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A 000	Initial Comment Complaint Investigation 2594861/IL193380 - No Deficiency Facility Reported Incident of 6/13/2025/IL194743 - 295.6000a)13), 295.6010a)1)c)d), 295.3040 Facility Reported Incident of 6/24/2025/IL195577 - 295.6000a)13), 295.6010a)1)c)d), 295.3040	A 000		
A3040	Section 295.3040 Health Care Worker Background Check This Regulation is not met as evidenced by: General Violation Section 295.3040 Health Care Worker Background Check An establishment shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code. (Source: Amended at 36 Ill. Reg. 13632, effective August 16, 2012) This requirement was NOT MET as evidenced by: Based on interview and record review, the facility failed to follow its policy in conducting background checks prior to employee start date for three (E7, E14, E15) of three employees reviewed for background checks. This failure has the potential to affect all 56 residents currently residing in the facility. Findings include: On 6/27/2025 facility census for Assisted Living and Memory Care Units was 56.	A3040		

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A3040	Continued From page 1 On 6/27/2025 at 3:46pm E6 (Business Office Manager/HR Director) stated, Health Care Workers Background checks were done on E15 prior to hire. She was hired 2/13/2025 and onboarding Date: 2/16/2025. Her background checks were done 2/14/2025, but when I went back to check the health care worker background checks, I could not find the paperwork for 2/14/2025 so I reprinted the reports on 6/17/2025. Background checks are supposed to be done the date of hire. I have to do health care worker registry and background checks when they start to work, she started to work on 2/16/2025, background checks are to be done prior to start of their work. When I know, the employee is going to start working and they are going to be here, I print the registry and background checks, but before they are hired, I do the health care eligibility to make sure they can work. I cannot find the health care worker registry. I validate with social security number. E6 stated, E7 should have been done on 1/27/2025 and I know I messed up tremendously, the other one for E15 got misfiled, not sure because they cannot work without it. E14 should have been done on 4/15/2025 Onboarding Date: 4/22/2025. Before anyone is hired the health care worker registry is run and it is validated with their social security number. We do background checks to make sure our residents are safe, it is part of our abuse policy. On 6/28/2025 at 1:26pm E1 (Senior Executive Director) stated, regarding new hires background checks are required prior to or upon hiring. E1 stated, we completed on IDPH website to make sure eligible for employment and I do interviews E21, and E6 do interviews. Surveyor asked when background checks are supposed to get done. E1	A3040		

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stated, we do a soft pull at time of interview and if we decide to move forward we make sure employee is eligible. The full background is done before day of orientation. Who is responsible for doing background checks. E1 stated, E6. They are supposed to be done when hired. Completing background checks is part of our abuse policy.

During record review, the following documentation was not presented for the following facility health care workers prior to or at start of hire date.

E7 Certified Nursing Assistant, Date of Hire - 1/27/2025 National Sex Offender search performed 6/18/2025, Illinois Sex Offender search performed 6/18/2025.

E14 Certified Nursing Assistant Date of Hire - 4/15/2025 National Sex Offender search performed 6/20/2025, Illinois Sex Offender search performed 6/20/2025.

E15 Certified Nursing Assistant Date of Hire - 2/13/2025 Office of Inspector General verification performed 6/17/2025, Illinois Sex Offender search performed 6/17/2025, National Sex Offender search performed 6/17/2025.

Facility Policy Title: Abuse and Neglect revision dated 8/1/2022 documents (in part): Policy It is the policy of American House to protect all resident rights, prohibit abuse, neglect, and misappropriation of resident property. All reports of suspected abuse will be investigated in a timely manner, with emphasis on protection of the resident after report of an incident and during the investigation. Purpose: To ensure resident safety Procedure: 1. Definition To assist our community's staff members in recognizing

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A3040	Continued From page 3 incidents of abuse, the following definitions of abuse are provided: PHYSICAL ABUSE is the willful act of inflicting bodily injury or physical mistreatment. This includes, but is not limited to, striking, with or without an object, slapping, pinching, choking, kicking, shoving, prodding, or the use of chemical restraints or physical restraints. 2. Screening a. All American House staff members will be screened for a history of abuse, neglect or mistreating residents as defined by the applicable requirements. i. Prospective associates will sign a release allowing a criminal background check. ii. All licenses will be verified through an appropriate licensing authority. b. All agency supplemental personnel utilized by American House will be screened for a history of abuse, neglect, or mistreating residents. A criminal background check and license will be obtained from the respective agency. c. American House will not employ any individual who they are aware have been found guilty of abusing, neglecting, or mistreating a resident by a court of law, or have had a finding entered into the State Nurse Aide Registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property.	A3040		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: GENERAL 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	A6000		

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account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights:
1) The right to live in an environment that promotes and supports each resident's dignity, individuality, independence, self-determination, privacy, and choice and to be treated with consideration and respect;
13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor;

This requirement was NOT MET as evidenced by:

Based on observation, interview and record review, the establishment failed to keep two (R1, R4) of six residents free from physical abuse. This failure resulted in R1 sustaining a black eye, and R4 sustaining a skin tear on right wrist.

Findings include:

R1 is a 92-year-old with diagnosis not limited to: Hypothyroidism, Major Depressive Disorder, Unspecified Dementia with Behavioral Disturbances, Insomnia, Venous Insufficiency, Atherosclerosis, Dysphagia Oropharyngeal Phase, Anemia, Vit D Deficiency, Essential (Primary) Hypertension

According to R1's face sheet printed 6/27/2025, R1 was admitted to Assisted Living Memory Care Unit on 10/31/2023.

Facility Reported Incident dated 6/16/2025 documents (in part) E7 (CNA) reported an allegation of physical abuse to R1 that occurred on the evening of 6/13/2025. E7 reported that R1 had a physical altercation with E15 (CNA). E7

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stated R1 punched E15 and E15 punched R1 back. Reported that R1 had a black eye.

On 6/27/2025 at 11:39am R1 observed sitting in dining room in wheelchair. R1 observed dressed, groomed and wearing shoes and able to feed self. R1 with bruising observed under left eye. R1 responded by looking at surveyor when name called. R1 asked how eye was bruised. R1 said a scuffle with girl and swung right hand. Surveyor asked R1 if someone hit him in his eye. R1 attempted to answer but unable to understand what R1 was trying to say.

On 6/28/2025 at 12:08pm R1 observed sitting in dining room in wheelchair dressed, groomed and wearing shoes. R1 alert and said he was okay. R1 observed feeding self-lunch. Bruise remains below left eye.

On 6/27/2025 at 11:51am E10 (LPN) stated, R1 is alert and oriented to self but unable to consistently follow direction and it can be hard to redirect him. I was not here when he got bruise. When I came that Monday (6/16/25), I saw R1 and started asking questions. I took care of R1 on 6/13/2027 6:00am to 2:00pm and he did not have any bruise. A CNA asked me if I saw a bruise on R1 and I stated, no and went to see R1 and assess him. When I assessed him, he had left eye ecchymosis and painful to touch. I notified E2 (Wellness Director Consultant) and others in a text doctor, E1, E2 and E21 and they started an investigation. I did not get anything reported to me in report. This happened after my shift, but when I saw it, I reported it. I cannot remember who the CNA was that told me. R1 did go to the hospital. He could not tell me what happened. I had abuse training recently and they talked about the different types of abuse and what to do.

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A6000	Continued From page 6 On 6/27/2025 at 12:24pm E11 (CNA) stated, I am familiar with R1. He is easy to get up but he sleeps a lot. He is not really oriented. I worked 6/13/2025 day shift and he was tired and sleeping in chair most of the day. He did not have a bruise when I left on 6/13/2025 between 6:30am-2:30pm. I worked the next day and E18 (Resident Assistant) said, can I show you something and she said look at him (R1). R1 had dried blood underneath his nose, left black eye and his lip was busted. E18 asked me did he look like that when you left. She said, this had to have happened on 2nd shift. E18 said she told V16 (LPN) the nurse to chart and to report it. R1 said a girl with red hair (E15) hit him and he motioned with his fist like he was fighting and said E15 girl with red hair. Surveyor asked E11 if E15 had red hair. E11 stated, I think. There were 4 CNAs on that night E3 (CNA), E15 (CNA), E18 (RA) and E7 (RA). I believe E15 had the west side which is where R1 is. It did look like someone tried to clean him up some. On 6/27/2025 at 2:29pm E3 (CNA) stated, I am familiar with R1. I worked 6/13/25 evening shift. I was not assigned to R1. Before I saw R1 had a bruise/black eye left, when I was walking past, I saw he sled out of his wheelchair and I immediately went over to him, me and 2 other caregivers and sat him back in chair. Then the nurse was notified, and he had spilled a drink and I mopped that up. I went back to doing what I was doing. At that time, he did not have any bruise or black eye. I did not see any bruise until the next day on 2nd shift. E15 (CNA) was assigned to R1 that evening and about 30 minutes after helping him in chair E15 took R1 back towards his room. I absolutely did not laugh at R1. The other CNA was E24 that helped get R1 up. The next day a	A6000		

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care giver said did you see R1's black eye. I went to see R1 and saw he had a black eye, and it was a shocker. R1 did not say how it happened. I did not see anything else. I have had abuse training. I did not see anyone laughing at R1 when he fell. The nurse was E16, I told her R1 slipped out of chair and landed on his butt, and I went back to doing what I was doing. I have had abuse training and I do courses on computer on abuse.

On 6/27/2025 at 2:44pm E5, Resident Assistant (RA) stated, I am familiar with R1. I saw R1 6/13/2025 morning he looked normal and had no bruises. I was called in to help out on 6/15/2025 that morning. I saw R1 his left eye was really swollen it was really bad. It was so bad that is what I noticed. I asked R1 what happened and R1 demonstrated he said someone did me like this baby and they did me like this (moving like someone was fighting him). R1 demonstrated with his fist and that someone was pulling his clothes. R1 did not say who it was at first when I approached him, he was very frighten (jumped a little) I bend down and noticed his eye was bruised really bad. R1 just demonstrated with his fist and clothes like being stretched out of place. I reported this to the nurse on Sunday (6/15/2025) on days who was working. After that I do not know what happened. On 6/13/2025 for evening whoever comes in first that is who we give our report to. There was nothing to report regarding any resident. Recent education given about abuse. I have not seen any resident be abuse like I have seen with R1 and his eye. R1 does not fall a lot. R1 will talk but have to catch him in that moment.

On 6/27/2025 at 3:02pm E4 (Culinary Server) stated, I worked 6/13/25 on the 4th floor 11:00am to 7:00pm but usually here until almost 8pm. I

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am familiar with R1. I was here when R1 fell in the common area the first time I saw R1 getting up out of his wheelchair and E15 kept yelling at him to get back in his wheelchair, no one got up to help him, the wheelchair rolled back, and he fell on his back. E15 proceeded to laugh at him, and they did not help him up for a few minutes. I walked over there then she was helping him up. R1 got mad. I was in the dining room, and I still hear him yelling. I walked in common area to bathroom, and I saw R1 was on the floor in the bathroom, and then E15 slammed the door but prior to that I saw R1 on the floor. After that I was done cleaning and after that E15 put R1 to bed. Prior to this incident, I did not see any bruising on R1. I speak to all of the residents up there and I am up close to see them, I worked the next day 6/14/2025 and I walked out of the kitchen and saw R1 with a black eye. I heard another CNA ask R1 what happened. I waited till everyone was gone out the dining room because R1 is always the last one to leave. The CNA was asking R1 what happened, I walked over and kneeled down and asked R1 what happened, did you fall or did someone hurt you. R1 looked up to me and he said the one with red hair and he showed liked he was parting his hair and said the one with the red hair and E15 has burgundy red hair. There was another CNA standing there and heard it loud and clear. I believe other CNA was E14 (CNA). I have not seen others being abusive to residents. If I see any abuse, I report it and I made a written statement that night. E14 was the other CNA that laughed at R1. I did see E3 coming to help him up. E3 did not laugh at him, he is a good CNA. We are doing abuse training. If I see or hear any abuse I report to the manager on duty. If no one was here I would call director of memory care. I made a written statement because no one was there, I did look for the nurse E16 Licensed

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Practical Nurse (LPN) but she was not there, I am not sure where she was.

On 6/28/2025 at 10:07am E15 (CNA) stated, I took care of R1. I worked with him on June 13, 2025, evening shift. When I put him down it was nothing wrong with that man. My nurse went behind me and said I have to go check R1's wife's sugar, she wanted to make sure sugar was not low. E16 came back out and said her sugar is a little low and I will go to kitchen and get jello. E16 (LPN) went back in room and gave her jello and insulin to get sugar up and said everything is good and thy are sleep. They sleep in the same bed next to each other. They said he had a big lip, busted nose and black eye and E16 would have seen R1 if he had that. Night shift is supposed to do round every hour, and he is a fall risk and both of them will get out of their bed and they should have eyes on them every hour. How could he have that at 3:00am if rounding is done every hour. Falsely accusing me and I always had them. When people need help, they come get me. Put on me because R1 said someone punched him and I punched R1. I get beat up every day and why all of a sudden, they said I put my hands on R1. When I left R1 was in good shape, he was changed and cleaned up and the next day I got a call saying R1 had a black eye. E16 did not come out of room to say what is wrong with R1. Someone went into the room behind me. R1 sleeps right next to his wife there is no way the nurse did not see the resident if he had a black eye. I spoke to E1 and E6 and they asked me what happened that day and R1 fell and wasted all of his meds and I changed him, and I came back out. I told an employee R1 punched me in my lip when he fell in the washroom. R1 legs are bad and complains of his legs hurting. R1 does what he wants to do. R1

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was in the washroom and an employee told me R1 fell in the bathroom, and I picked him up and R1 elbowed me and no one knew my lip was busted until I said something. After that I put him to bed. R1 fell in the dining room since his wheelchair was close to garbage can and he walked to garbage can and when he tried to sit down in his chair, he fell. He started cursing and we started laughing because he started cursing. I said R1 is starting to get crazy, so I am going to put him to bed. If R1 is fighting you, you will need help taking care of him. When R1 fell out of chair E14 (CNA) helped me put him back in chair. They did not tell me why they terminated, and they told me I could return back Wednesday. I called E6 back and she said it is okay for me to return and she would talk to E1, and she would call me back and she never called me back. She called me Thursday and asked me to come in for Friday because they were short staffed. I realized it was my daughter's birthday and I could not make it. E6 said can you come in at 9:00am because the team wants to talk to me. They had corporate, E1 and E21 and were talking and said they had to terminate me because other employee said R1 hit you in your lip and R1 ended up with a black eye. I said, I will take my termination because you are listening to 'he said, she said'. E16 knows she did not see R1 with a bloody nose or black eye, and I said you are accusing me of something I did not do.

On 6/28/2025 at 10:36am E18 (Resident Assistant) stated, I am familiar with R1. I worked the night of June 13, 2025, on night shift. I was asked if I heard anything regarding R1 having a black eye and busted nose. I asked him about it and he said it hurt and he was doing motion trying to describe what I asked him. R1 was laying downing and was not aggressive. He said he fell,

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and I asked him when and where. He said he could not remember. There were other CNAs. I take care of R1 all the time. He can be combative but can be redirected. When he is combative, you have to walk away and let him calm down. I did not get in report that R1 had a black eye. The nurse was doing rounds and asked is it normal for R1 to sit at the edge of the bed and I told her yes. She said she saw it and did an assessment he was not in any real pain but did not get report from 2nd shift that R1 had a black eye. I reported to 3rd shift nurse on duty. It was a agency female nurse.

On 6/28/2025 at 10:52am E19 (CNA) stated, I remember incident that happened on 6/13/2025, it did not happen on my shift. On 6/14/2025 day shift when I came in R1 had a black eye and his lip was busted. I told E21 and asked E21 about R1's eye and the people that worked 2nd shift on the 13th I asked them if they knew what happened to R1's eye. The facility started to investigate and asked us questions. I was not here when it happened, but I heard staff talk about it and when I found out what happened I told E6 (Business Office Manager/HR Director). I heard a girl name E15 was in a room getting R1 up but when E15 came out she looked irritated and tried to fix her hair and she said she punched R1 because he hit her, and they were looking and did not want to be in it. I asked R1 what happened, and he told me no I did not fall, and he motioned to me that it was like this and did fighting gestures and I told E6 what R1 told me. I have not seen any residents being abused because if I do, I am telling. I feel employees yell and are aggressive, but you have to have an understanding because it is complex for these residents. R1 has never been aggressive but you have to tell him what you are doing. I believe E15

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was forceful with him, and he has not been aggressive.

On 6/28/2025 at 12:57pm, E14 stated, I am familiar with R1. Surveyor asked about 6/13/25 incident with R1. Between 8:30-10:30pm, E15 and I were sitting at the booth on the memory area when R1 tried to get up and empty spit cup. We told him to sit down and tried to redirect him, but he fell backward in cradle position and knees bent and back hunched over. We picked him up and put him in wheelchair. E15 took R1 to put to bed and I was putting another resident to bed. E15 said R1 busted her lip, and she was serious she did not say she hit him or anything. She was mad about that. Before he went to bed R1 did not look the same the next morning he had busted lip, busted nose, and busted eye. He was not injured when he fell out the chair. He did not hit his head or hit his face.

On 6/28/25 at 1:07pm E7, Resident Assistant stated, I am familiar with R1. I worked 6/13/2025 2:00pm to 10:30pm. We were finishing up rounds and putting resident to beds. E15 had R1 and he usually goes last. It was about 9:00pm I was sitting in booth in day room and E15 came and sat down breathing heavy and she said R1 hit her in the mouth and her lip was a little swollen but she was upset then continued to say she and R1 got into a tussle and said you want to fight old man, and R1 put his fists up and they had a brawl in R1's room and E15 said she grabbed him by the beard and they were going round and round in his room. E15 seemed proud of it. The next day, I saw R1's face and dry blood on mustache and beard and eye black and top lip swollen and bottom lip swollen and I texted E21, Memory Care Director and told him E15 gave R1 that shiner and swollen lip and the next day or 2 days

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later I said she is on the shift, and he said I cannot do anything without writing a statement. I reported it to E21 the next morning 6/14/2025 when I saw R1's face. I came to see a different resident and saw R1's face. About 9:30am I texted E21 phone that morning on Saturday 6/14/2025. Regarding R4 I dressed him, and I will put him to bed. I saw skin tear, but I did not know what happened. I thought it was reported.

On 6/28/2025 at 1:15pm E16 LPN stated, I was employed at facility. I am familiar with R1, I was the nurse. I do not know what happened. They told me Monday when I came back, and no one said anything to me that he had a black eye. I found out Monday that afternoon when I came in and was approached by E21 and E1. R1 did not have a black eye when I left Friday evening. R1 did not report that he had a fall, and I did not see that he had a fall. E15 did not tell me that R1 fell or had a black eye. She did not say nothing. I did not know anything. If they told me, I would have documented and done my due diligence. I resigned from facility Thursday night at 10pm. Because of this no one know nothing, and I do not like being put in the middle of anything. I need a DON with good leadership and professional license.

On 6/28/2025 at 1:26pm E1 (Senior Executive Director) stated, going thorough time of events, statements and altercation between E15 and R1 in bathroom and fall in common area. E15's original statement to E6 and E7 said she had an altercation with R1 which resulted in E15 punching R1. Progress note overnight that V22 saw bruising around his eye on the night of 6/13/2025. E1 stated regarding R4 and while in patient care, E14 shared he was a little upset and was scratching her and she grabbed his arm and

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A6000	Continued From page 14 caused a skin tear. On 6/29/2025 at 2:26pm E22 (LPN Agency) stated, I only had R1 as a resident when I worked there. I took care of him on 6/13/2025 night shift 10:00pm-6:00am. I did not get anything from the nurse that R1 had any altercation. No one said anything to me. At 10:00pm I made my rounds and resident was sleeping in bed with his wife. At 12:00am I made rounds and R1 was sleeping with wife. At 2:00am I saw R1 sitting on edge of bed, and I asked R1 what was wrong. R1 stated he was cold, and I turned off the air conditioner. I turned on the light and saw his eyes. I thought it happened on previous shift, so I asked the CNAs about R1's eye. The CNAs said he usually get up to go pee. I made a progress note about his eye and communicated with morning nurse. I did my assessment and evaluated for pain, no sign of pain or bleeding. I continued to monitor and assess and communicated with morning nurse. When I saw him, I assessed him immediately and he said he did not feel any pain. I went to the CNA, and I told them what I saw, and they said maybe it happened on shift prior and I said ok, but I did not get any report about R1 having any black eye. I only got report about his wife because her sugar can drop very quickly. I communicated with the CNAs because they know him better than I do. In the morning the CNA that worked the day prior said that did not happen during my shift and I told the night CNA to put down about his eye in her charting. I documented on the progress notes, and I communicated it to the morning nurse that was taking over from me. I did not do an incident report because it did not happen on my shift. The facility contacted me and asked me to come back and complete an incident note. R1 was not able to tell me what happened. He had a black eye on the left, I don't remember	A6000		

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anything else. R2's wife was asleep, but she is not able to understand what goes on around her.

R1's Progress Note entry datetime 6/14/2025 6:56am, Note Datetime 2025-06-14 2:00am Wellness documents Nurse (E22) observed that patient had a black eye while rounding at 2am, and communicated this to CNA's. Nurse assessed resident for fall, bleeding and pain. Resident show no sign of bleeding, fall or pain. Nurse also communicated this to the morning nurse.

R4 is a 100-year-old with diagnosis not limited to: Posterior Displaced Type II Dens Fracture, Fracture of Unspecified Part of Left Clavicle, Unspecified Dementia, Benign Prostatic Hyperplasia, Repeated Falls

On 6/28/2025 at 12:14pm R4 alert, dressed, groomed, wearing shoes and sitting in high back chair in dining room eating lunch. Staff feeding R4 with no concerns. No concerns with resident to staff interaction. R4 able to answer simple questions but unable to make needs known. R4 in hospice and has a wound aide due to wound on sacral area. Surveyor unable to observe right arm skin tear due to bandage in place.

On 6/28/2025 at 12:23pm E23 (RN Agency) stated, R4 is active and is doing okay. E23 stated, she has not seen skin tear on right wrist. E23 stated, R1 is doing okay, taking meds and will eat by self, but sometimes the CNA has to help him.

On 6/28/2025 at 12:49pm E17 (LPN) stated, I am familiar with R4 and his arm. R4 sustained a skin tear. E14 was the CNA. R4 can be combative. E14 said he scratched her. If a resident becomes aggressive, CNA should walk away and get the

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nurse. When she told me I went and assessed the resident and saw R4 was in bed, and he had a skin tear right forearm semi u shaped. I cleaned it and put a dry bandage on and contacted E1, E2 and Medical Doctor (MD). MD gave order to put steri strips on it. I completed incident report.

On 6/28/2025 at 12:57pm, E14 stated, I am familiar with R4 and 6/24/25 incident with R4. R4 was combative and put his nails in my arm when I was putting him to bed. Every time I tried to wipe him, he kept swapping, and I was saying R4 let me finish. I put my arm up and when I was done with him, I realized he had a skin tear. I do not know how it happened I am not sure how, but I did not hold his arms violently. Did you hold R4's arm. I did but not violently. I was not sent home, I quit the facility on 6/26/2025 because I was not getting paid enough.

R4's progress note dated 6/24/2025 8:15pm incident documents (in part) by E17: while putting resident to bed he became physically aggressive with care staff. Scratching care staff. Care staff placed her hand on residents right forearm in attempt to stop resident from scratching her. Resident obtained a skin tear during the incident.

Facility Policy Title: Abuse and Neglect revision dated 8/1/2022 documents (in part): Policy It is the policy of American House to protect all resident rights, prohibit abuse, neglect, and misappropriation of resident property. All reports of suspected abuse will be investigated in a timely manner, with emphasis on protection of the resident after report of an incident and during the investigation. Purpose: To ensure resident safety. Procedure:
1.Definitions To assist our community's staff

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A6000	Continued From page 17 members in recognizing incidents of abuse, the following definitions of abuse are provided: ABUSE is the willful action or inaction that inflicts injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain or mental anguish. PHYSICAL ABUSE is the willful act of inflicting bodily injury or physical mistreatment. This includes, but is not limited to, striking, with or without an object, slapping, pinching, choking, kicking, shoving, prodding, or the use of chemical restraints or physical restraints. 4. Prevention a. Staff/direct care agents must not use verbal abuse, mental abuse, sexual abuse, physical abuse, corporal punishment, or involuntary seclusion with a resident. Facility's "STATE OF ILLINOIS RESIDENT RIGHTS" documents in part: 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: 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor;	A6000		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr This Regulation is not met as evidenced by: General Violation Section 295.6010 Abuse, Neglect, and Financial Exploitation Prevention and Reporting	A6010		

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A6010	Continued From page 18 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. c) Establishment employees and volunteers are obligated to report abuse, neglect, or financial exploitation of a resident to the establishment management and to the Department. d) When the establishment has a reasonable belief that abuse, neglect or financial exploitation occurred, the perpetrator, if an employee or volunteer, shall be removed from direct contact with residents. This requirement was NOT MET as evidenced by: Based on interview and record review, the facility failed to follow its abuse policy related to prevention, protection, screening, and reporting for two (R1 and R4) of six residents reviewed for abuse. This failure has the potential to affect 56 residents currently residing on the memory care unit in the facility. Findings include: R1 is a 92-year-old with diagnosis not limited to: Hypothyroidism, Major Depressive Disorder,	A6010		

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A6010	Continued From page 19 Unspecified Dementia with Behavioral Disturbances, Insomnia, Venous Insufficiency, Atherosclerosis, Dysphagia Oropharyngeal Phase, Anemia, Vit D Deficiency, Essential (Primary) Hypertension According to R1's face sheet printed 6/27/2025, R1 was admitted to Assisted Living Memory Care Unit on 10/31/2023. R1 is a 92-year-old with diagnosis not limited to: Hypothyroidism, Major Depressive Disorder, Unspecified Dementia with Behavioral Disturbances, Insomnia, Venous Insufficiency, Atherosclerosis, Dysphagia Oropharyngeal Phase, Anemia, Vit D Deficiency, Essential (Primary) Hypertension On 6/27/2025 at 11:39am R1 observed sitting in dining room in wheelchair. R1 observed dressed, groomed and wearing shoes and able to feed self. R1 with bruising observed under left eye. R1 responded by looking at surveyor when name called. R1 asked how eye was bruised. R1 said a scuffle with girl and swung right hand. Surveyor asked R1 if someone hit him in his eye. R1 attempted to answer but unable to understand what R1 was trying to say. On 6/28/2025 at 12:08pm R1 observed sitting in dining room in wheelchair dressed, groomed and wearing shoes. R1 alert and said he was okay. R1 observed feeding self-lunch. Bruise remains below left eye. On 6/27/2025 at 11:51am E10 (LPN) stated, R1 is alert and oriented to self but unable to consistently follow direction and it can be hard to redirect him. I was not here when he got bruise. When I came that Monday (6/16/25), I saw R1	A6010		

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and started asking questions. I took care of R1 on 6/13/2027 6:00am to 2:00pm and he did not have any bruise. A CNA asked me if I saw a bruise on R1 and I stated, no and went to see R1 and assess him. When I assessed him, he had left eye ecchymosis and painful to touch. I notified E2 (Wellness Director Consultant) and others in a text doctor, E1, E2 and E21 and they started an investigation. I did not get anything reported to me in report.

On 6/27/2025 at 3:46pm E6 (Business Office Manager/HR Director) stated, I am familiar with R1. I was not here at the time it occurred. I found out 6/16/2025 when I made a trip to memory care. I walked into memory care unit and in the common area I was greeted by the nurse who said, did you know about R1. I asked what happened to R1 and the nurse took me over to R1 and removed his cap and I saw a bruise on his face. It looked like R1 had a black eye. I asked R1 what happened, and he just looked at me. E21 (Memory Care Director) was with me and I started to ask E21 what happened. I also received an email from one of the CNAs and that is when I opened up investigation. E7 sent the email to E21 and E21 forwarded it to me. I called everyone on the PM shift and night shift. E1 notified our supervisors then I had everyone write a statement. E15 told staff she was in a scuffle with R1, we terminated E15. E16 (LPN) received discipline for not starting incident report when incident was not reported to anyone. E15 and E3 stated they told the nurse, but the nurse did not report it. E16 claimed no one reported anything to her so she resigned. E15 was suspended 6/16/2025 pending investigation. No one notified me until then and no one reported it to E1 or E2. E4 wrote a statement she submitted a statement but did not call anyone and she was counseled

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that she needed to call right away. E15 worked 6/13/24, 6/14/25, and 6/15/25 before she was suspended.

On 6/28/2025 at 11:48am E2 (Clinical Specialist, LPN) stated, I am familiar with R1 incident. E7 reported that E15 got into a fight with R1. I believe the black eye was noted by an agency nurse on Saturday 6/14/2025 but an incident was not put in. On 6/16/2025 we sent R1 out to rule out any injury. R1 sent out and came back same evening with no further injury. I was told E15 went to put R1 to bed and E7 said E15 had a swollen lip and E15 said I got in a fight with R1 and I punched him. E7 heard R1 had a black eye and reported it that Monday (6/16/2025). I in-serviced everyone on Monday, 6/16/2025 and reporting injury of unknown origin. E15 gave statement and I asked her on a call when she was let go, if she told the nurse. E15 had an attitude on the phone and sounded annoyed. E15's attitude and demeanor were concerning. Conversation with her was very short. Surveyor asked, was she terminated. E6 stated, yes, she was let go due to this incident and altercation was substantiated between R1 and E15. What is the process for abuse. Make sure resident and staff are safe and immediately report to floor nurse who lets management know and if we have to call the police we will. Once resident is safe, the nurse completes incident report and report PCP, POA and report to IDPH. Get statements that witnessed this incident and deep dive into what went on. Immediately maintain the safety of the resident. Must immediately report and make sure resident is safe. We will interview memory care residents. E2 stated, I am somewhat familiar with R4 and he recently got a skin tear when she was putting him to bed and he scratched her and she grabbed his arm and that is when he got skin tear

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and she reported to the nurse and said just so you know R4 has a skin tear he was scratching me and I grabbed his arm and it caused a skin tear. This should not have happened. The staff are trained if they have behaviors to disengage and reapproach and let the nurse know and wait to reengage.

On 6/28/25 at 1:07pm E7 (Resident Assistant) stated, I am familiar with R1. I worked 6/13/2025 2:00pm to 10:30pm. We were finishing up round and putting resident to beds. E15 had R1 and he usually goes last. It was about 9:00pm I was sitting in booth in day room and E15 came and sat down breathing heavy and she said R1 hit her in the mouth & her lip was a little swollen but she was upset then continued to say she and R1 got into a tussle and said you want to fight old man, R1 put his fists up and they had a brawl in R1's room and E15 said she grabbed him by the beard and they were going round and round in his room. E15 seemed proud of it. The next day, I saw R1's face and dry blood on mustache and beard and eye black and top lip swollen and bottom lip swollen and texted E21 and told him E15 gave R1 that shiner and swollen lip and the next day or 2 days said she is on the shift, and he said I cannot do anything without writing a statement. I reported it to E21 the next morning 6/15/2025 when I saw R1's face. I came to see a resident and saw R1's face. About 9:30am I texted E21's phone that morning on Saturday (6/14/2025). Regarding R4 I dressed him, and I will put him to bed. I saw skin tear but I did not know what happened. I thought it was reported.

On 6/28/2025 at 1:26pm E1 (Senior Executive Director) stated, going thorough time of events, statements and altercation between E15 and R1 in bathroom and fall in common area. E15's

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original statement to E6 and E7 said she had an altercation with R1 which resulted in E15 punching R1. Progress note overnight that V22 saw bruising around his eye on the night of 6/13/2025. We called in V22 to do an incident report to properly complete the incident report. we got notice about 11:00am on 6/16/25 that E15 told her R1 had altercation and E15 was suspended and started investigation and gathering statement to see what exactly happened and reported to IDPH. We did call the police and do a police report.

On 6/29/2025 at 9:50am E21(Memory Care Director) stated, I am familiar with R1. I did not hear anything about the incident regarding R1 that occurred on 6/13/25 on that day. I received a report on Saturday I was manager on duty, E7 (CNA) sent me a report via email describing the incident with R1 and what E15 told E7 that stated E15 and R1 got into a fight, and she seemed proud of it. E21 stated, any type of incident like that is to be reported and we are mandated reporters so it should have been reported, get statements and start investigation and the perpetrator would get suspended. E15 was not suspended until that Monday (6/16/2025). The staff would report to any manager then E6 gets involved and V1. While E15 was talking to E6, I heard her side of her story, I did my portion to make sure residents felt safe using a questionnaire. I briefly spoke with E16 but I do not remember conversation, but I asked her to submit a statement of what happened because she was the nurse on that day. I am familiar with R4, and the incident that occurred on 6/24/2025 during the time he was placed into bed. R4 was being aggressive and E14 grabbed his arm which resulted in R4 getting a skin tear. I followed up with E17 the nurse and I spoke to E16. I did not

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speak with E14, I did not see her. That was not appropriate what E14 did, she should have stepped away and got another CNA and approached resident differently and reassure resident that everything is okay and talk in nice tone. Incident should have been reported and coaching and possible discipline should have been done and in-service regarding dementia behavior and scenarios when resident are agitated. I would get her statement and get her side of the story, not sure if abuse or accident. It should be reported, and I would have spoken to her to see how she is approaching resident. An investigation should be started. How is resident protected during time period of investigation. E21 stated, she probably should not work, and I would discuss with the team. I did go to look at skin tear but there was a bandage, so I did not see actual skin tear.

On 6/29/2025 at 2:26pm E22 (LPN Agency) stated, I only had R1 as a resident when I worked there. I took care of him on 6/13/2025 night shift 10:00pm-6:00am. I did not get anything from the nurse that R1 had any altercation. No one said anything to me. At 10:00pm I made my rounds and resident was sleeping in bed with his wife. At 12:00am I made rounds and R1 was sleeping with wife. At 2:00am I saw R1 sitting on edge of bed and I asked R1 what was wrong. R1 stated he was cold, and I turned off the air conditioner. I turned on the light and saw his eyes. I thought it happened on previous shift, so I asked the CNAs about R1's eye. The CNAs said he usually get up to go pee. I made a progress note about his eye and communicated with morning nurse. I did my assessment and evaluated for pain, no sign of pain or bleeding. I continued to monitor and assess and communicated with morning nurse. When I saw him, I assessed him immediately and

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he said he did not feel any pain. I went to the CNA and I told them what I saw and they said maybe it happened on shift prior and I said ok, but I did not get any report about R1 having any black eye. I only got report about his wife because her sugar can drop very quickly. I communicated with the CNAs because they know him better than I do. In the morning the CNA that worked the day prior said that did not happen during my shift and I told the night CNA to put down about his eye in her charting. I documented on the progress notes, and I communicated it to the morning nurse that was taking over from me. I did not do an incident report because it did not happen on my shift. The facility contacted me and asked me to come back and complete an incident note. R1 was not able to tell me what happened. He had a black eye on the left, I don't remember anything else. R2's wife was asleep, but she is not able to understand what goes on around her.

R4 is a 100-year-old with diagnosis not limited to: Posterior Displaced Type II Dens Fracture, Fracture of Unspecified Part of Left Clavicle, Unspecified Dementia, Benign Prostatic Hyperplasia, Repeated Falls
According to R4's face sheet printed 6/27/2025, R4 was admitted to Assisted Living Memory Care Unit on 09/02/2023.

On 6/28/2025 at 12:14pm R4 alert, dressed, groomed, wearing shoes and sitting in high back chair in dining room eating lunch. Staff feeding R4 with no concerns. No concerns with resident to staff interaction. R4 able to answer simple questions but unable to make needs known. R4 in hospice and has a wound aide due to wound on sacral area. Surveyor unable to observe right arm skin tear due to bandage in place.

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A6010	Continued From page 26 On 6/28/2025 at 12:57pm, E14 (CNA) stated, I am familiar with R4 and incident that occurred on 6/24/25. R4 was combative and put his nails in my arm when I was putting him to bed. Every time I tried to wipe him, he kept swapping, and I was saying R4 let me finish. I put my arm up and when I was done with him, I realized he had a skin tear. I do not know how it happened I am not sure how, but I did not hold his arms violently. Did you hold R4's arm. I did but not violently. I was not sent home, I quit the facility on 6/26/2025 because I was not getting paid enough. On 6/29/2025 at 9:50am E21(Memory Care Director) stated, I am familiar with R1. I did not hear anything about the incident regarding R1 that occurred on 6/13/25 on that day. I received a report on Saturday I was manager on duty, E7 (CNA) sent me a report via email describing the incident with R1 and what E15 told E7 that stated E15 and R1 got into a fight, and she seemed proud of it. E21 stated, any type of incident like that is to be reported and we are mandated reporters so it should have been reported, get statements and start investigation and the perpetrator would get suspended. E15 was not suspended until that Monday (6/16/2025). During same interview, E21 stated, I am familiar with R4, and the incident that occurred on 6/24/2025. during the time he was placed into bed. R4 was being aggressive and E14 grabbed his arm which resulted in R4 getting a skin tear. I followed up with E17 the nurse and I spoke to E16. I did not speak with E14, I did not see her. That was not appropriate what E14 did, she should have stepped away and got another CNA and approached resident differently and reassure resident that everything is okay and talk in nice tone. An investigation should be started. How is resident protected during time period of	A6010		

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investigation. E21 stated, E14 probably should not work, and I would discuss with the team.

Review of employee assignment sheet for 6/13/2025, 6/14/2025, 6/15/2025, E15 continued to work. E15 was suspended on 6/16/2025.
Review of employee assignment sheet for 6/24/2024 (day of incident), 6/26/2026 E14 was not removed from resident care after reporting incident and worked 6/26/2025.
Review of facility reported incident for R1 incident occurred on 6/13/2025, facility did not report abuse to IDPH until 6/16/2025.

Facility Policy Title: Abuse and Neglect revision dated 8/1/2022 documents (in part): Policy It is the policy of American House to protect all resident rights, prohibit abuse, neglect, and misappropriation of resident property. All reports of suspected abuse will be investigated in a timely manner, with emphasis on protection of the resident after report of an incident and during the investigation. Purpose: To ensure resident safety Procedure: 1. Definition To assist our community's staff members in recognizing incidents of abuse, the following definitions of abuse are provided: PHYSICAL ABUSE is the willful act of inflicting bodily injury or physical mistreatment. This includes, but is not limited to, striking, with or without an object, slapping, pinching, choking, kicking, shoving, prodding, or the use of chemical restraints or physical restraints. 3. Training a. All employees/ Direct Care Agents are trained to report suspected abuse, neglect or exploitation. b. American House Associates and agency supplemental personnel will be trained regarding abuse prevention, reporting, and investigation upon orientation and annually thereafter. vi. How, and to whom staff should report their knowledge related to

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allegations 5. Identification a. Through implementation of the training and prevention processes, all staff; residents, and families will be knowledgeable of how to identify and report incidents of abuse, or suspected abuse. i. Associates will identify events, such as suspicious bruising of resident's occurrences, patterns and trends that may constitute abuse. 6. Immediate Response a. Anyone who witnesses an incident of suspected abuse, neglect, involuntary seclusion, or misappropriation of resident property is to tell the alleged abuser to stop, and report the incident to the supervisor on duty. The supervisor's immediate responsibility is to protect the resident by implementing the following steps. i. The associate alleged to have committed the act of abuse would be immediately removed from duty, pending an investigation. 7. Investigation a. The Executive Director may delegate all or part of the investigation, but he/she remains accountable for the process. i. If an allegation or suspected abuse, neglect or exploitation has been reported, complete an Incident Report. 8. Protection a. The resident will be protected from harm during the investigative process through an action that is least disruptive to the resident. i. Protection from further abuse can take place as applicable through the following: 1. Separation of resident from caregiver. 9. Reporting a. American House employees and/or Direct Care Agents who have reasonable cause to believe that a resident is being or has been abused, neglected or exploited shall report the information immediately to the Executive Director. i. American House Employees/ Direct Care Agents are mandated reporters so they must report any known or suspected resident abuse, neglect or exploitation. Reports should be without fear of reprisal, retaliation, disciplinary action, or termination. ii.

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A6010	Continued From page 29 Failure to report can make employee/ Direct Care Agents just as responsible for the abuse in accordance with State Law. Failure to follow this policy may result in discipline, up to an including termination.	A6010		