the photos. Here's another photo I took of (R5) before she had the catheter put in." The photo is of what appears to be a sheet with urine ring covering the middle of a bed. E13 stated "When I did my 6:00 am check on (R5), she had an incontinence pad under her on top of the sheet. I changed her and took out the pad. That's when I saw the urine ring. It had already dried. The caregiver changed (R5) but didn't bother to change the wet bedding so she just laid an incontinence pad down. I'll give you another example of what they do, or I should say don't do around here. When we do our rounds and find a resident has had a bowel movement, the expectation is that 3rd shift cleans them up before they leave. Not that long ago I came in and found that (R7) had a bowel movement. So I told (E15 3rd shift caregiver) that she needed to change (R7) before she leaves. (E15) went into (R7)'s room, was only in there a few minutes, came out and left. That made me suspicious and I thought to myself, "there's no way she had enough time to clean her up" so I went into (R7)'s room to check. (E15) changed the (incontinence brief) without cleaning (R7). There was BM all over her and the (incontinence brief) was only pulled up to the top of her thighs. It wasn't even covering her private area of butt. There was also dried BM on her. I got all cleaned up and dressed. I reported it to (E2). It's an ongoing issue here. 3rd shift is not doing incontinence care at night. Even after being re-educated to do so."

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A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr This Regulation is not met as evidenced by: Type 1 Violation Section 295.6010 Abuse, Neglect, and Financial Exploitation Prevention and Reporting a) When the establishment has a reasonable belief that a resident has been the victim of abuse, neglect, or financial exploitation, the establishment shall: 1) Notify the Department within 24 hours after receiving the allegation, by contacting the Assisted Living Complaint Registry by telephone, fax, or other electronic means. The establishment shall document this report and maintain documentation on the premises for 12 months after the date of the report. Based on interview and record review, the facility failed to report known instances of neglect of residents in the memory care unit to the state agency. The failure to report neglect to the state agency resulted in continued neglect of the residents who did not recieve cares and safety checks. This failure resulted in a resident (R4) being found unresponsive and later pronounced dead at the scene and creates a substantial probability of sever harm or death to a resident or residents. This applies to four (R4, R5, R6 and R7) resident. Findings include. R4 was admitted to the Memory Care unit on	A6010		

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A6010	Continued From page 24 9/3/25 with a diagnosis of Alzheimer's , Atrial Fibrillation, Congestive Heart Failure, Overactive Bladder, and Cardiac Pacemaker. R4's service plan documents "Supervision Needs: (R4) will be provided supervision at her needed level to keep her safe. Extensive: (R4) requires regular supervision in the home and cannot leave home unattended; unaware of unsafe areas." R4's progress notes dated 1/16/2026 at 6:11 AM "Upon shift change at 06:11am, caregiver 1 (E8, Caregiver) was doing rounds to get residents up for the day. Upon caregiver 1 entering resident's room, resident was observed lying face down on the floor in her bathroom unresponsive. Immediately, caregiver 1 called Rock River Hospice to alert them of fall and get direction on what step to take next. Caregiver 1 states that hospice nurse said she will send an alert to the on call nurse and will have the on-call nurse call caregiver 1 back. At 06:19am, caregiver called assistant director or nursing as there was no floor nurse on duty at the time. Assistant director of nursing advised caregiver 1 to call 911 if the hospice nurse wasn't coming right away. Around 06:20, caregiver 1 made the call to 911 while still in resident's room. At that time, caregiver 1 called for help from caregiver 2 (E14, Caregiver). When caregiver 2 entered resident's room, she checked resident's pulse while caregiver 1 remained on the line with 911. Caregiver 2 reported she checked resident's carotid pulse and wasn't sure if it was resident's pulse or her own pulse. A few moments later, caregiver 3 entered the resident's room. She took the phone from caregiver 1 so that caregiver 1 could run and get the AED (Automated External Defibrillators) which was advised by the dispatcher. At that time, caregiver2 and caregiver 3 flipped resident to her	A6010		

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back to start CPR. Caregiver 2 started compressions and continued compressions until caregiver 1 returned with the AED. Two rounds of 30 compressions were done by caregiver 2. At that time, AED pads were applied, however AED alerted "shock not advised". While AED was being used, EMT's arrived and took over. They asked if resident was a DNR, and once DNR was obtained, compressions were stopped. EMT's hooked resident up to EKG, and alerted caregivers that no heartbeat was noted on the EKG. Hospice nurse called back around 06:30am and caregivers alerted them there was no heart-beat. Hospice nurse stated she would be in shortly. Caregiver reports EMT's called coroner. Around 06:50am, staff nurse had arrived to community - shortly after, EMT's assisted resident off the floor and into her bed. Nurse then cleaned the blood off resident's face. Hospice nurse showed up around 07:00am and staff nurse and hospice nurse called daughter to alert her of resident's passing. Family stated they were not planning on coming to the community at that time. Coroner showed up around 09:00am."

R5 was admitted to the memory care unit on 3/30/24 with a diagnosis of Hypothyroidism, Atrial Fibrillation, Alzheimer's, and Urge Incontinence.

R5's service plan documents "Toileting: Date Initiated: (R5) will maintain her current ability to manage her toileting needs. (R4) is dependent on her caregivers for all continence management needs, needs assist every 2 hours.

R6 was admitted to the memory care unit on 1/4/24 with a diagnosis of Dementia, Anxiety, and Urinary Incontinence.

R6's service plan documents "Toileting: (R6) will

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maintain her current ability to manage her toileting needs. Toileting - Physical Assist. (R6) needs physical assistance with her toileting tasks; timed toileting program; incontinent care. She is able to participate in some toileting activities."

R7 was admitted to the memory care unit on 3/12/25 with a diagnosis of Dementia, Urinary Tract Infection and Anxiety.

R7's service plan documents "Toileting: (R7) will remain free from skin breakdown due to incontinence and brief use. Toileting - Physical Assist. (R6) needs physical assistance with her toileting tasks; timed toileting program; incontinent care. She is able to participate in some toileting activities."

On 2/13/26 at 9:00 AM, E7, Caregiver, stated "I have heard issues on nights of caregivers leaving the Memory Care unit and going over to AL (Assisted Living). I know there was an issue involving (R4) where staff left the memory care unit and went to AL and not checking on (R4)."

On 2/13/26 at 9:15 AM, E8, Caregiver, stated that the facility had an issue with some night shift caregivers assigned to memory care going over to the Assisted Living (AL) side and stated "I used to work nights with (E5 and E6) in memory care. They would go over to AL and leave me by myself. They would be gone for a couple of hours at a time and didn't do their rounds. I reported it to (E1, E2 and E10)." E8 was asked about R4 being found on the floor by day shift. E8 stated "I was the one that found (R4) on the floor. I came in, started doing my 6:00 am rounds, opening doors and checking on the residents. I opened (R4)'s door at 6:11 am and found her lying face down on the floor. She was unresponsive and had dried

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blood on her face. I don't know how long she had been lying there." E8 was asked if R4 was on a frequent check schedule and if she knew the last time someone checked on her. E8 stated "We do safety checks and have to lay eyes on every resident at least every two hours. We also have toileting checks every 2 hours on a lot of the residents, so I do my checks at least hourly when on Memory Care Unit."

On 2/13/26 at 9:18 am, E9, Caregiver, stated there have been ongoing issues with E3, E4, E5 and E6 (Caregivers) leaving the memory care unit and going over to AL. E9 stated" I know (R4) passed away while (E6) was over on AL. When a caregiver is assigned to the memory care unit, they're supposed to stay on memory care and not go over to AL. There have been times first shift came in to do morning cares and get ups and the residents (incontinence briefs) were completely saturated (with urine). We could tell night shift wasn't doing incontinence care. I know (E13, caregiver) talked to (E2, Director of Nursing and E11, Assistant Director of Nursing) about it. Management did a re-education on completing incontinence care and doing rounds with them." E9 was asked if she knew of any residents that did not receive incontinence care at night. E9 stated "I know (R5 and R6) are two residents that I've seen with over saturated (incontinence briefs). They can't go the entire night without being changed."

On 2/13/26 at 9:26 am, E10, Memory Care Director stated "(E6) was fired over R4's fall, but I don't have the details on what happened." E10 confirmed the caregivers on night shift were re-educated on ensuring incontinence care was being completed. E10 stated "I can't confirm that the incontinence wasn't being done because it

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was being reported by the day sift caregivers. I wasn't here to see it for myself so I can't confirm if it was being done or not. I know (E2, and E 11) did some verbal counseling with (E4, E5 and E6)."

On 2/13/26 at 9:55 AM, E1, Executive Director, was asked about the staff leaving the memory care unit and going to AL, R4's fall and staff not providing incontinence care or doing rounds. E1 stated "We've had some issues with 3rd shift. We had a nurse (E12, LPN), that was hired to manage the night shift, but she no longer works here. (E12) told me that she can't manage the girls (nights shift caregivers). She couldn't watch over them and they weren't doing their job. The morning (R4) fell, (E6) said she last checked on (R4) around 5:30 AM, but (E3) had a different story and said (E6) didn't do her rounds. (E6) left (E3) on the memory care unit by herself and went to AL. I have talked to (E5) about not going over to the AL side when assigned to the memory care unit. (E2) did an in-service with the night shift staff about doing incontinence care and rounds. I don't have a lot of details about it, you'll have to talk to (E2) when she get here."

On 2/13/26 at 10:20 AM, E12, LPN stated "I was hired to control the night shift caregivers because there's really no nursing duties to perform on nights. I told (E1) that I can't get them to do their rounds. (E3) was good about doing her rounds, but (E4, E5 and E6) wouldn't do their rounds or incontinence care. They would come in at 10pm, report off with the 2-10pm shift and then sit in the living room eating, socializing and being on their devices until 4:30 AM, 4:30 is when they would start doing 3rd shift cares before morning shift came in, but that was only half the time. Most of the time they wouldn't do cares. They would sit

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there and not move all night. I told them it's a requirement that they do rounds and provide cares, but they said they didn't want to wake the residents. When they weren't sitting in the living room, they would go over to Assisted Living for hours at a time. Anywhere from 2-3 hours. The problem was that they'd been working on nights without supervision for years so they didn't want to change when I got hired. I had a heart attack on 9/22 and was out for 6 weeks. When I came back, I didn't have the health or energy to fight them anymore. When I found out about (R4), I told myself I should have been harder on those girls. I blame myself for what happened to (R4). I know they didn't check on her all night. (R4) never came out of her room at night so it was our responsibility to check on her. It's the girls' fault. They should have checked on (R4). As much as I tried, they just wouldn't do their rounds. I pleaded with them, cried over it with them and even bought them pizza, but nothing worked. (E3) was the only one that would do her checks and morning cares. They're supposed to round at 10pm, 12am, 2am and 4 am for toileting and lay eyes on every resident. Other than (E3) the others just wouldn't do rounds. They literally sat in the living room or disappeared to AL every night. Especially (E5 and E6). (E5) would go over to AL around 11PM and I wouldn't see her again until 2 am. When I left employment, I told (E1) that I couldn't control those girls. Nothing I did worked. They just won't do their work. They wouldn't do rounds, cares, safety checks, nothing. There were complaints about them not doing incontinence care. I believe it because I literally saw them with my own eyes doing absolutely nothing. (E13) showed me a photo she took of a (R5) and (R6)'s (incontinence brief) when she did her 6:00 am rounds. They were so saturated with urine, the crystals in the (incontinence brief) were

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beaded. You could see the discoloration and crystallization from the urine. She (E13) also showed me a photo of urine ring on (R5)'s sheets. R5 soaked through her (incontinence brief) to the bedding. The caregivers changed her, then threw a pad over the sheets without changing them."

On 2/13/26 at 2:00 PM, E2, Director of Nursing stated "(E6) was terminated because the night of (R4)'s fall, we found out she never did rounds and was over on the AL side until 2:00 am." E2 was asked about R4's 5:30 check. E2 stated "She (E6) didn't check on her (R4). During our investigation we confirmed that (E6) never checked on (R4) the entire night." E2 was asked about the incontinence care issues and E2 stated "We had several educations with the nights shift caregivers about not completing incontinence care." E2 was asked if she saw (E13)'s photo and E2 stated "I saw several. You could tell the briefs were over saturated from not being changed." E2 also stated E12 reported to her that the caregivers were not doing rounds, sitting in the living room all night and going over to the AL side for hours at a time. E2 Also confirmed E12 told her that she could not control the caregivers or get them to do anything. Verified knowing she begged, pleaded, cried and even bought them pizza, but they still wouldn't listen or do their rounds. E2 confirmed safety checks are to be completed every 2 hours with eyes laid on each resident. E2 was asked if R5 and R6 could go through the night without having incontinence care completed. E2 stated "They definitely need incontinence care done at night."

On 2/14/26 at 8:50 AM, E13, Caregiver, was asked about incontinence care not being completed on residents during 3rd shift. E13

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stated "It's not being done. 3rd shift is supposed to be doing toileting and incontinence care every 2 hours starting at 10pm, then 12am, 2am and 4am and then day shift comes in at 6:00 am. When I come in at 6:00 am, the first thing I do is rounds. I check on every resident. There have been many times I could tell 3rd shift never did incontinence care on the resident's. (R5, R6 and R7) are ones that definitely have to be changed at night, but it's not getting done. They're on a 2 hour check for toileting and incontinence care. Actually (R5) is no longer a 2 hour check because they just put a catheter in on Thursday. I come in in the morning and (R5, R6 and R7)'s (incontinence briefs) were so saturated, they were beaded." E13 was asked what she meant by beaded. E13 stated "Here I'll show you (pulling up her phone and showing a photo of a urine soaked incontinence brief). This is (R6)'s incontinence brief when I did my 6 am rounds. You see how the crystals in the (Incontinence brief) look like beads. That only happens when it's over saturated. Just this morning I came in at 6:00am, did my rounds and (R6)'s (incontinence brief) was completely soaked again. They never changed her last night." E13 was asked if she had reported the concerns to nursing management. E13 stated "I've told them several times. I even showed (E2) the photos. Here's another photo I took of (R5) before she had the catheter put in." The photo is of what appears to be a sheet with urine ring covering the middle of a bed. E13 stated "When I did my 6:00 am check on (R5), she had an incontinence pad under her on top of the sheet. I changed her and took out the pad. That's when I saw the urine ring. It had already dried. The caregiver changed (R5) but didn't bother to change the wet bedding so she just laid an incontinence pad down. I'll give you another example of what they do, or I should say

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A6010	Continued From page 32 don't do around here. When we do our rounds and find a resident has had a bowel movement, the expectation is that 3rd shift cleans them up before they leave. Not that long ago I came in and found that (R7) had a bowel movement. So I told (E15 3rd shift caregiver) that she needed to change (R7) before she leaves. (E15) went into (R7)'s room, was only in there a few minutes, came out and left. That made me suspicious and I thought to myself, "there's no way she had enough time to clean her up" so I went into (R7)'s room to check. (E15) changed the (incontinence brief) without cleaning (R7). There was BM all over her and the (incontinence brief) was only pulled up to the top of her thighs. It wasn't even covering her private area of butt. There was also dried BM on her. I got all cleaned up and dressed. I reported it to (E2). It's an ongoing issue here. 3rd shift is not doing incontinence care at night. Even after being re-educated to do so." On 2/14/26 at 11:30 AM, E2, Director of Nursing, confirmed knowing of all the above issues and did not report any neglect to the state agency.	A6010		