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A 000	Initial Comment Annual Licensure Survey Violations cited: 295.2040b)5)c)3)e)g)h) 295.3000f)3) 295.3030a)b)c)d)e)1)2) 295.3040 295.4010d)e)g)1)A)B)C)h) 295.4050 295.7000b)5) Facility Reported Incident to 2/7/26, IL200893 Violations cited: 295.5000f)1)2)j)1)2)3)4)5) 295.6000a)13 295.6010a)1)	A 000		
A2040	Section 295.2040 Disaster Preparedness This Regulation is not met as evidenced by: Section 295.2040 Disaster Preparedness b) Each establishment shall: 5) Orient each resident to the emergency and evacuation plans within 10 days after the resident's arrival. Orientation shall include assisting residents in identifying and using emergency exits. Documentation of the orientation shall be signed and dated by the resident or the resident's representative. c) At least six drills shall be conducted per year on a bimonthly basis. At least two of the drills shall be conducted during the night when residents are sleeping. All drills shall be held under varied conditions to: 3) Evaluate the effectiveness of disaster plans, procedures and training. e) Drills shall include residents, establishment personnel, and other persons in the	A2040		

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A2040	Continued From page 1 establishment. g) Drills shall involve the actual evacuation of residents to an assembly point as specified in the emergency plan and shall provide residents with experience using various means of escape. If an establishment has an evacuation capability classification of impractical, those residents who cannot meaningfully assist in their own evacuation or who have special health problems shall not be required to participate in the drill; however, other requirements of the Life Safety Code will apply. h) A written evaluation of each drill shall be submitted to the establishment manager and shall be maintained for one year from the date of the drill. The evaluation shall include the date and time of the drill, names of employees participating in the drill, and identification of any residents who received assistance for evacuation. Type 1 Violation Based on interview and record review the establishment failed to ensure four (R1, R2, R3, and R4) of four residents were oriented to the disaster evacuation plan and failed to perform required emergency evacuation drills, list residents requiring assistance and document evaluation. These failures create a substantial probability of severe harm to a resident or residents. Findings include: The establishments Disaster Policy and Procedure dated 7/2012 documents the Director shall conduct fire drills monthly, on alternating shifts. During a drill all persons will evacuate beyond "the egress doors at the furthest point away from the fire. The Director shall conduct	A2040		

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A2040	Continued From page 2	A2040		

evacuation drills, each quarter, and maintain a record of the date, participants, and duration of the drill.

The undated Resident Handbook documents Emergency Drills: "(Establishment) will conduct periodic emergency drills, including fire, tornado and evacuation drills. All residents are expected to participate in all drills and actual emergency evacuations."

1. The resident records for R1 through R4 do not include documentation of emergency evacuation orientation having been completed.

On 3/26/26 at 2:00 pm, E1 ED/Executive Director stated the establishment does not do emergency disaster orientation for residents and does not have residents sign that they have been oriented.

2. E1 ED/Executive Director provided four Fire Drill Reports for 2025 to current. Fire Drill Reports dated 7/18/25 and 9/1/25 document drills were conducted for new and existing second and third shift employees as an in service on procedures and plans. No resident names listed as participating, residents requiring assistance, or evaluation of drill. The Fire Drill Reports dated 12/11/25 and 1/23/26 document fire drills were conducted on the third and second shift. These reports do not document residents who participated, residents who required assistance, or an evaluation of the drill.

On 3/27/26 at 2:00 pm, E4 Maintenance Coordinator confirmed there were only four fire drills completed and there were no drills completed for the first shift. July and September 2025 drills were only for the staff in servicing and residents were not included. The December 2025

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A2040	Continued From page 3 and January 2026 drills included the residents and the staff. E4 stated he was unaware that he needed to document residents who required assistance. The Resident Roster dated 3/24/26 documents there are 42 Assisted Living Residents residing in the establishment.	A2040		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: Section 295.3000 Personnel Requirements, Qualifications and Training f) In addition to the information required in subsection (e) of this Section, the file for each direct care employee shall contain documentation of: 3) Compliance with the Health Care Worker Background Check Act; and 4) Documentation that the employer has checked the status of the employee with the Nurse Aide Registry. Type 2 Violation Based on interview and record review the establishment failed to ensure employee annual verifications were completed for twelve (E3, E6, E9, E11, E13, E15, E16, and E18 through E22) of 14 employees who have worked for greater than one year at the establishment. This failure creates a substantial probability of harm to a resident or residents. Findings include:	A3000		

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The Employee Roster documents there are currently 14 staff members who have worked at the establishment for greater than a year. This Roster includes the following the staff name, title and start dates as: E15 Certified CG/Caregiver as 4/11/2000; E16 Certified CG as 9/6/2001; E6 Wellness Nurse as 6/6/2014; E3 Family Advocate as 7/25/22; E13 CG as 3/22/23; E17 Wellness Nurse as 3/4/24; E18 Montessori Engagment Coordinator as 5/31/24; E19 Certified CG as 2/20/25; E20 Certified CG as 2/18/25; E9 Dishwasher as 2/27/25; E12 Certified CG as 3/12/25; E21 Certified CG as 3/12/25; E22 Certified CG as 3/12/25; and E25 Wellness Nurse as 3/24/25.

E1 ED/Executive Director provided a printed list of employee registry verifications from 2015 to current and highlighted all current employees still working at the establishment. This list only documents three staff have been checked since 2022; E12 Certified CG, E13 Certified CG, and E14 Certified CG.

On 3/27/26 at 4:15 pm E1 ED demonstrated the Health Care Worker Background Registry system to show how employee verifications are completed. During observation E1 ED pulled up full list of employees who have been verified through the registry and confirmed E12 Certified CG/Caregiver start date 3/12/25 was verified on 3/12/26, E13 Certified CG start date 3/22/23 was verified on 8/22/25, and E14 start date 10/7/25 was verified on 3/3/26. E1 ED confirmed no other employee verifications have been completed since 2022.

On 3/27/26 at 4:20 pm E1 ED stated he does all the health care worker background checks for

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A3000	Continued From page 5 new hires but was unaware employee verifications had to be completed annually. The establishment Resident Roster dated 3/24/26 documents there are currrently 42 residents residing in the assisted living.	A3000		
A3030	Section 295.3030 Initial Health Eval for Dir Care and FS empl This Regulation is not met as evidenced by: Section 295.3030 Initial Health Evaluation for Direct Care and Food Service Employees a) Each direct care and food service employee shall have an initial health evaluation, which shall be used to ensure that employees are not placed in positions that would pose undue risk of infection to themselves, other employees, residents, or visitors. b) The initial health evaluation shall be conducted not more than 30 days prior to and no later than 30 days after the employee's initial employment in the establishment. c) The initial health evaluation shall include the employee's immunization status. d) The initial health evaluation shall include a physical examination. The examination shall include a determination that the employee appears to be physically able to perform the job functions that the establishment intends to assign to the employee. e) Each employee shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696). The test must meet one of the following time frames: 1) The test must be completed no more than 90 days prior to the date of initial employment in the	A3030		

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A3030	Continued From page 6	A3030		

establishment; or
2) The test must be commenced no more than ten days after the date of initial employment in the establishment.

Type 2 Violation

Based on interview and record review the establishment failed to ensure all staff obtained an initial health evaluation and received TB (tuberculosis) testing and annual screening for eight (E2, E5, E6, E7, E8, E9, E10, and E11) of nine employees reviewed for staffing requirements. These failures create a substantial probability of harm to a resident or residents.

Findings include:

The establishment Tuberculosis Screening policy and procedure dated 4/2025 documents TB screening will be done at the time of hire and annually. "1. Upon hire, all (establishment staff) must undergo a two-step Mantoux Purified Protein Derivative (PPD) test to ensure that they are not infected with tuberculosis. 2. If they bring proof of a recent (within the last 30 days) negative two-step Mantoux test, the (establishment staff) will not need to undergo additional testing." Establishment staff members "must complete a Tuberculin Screening Assessment Questionnaire annually."

The employee files for E2 HWD/Health and Wellness Director with start date of 10/9/25, E5 Breadbasket Manager with start date of 6/11/25, E6 Wellness Nurse with start date of 6/6/14, E7 Certified CG/Caregiver with start date of 3/5/26, E8 CG Assistant with start date of 1/29/26, E9 Dishwasher with start date of 2/27/25, E10 Housekeeper with start date of 12/29/25, and E11

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A3030	Continued From page 7 CG Assistant with start date of 12/1/23 do not include an initial TB Mantoux two-step test or chest x-ray having been completed. The employee files for E6 Wellness Nurse with start date of 6/6/14, E9 Dishwasher with start date of 2/27/25, and E11 CG Assistant with start date of 12/1/23 do not include documentation of annual TB screenings having been completed. On 3/26/26 at 10:40 am, E2 HWD (Health and Wellness Director) stated we do not have any TB serum here to do TB skin tests. "I don't know where we get that from." E2 HWD stated she is not sure about the annual screenings as she has not seen a form at the establishment to complete them. On 3/26/26 at 2:00 pm, E1 ED stated "I'm gonna be honest with you" the employees have not had the initial TB tests done and annual TB screenings have not been done. The establishment Resident Roster dated 3/24/26 documents there are currently 42 assisted living residents residing in the establishment.	A3030		
A3040	Section 295.3040 Health Care Worker Background Check This Regulation is not met as evidenced by: 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	A3040		

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A3040	Continued From page 8 August 16, 2012) Type 2 Violation Based on observation, interview, and record review the establishment failed to complete annual verification employment through the Health Care Worker Registry for twelve (E3, E6, E9, E11, E13, E15, E16, and E18 through E22) employees who have worked for greater than one year at the establishment. These failures create a substantial probability of harm to a resident or residents residing in the establishment. Findings include: The Establishments Employee Roster documents 14 of 53 employees have worked at the establishment for greater than a year. 12 of the 14 employees have not been verified on the Registry. This same Roster documents the following staff, title and hire dates as: E3 Family Advocate as 7/25/2022; E6 Wellness Nurse as 6/6/2014; E9 Dishwasher as 2/27/2025; E11 CG (Caregiver) Assistant as 12/1/2023; E13 Certified CG as 3/22/2023; E15 Certified CG as 4/11/2000; E16 Certified GG as 9/6/2001; E18 Montessori Engagement Coordinator as 5/31/2024; E19 Certified CG as 2/20/2025; E20 Certified CG as 2/18/2025; E21 Certified CG as 3/12/2025; and E22 Certified CG as 3/12/2025. On 3/27/26 at 4:15 pm, E1 ED/Executive Director demonstrated the Health Care Worker Background Registry system to show how employee verifications are completed. During observation E1 ED pulled up full list of employees who have been verified through the registry and confirmed E12 Certified CG/Caregiver, start date 3/12/25 was verified on 3/12/26, E13 Certified	A3040		

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A3040	Continued From page 9 CG start date 3/22/23 was verified on 8/22/25, and E14 with start date 10/7/25 was verified on 3/3/26. E1 ED also confirmed no other employee verifications having been completed prior to 2022. The Resident Roster dated 3/24/26 document there are currently 42 assisted living residents residing in the establishment.	A3040		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Section 295.4010 Service Plan d) The service plan, which shall be reviewed annually or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for their service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act) e) The service plan shall be reviewed and revised if necessary immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000). g) Service plans shall address: 1) The level of service the resident is receiving, including: A) assistance with activities of daily living; B) dietary needs, if the establishment provides therapeutic diets; and C) special accommodations for the resident: h) The service plan shall include all support services provided or arranged for by the establishment.	A4010		

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A4010	Continued From page 10 Type 2 Violation Based on observation, interview, and record review the establishment failed to revise resident service plans to reflect resident care and services for three (R1, R2, and R3) of four residents reviewed for service plans in the sample of four. This failure creates the substantial probability of harm to a resident or residents. Findings include: The establishment Service Planning and Agreement policy and procedures dated 3/2024 documents "A Service Plan shall be developed and maintained for each resident that corresponds with their individual needs and preferences." Staff shall provide services as documented in the Service Plan. The service plan is to be reviewed and updated every 180 days or as needed. 1. The electronic record for R1 documents R1 had a fall on 3/18/26 at 2:15 am in his room hitting his face on a table below his television. This fall resulted in lacerations to R1's right and left forehead, bruising to entire face extending down the sides of his face, under his chin, and down his neck. The current Service Plan for R1 dated 1/28/26 documents R1 is independent with toileting, transfers, mobility, activities, and eating. Requires assist of one staff member for bathing and dressing and uses a walker for ambulation. This current Service Plan was not revised to include R1's fall or fall interventions. 2. The electronic record for R2 documents R2 with recurrent falls on 8/27/25 and 10/1/25 due to	A4010		

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attempting self-transfers and 2/11/26 fell out of bed.

The current Service Plan for R2 dated 12/9/2025 documents R2 requires assistance of staff with bathing, dressing, toileting, oral care, eating, transfers, mobility, activities, and evacuation. This Service Plan does not address or include interventions for R2 falls on 8/7/25, 10/1/25, and 2/11/26.

3. The electronic record for R3 documents R3 with 18 recurrent falls on 6/13/25 slid out of wheelchair; 6/21/25 at 9:01 am and 11:43 am fell out of wheelchair; 6/26/25 fell out of wheelchair; 7/2/25 fell off toilet; 8/12/25 fell off toilet; 9/23/25 fell during self-transfer to toilet; 11/2/25 fell off toilet; 11/16/25 self-transfer from toilet to wheelchair; 1/3/26 fell off toilet; 1/9/26 fell out of wheelchair; 1/23/26 fell out of wheelchair; 1/26/26 fell self-transfer from toilet to wheelchair; 1/30/26 at 2:27 pm fell during self-transfer from wheelchair and 6:26 pm fell out of wheelchair; and 2/2/26 during self-transfer from wheelchair.

The current Service Plan for R3 dated 2/9/26 documents R3 requires assistance with bathing, toileting, transfers, dressing, mobility, activities, and evacuation. This Service Plan does not address or include fall interventions for any of R3's falls.

On 3/27/26 at 2:30 pm, E2 HWD/Health and Wellness Director stated she does the annual Service Plans and the Service Plans for all new residents. E2 HWD confirmed the Service Plans for R1, R2, and R3 have not been revised to include their falls or fall interventions and not sure how to add interventions without doing a whole new service plan. Confirmed there are no

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A4010	Continued From page 12 residents with Negotiated Risk at this time.	A4010		
A4050	Seciton 295.4050 Tuberculin Skin Test Procedures This Regulation is not met as evidenced by: Section 295.4050 Tuberculin Skin Test Procedures Tuberculin skin tests for employees and residents shall be conducted in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696). Type 2 Violation Based on interview and record review the establishment failed to do TB (tuberculosis) testing for four (R1, R2, R3, and R4) of four residents reviewed for immunizations in the sample of four. This failure creates a substantial probability of harm to a resident or residents. Findings include: 1. The establishments Tuberculosis Screening - Resident policy and procedure dated 4/2025 documents "Tuberculosis (TB) screening will be done at the time of move-in on all new Residents. 1) Upon move-in, all Residents must undergo a two-step Mantoux Purified Protein Derivative (PPD) testing to ensure that they are not infected with tuberculosis, unless the Resident brings proof of a recent (within the last 30 days) negative two-step PPD test, or is a known reactor." The Face sheet for R1 documents R1 admitted to the establishment on 2/7/26. R1's health record does not include documentation of R1 receiving	A4050		

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A4050	Continued From page 13 the two-step TB testing. The Face sheet for R2 documents R2 admitted to the establishment on 5/24/25. R2's health record does not include documentation of R2 receiving the two-step TB testing. The Face sheet for R3 documents R3 admitted to the establishment on 6/12/25. R3's health record does not include documentation of R3 receiving the two-step TB testing. The Face sheet for R4 documents R4 admitted to the establishment on 3/28/25. R4's health record does not include documentation of R4 receiving the two-step TB testing. 2. The establishments Tuberculosis Screening policy and procedure dated 4/2025 documents "Tuberculosis (TB) screening will be done at the time of hire and annually. 1) Upon hire, all (staff members) must undergo a two-step Mantoux Purified Protein Derivative (PPD) testing to ensure that they are not infected with tuberculosis." "(Staff Members) must complete a Tuberculin Screening Assessment Questionnaire annually." The employee files for E2 HWD/Health and Wellness Director with start date of 10/9/25, E5 Breadbasket Manager with start date of 6/11/25, E6 Wellness Nurse with start date of 6/6/14, E7 Certified CG/Caregiver with start date of 3/5/26, E8 CG Assistant with start date of 1/29/26, E9 Dishwasher with start date of 2/27/25, E10 Housekeeper with start date of 12/29/25, and E11 CG Assistant with start date of 12/1/23 do not include an initial TB Mantoux two-step test or chest x-ray having been completed.	A4050		

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A4050	Continued From page 14 The employee files for E6 Wellness Nurse with start date of 6/6/14, E9 Dishwasher with start date of 2/27/25, and E11 CG Assistant with start date of 12/1/23 do not include documentation of annual TB screenings having been completed. On 3/26/26 at 10:40 am and 11:15 am, E2 HWD stated there is no TB serum in the establishment to do TB testing and does not know where to get it from. E2 HWD stated she even checked with sister memory care establishment next door. E2 HWD stated she has not seen an annual TB Screening Form at the establishment. E2 HWD confirmed no TB testing or annual TB screenings are being done for the residents or staff. The establishment's Resident Roster dated 3/24/26 documents there are currently 42 assisted living residents residing in the establishment.	A4050		
A5000	Section 295.5000 Medication Reminders, Supervision of Self Med This Regulation is not met as evidenced by: Section 295.5000 Medication Reminders, Supervision of Self-Medication, Medication Administration and Storage f) If an establishment provides medication administration or supervision of self-administered medication, the establishment's medication policies and procedures shall be approved by a physician, pharmacist, or registered nurse and shall address: 1) Obtaining and refilling medication; 2) Storing and controlling medication; j) A separate medication record shall be	A5000		

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A5000	Continued From page 15 maintained for each resident receiving medication administration and shall include: 1) Name of resident; 2) Name of medication, dosage, directions, and route of administration; 3) Date and time medication is scheduled to be administered; 4) Date and time of actual medication administration; and 5) Signature or initials of the employee administering medication. Type 1 Violation Based on interview and record review the establishment failed to ensure physician ordered medications were obtained upon admission for one (R1) of four residents reviewed for medication administration in the sample of four. This failure resulted in R1 not receiving physician ordered cancer medication for 33 days, requiring more blood testing and possibly reimaging scans for Prostate Cancer. This failure creates a substantial probability of severe harm to a resident or residents. Findings include: The establishments Medication Administration policy and procedure dated 4/2025 documents "An accurate up-to-date MAR (medication administration record) shall be maintained." "The HWD (Health and Wellness Director) monitors each resident for response to a Branch-administered medication, ensures that the medication orders are current and that the medications are administered as ordered." The establishments Medication Record Maintenance policy and procedure dated 4/2025	A5000		

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A5000	Continued From page 16 documents "(Establishment) shall maintain a current Medication Administration Record (eMAR) and Physician's Order Sheet (POS) on all residents." The establishments Medication Error policy and procedure dated 4/2025 documents "A system shall be maintained that ensures medication will be given correctly, according the 'Medication Rights'. Any medication error that occurs shall be documented as an Incident Report in the EHR (electronic health record) and reported, so that action may be taken to correct deviation from these expectations. The medication cart and Medication Administration Record (eMAR) shall be monitored weekly by the Health & Wellness Director (HWD) or Licensed Nurse. The HWD or Licensed Nurse will inspect to see that all meds are given and documented per physician's order." The EHR for R1 documents R1 was admitted to the establishment on 2/7/26 with a diagnosis of Prostate Cancer and a physician order for the cancer medication Abiraterone 250 mg (milligrams) to be taken by mouth every day. The Physician Orders for R1 dated February 2026 to March 2026 documents a physician order for Abiraterone 250 mg was added on 3/12/26 to be given daily at 9:00 am. The eMAR for R1 for February does not document R1 received Abiraterone. The eMAR for R1 for March 2026 documents R1 started receiving Abiraterone on 3/13/26. A Medication Error Report for R1 dated 3/13/26 documents admission physician ordered abiraterone 250 mg daily was omitted by	A5000		

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A5000	Continued From page 17	A5000		

establishment pharmacy due to needing physician clarification of dosage. Error was discovered while R1 was being seen by cancer doctor. To prevent further medication errors "Health & Wellness Director will reconcile admission orders of all new admits."

On 3/25/26 at 2:40 pm, R1 stated the Nurses bring him his medications and he takes them. R1 stated he recently discovered there was one of his medications he wasn't getting but cannot remember the details.

On 3/25/26 at 11:50 am, E2 HWD stated R1 was admitted to the establishment on 2/7/26. The process for admissions is that the medication list is sent to the pharmacy, pharmacy puts the medications into the eMAR and then sends the medications to the establishment. E2 HWD stated R1 had an appointment with Z2 (R1's) Oncologist on 3/12/26 and R1 told Z2 that he was not taking one of his medications. Z2 Oncologist and Z4 (R1's) POA/Power of Attorney called the establishment and this was when the establishment was first made aware of R1's cancer medication (Abiraterone). E2 HWD stated R1 did not receive the Abiraterone medication for about five weeks because no one at the establishment knew about the medication. E2 HWD stated the pharmacy did not send the medication or put it on R1's eMAR. E2 HWD confirmed no one at the establishment reconciles the admission medications, they are just sent to the pharmacy. E2 HWD stated "I will now be reconciling all new admission medications orders."

On 4/1/26 at 10:23 am, Z3 (Z2's) RN/Registered Nurse the concern is with the PSA (prostate specific antigen) levels. Abiraterone significantly

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A5000	Continued From page 18 reduces the PSA levels by depriving the body of hormones. Cancer feeds off hormones and could thereby cause the spread of cancer. We like to keep PSA levels low; like to see undetectable. Normal level is 4.0. R1's PSA level was 0.67 on December 18, 2025, and on March 12, 2026, it increased to 1.01. Even though it is still considered under the normal level it has increased some. R1 is scheduled to have another PSA level drawn on April 15th so we can see if it has lowered now that he is back on the medication or if it is continuing to rise. Unsure at this point what Z2 will decide to do but may order reimaging due to the elevation.	A5000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: 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: 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor. Type 1 Violation Based on observation, interview, and record review the establishment failed to ensure admission physician ordered medications were processed, received, and available to administer for one (R1) of four residents reviewed for medication administration in the sample of four.	A6000		

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A6000	Continued From page 19	A6000		

These failures resulted in R1 not receiving physician ordered cancer medication for 33 days, having more frequent blood draws, and possibly reimaging scans regarding cancer. These failures create a substantial probability of severe harm to a resident or residents.

Findings include:

The establishments Resident Bill of Rights policy for R1 dated 2/4/26 documents the Resident has "The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor."

The establishments Medication Record Maintenance policy and procedure dated 4/2025 documents "(Establishment) shall maintain a current Medication Administration Record (eMAR) and Physician's Order Sheet (POS) on all residents."

The establishments Medication Administration policy and procedure dated 4/2025 documents "An accurate up-to-date MAR (medication administration record) shall be maintained." "The HWD (Health and Wellness Director) monitors each resident for response to a Branch-administered medication, ensures that the medication orders are current and that the medications are administered as ordered."

The establishments Medication Error policy and procedure dated 4/2025 documents "A system shall be maintained that ensures medication will be given correctly, according the 'Medication Rights'. Any medication error that occurs shall be documented as an Incident Report in the EHR (electronic health record) and reported, so that action may be taken to correct deviation from

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A6000	Continued From page 20	A6000		

these expectations. The medication cart and Medication Administration Record (eMAR) shall be monitored weekly by the Health & Wellness Director (HWD) or Licensed Nurse. The HWD or Licensed Nurse will inspect to see that all meds are given and documented per physician's order."

The EHR for R1 documents R1 admitted to the establishment on 2/7/26 with a diagnosis Prostate Cancer. R1's admission physician orders include the medication abiraterone 250 mg (milligrams) tablet, to be taken by mouth every day, and is documented that R1 has been taking the medication since 12/7/2023.

The National Cancer Institute documents abiraterone is a medication used to treat prostate cancer that has spread to other parts of the body and is used to treat patients whose cancer has not responded to treatments that lower testosterone levels or whose cancer is high risk.

A Medication Error Report for R1 dated 3/13/26 documents admission physician ordered abiraterone 250 mg daily was omitted on 2/7/26 admission by establishment pharmacy due to needing physician clarification of dosage. "No communication from pharmacy regarding the need for provider clarification." Error was discovered while R1 was being seen by Z2 (R1's) Oncologist. To prevent further medication errors "Health & Wellness Director will reconcile admission orders of all new admits."

The Initial and Final Report to the State Agency for R1 dated 3/20/26 documents "Upon admission, medication list sent to pharmacy for medications to be entered into (eMAR) as well as send the medication to (establishment). Pharmacy noted an incomplete medication order

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A6000	Continued From page 21	A6000		

for abiraterone and did not enter the medication nor send it to (establishment). The medication was then not available for (establishment) nurses to administer. Resident went to an appointment with V2 (R1's) Cancer Physician on 3/12/26 and provider corrected the original admission order for abiraterone."

On 3/25/26 at 2:40 pm, R1 stated he goes to the cancer center for Prostate Cancer and recently discovered there was one of his medications he wasn't getting but cannot remember any details. R1 stated the Nurses bring him his medications and he takes them.

On 3/25/26 at 11:50 am, E2 HWD stated R1 was admitted to the establishment on 2/7/26. The process for admissions is that the medication list is sent to the pharmacy, pharmacy puts the medications into the eMAR and sends the medications to the establishment. E2 HWD stated R1 had an appointment with Z2 (R1's) Oncologist on 3/12/26 and R1 told Z2 that he was not taking one of his medications. Z2 Oncologist and Z4 (R1's) POA/Power of Attorney called the establishment and this was when the establishment was first made aware of R1's cancer medication (Abiraterone). E2 HWD confirmed the stated the establishments pharmacy was called and said they did not process the medication order because it was incomplete and that they faxed the facility however, no one at the establishment saw a fax come in. E2 HWD stated R1 did not receive the cancer medication for about five weeks because no one at the establishment knew about the medication. E2 HWD confirmed no one at the establishment reconciles the admission medications, they are just sent to the pharmacy. E2 HWD stated "I will now be reconciling all new

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A6000	Continued From page 22 admission medications orders." On 4/1/26 at 10:23 am, Z3 (Z2's) RN/Registered Nurse stated there are no withdrawal symptoms from not getting the medication. The concern is with the PSA (prostate specific antigen) levels. Abiraterone significantly reduces the PSA levels. It deprives the body of hormones. Cancer feeds off hormones and could cause the spread of cancer. We like to keep PSA levels low, like to see undetectable. Normal level is 4.0. R1's PSA level was 0.67 on December 18, 2025, and on March 12, 2026, it increased to 1.01. Even though it is still considered under the normal level it has increased some. R1 is scheduled to have another PSA level drawn on April 15th so we can see if it has lowered now that he is back on the medication or if it is continuing to rise. Unsure at this point what Z2 will decide to do but may order reimaging due to the elevation.	A6000		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr This Regulation is not met as evidenced by: 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	A6010		

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A6010	Continued From page 23	A6010		

the report.

General Violation

Based on interview and record review the establishment failed to report a significant medication error to the State Agency within 24 hours after receiving an allegation for one (R1) of one resident reviewed for neglect in the sample of four.

Findings include:

The establishments Abuse and Neglect policy dated 2/2025 documents "Reporting procedure will be to call: The State licensure authority or State Ombudsman, whose numbers are posted in the Branch. A report will be called to the State office(s) within 24 hours by the Executive Director."

The establishments State Agency Incident and Accident Report for R1 is date and time stamped as 3/20/26 at 3:44 pm. This report documents R1 admitted to the establishment on 2/7/26 with a physician ordered cancer medication, abiraterone 250 mg (milligrams) by mouth daily. This medication was not processed by the establishment's pharmacy, not delivered to the establishment and therefore R1 did not receive the medication for 33 days.

On 3/26/26 at 10:00 am, E2 HWD (Health and Wellness Director) stated R1 went to the cancer center for an appointment on 3/12/26 and it was reported that R1 had not been receiving his cancer medication. E2 HWD stated it was not reported to her until 3/13/26. E2 HWD stated she made sure the pharmacy had the order and sent an email to the establishments corporate office

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A6010	Continued From page 24 on 3/16/26 for direction as "I was uncertain if this was supposed to be reported to the State. A few days later I was emailed back to notify the State, so I did. That's why it was late." E2 HWD confirmed that the State Agency was notified on 3/20/26.	A6010		
A7000	Secton 295.7000 Resident Records This Regulation is not met as evidenced by: Violation Section 295.7000 Resident Records b) An establishment shall maintain a resident's record that contains at least the following: 5) Documentation of orientation to the evacuation plan; Based on interview and record review, the facility failed to maintain documentation of a resident's orentation to emergency evacuation procedures for four residents (R1, R2, R3, R4). Findings include: The resident records for R1 through R4 do not include documentation of emergency evacuation orientation having been completed. On 3/26/26 at 2:00 pm, E1 ED/Executive Director stated the establishment does not do emergency disaster orientation for residents and does not	A7000		

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A7000	Continued From page 25 have residents sign that they have been oriented.	A7000		