STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510569	A. BUILDING: _____ B. WING _____	C 04/28/2026

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CARRIAGE CROSSING SENIOR LIVING	1121 COMMUNITY DRIVE ROCHESTER, IL 62563

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A 000	Initial Comment Original investigation of Complaint#2644712/IL201383. 295.2030 b) 5) 295.4000 b) 295.4010 d) e) g) 1) A) C) 2) 3) h) 295.6000 a) 1) 13) 16) 295.7000 b) 9)	A 000		
A2030	Section 295.2030 Establishment Contacts This Regulation is not met as evidenced by: Violation Section 295.2030 Establishment Contracts b) The establishment contract shall also include: 5) The establishment's policy concerning notification of a relative or other individual in an emergency, significant change in the resident's condition, or termination of residency. Based on interview and record review, the establishment failed to notify the resident's representative of a change in condition regarding verbalizations of suicidal ideations and falls, as stated in the admission contract, for one of three residents (R1) reviewed for representative notification in the sample of three. Findings include: The establishment's Fall/Injury Processes policy (revised 03/18/26) documents the following: "The nurse should be notified in all occasions of all	A2030		

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A2030	Continued From page 1	A2030		

resident falls or injuries. The nurse, once notified, will assess the resident at time of fall/injury and will determine the next steps. Fall without injury. If the resident does not have an injury, the nurse will: Notify the POA (Power of Attorney)/Responsible party; Notify the Director of Nursing, Complete an Incident/Accident Report, Document Nursing Note in Medical Record; Fall with Injury. If the resident does have an injury, the nurse will: Notify the POA/Responsible Party, Send the resident out for evaluation (if warranted), Notify the Director of Nursing, Complete an Incident/Accident Report, Document Nursing Note in the Medical Record, Complete the State Reportable if sent out for Urgent/Emergent services."

R1's Admission Contract (dated 09/01/25) documents the following: "Emergency Contact: At ant time there is a significant change in condition to the resident, or any situation that the Residence deems as an 'emergency situation,' the resident's designated representative will be notified in a timely manner."

On 04/22/26, Z1 (R1's Son/Power of Attorney) provided an email communication that includes the following concerns regarding notification of changes with R1: "Unless (E2, Director of Nursing) failed to print off certain documents, my mother's medical record is incomplete and not reflective of her current condition; and if true, the lack of documentation is terrifying. Absent of the records provided to me are: Communications regarding my mother vocalizing several times to one of her therapists that she wants to 'kill herself'. Neither myself or my aunt were contacted about these statements. Note: My Aunt and I are both aware of my mother acting out while in our respective company; however,

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A2030	Continued From page 2	A2030		

neither of us were consulted by (establishment). My mother is very appearance-oriented and has tried to hide things for years- she has, colloquial speaking, a Pollyanna Complex, in that perfect appearances override everything, including asking for help. Other relatives are clueless as to this behavior. While in our company, the tone and tenor of her actions are that of an adolescent/teen throwing a tantrum. However, the fact that she said this to someone who is neither my aunt or me is medically relevant in that it shows, at a minimum, deterioration in impulse control."

On 04/22/26 at 11:55 AM, Z1 (R1's Son/Power of Attorney) confirmed the details in the above noted email and stated, "My mother has verbalized statements of suicide in the past, but I was not notified of the increase verbalizations she was exhibiting to the staff. If I would have been made aware of these statements, I would have had her taken to the hospital to be evaluated."

R1's Physical Therapy Note (dated 02/26/26) documents the following: "Patient seen for skilled Physical Therapy Evaluation at moderate complexity secondary to three or more functional limitations related to decreased independence with gait, transfers, and increased risk for falls, Patient referred to Skilled Physical Therapy due to recent falls and decline in functional mobility. Also this date, patient reports she 'wants to kill herself.' Nursing made aware and states patient has been having suicidal ideation. Patient does not have a plan ..."

R1's Progress Notes contain no documentation that Z1 (R1's Son/Power of Attorney) was notified of R1's verbalizations of suicidal ideations during her therapy evaluation on 02/26/26.

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A2030	Continued From page 3	A2030		

R1's Progress Note (dated 02/23/26) documents, "Resident very anxious tonight, resident states she wants to kill herself and doesn't want to be here anymore, resident states she spoke with her sister and her sister told her to make sure to take this medication tonight. Resident seems fixated on incontinence episode that occurred early morning on 02/22/26, writer has tried to assure her that it happens to everyone at times, resident continues to state she does not want to be here anymore." This progress note does not document that R1's Power of Attorney, Z1, was ever notified of R1's verbalizations of suicide.

On 04/22/26 at 11:55 AM, Z1 (R1's Son/Power of Attorney) stated he was never notified of R1's verbalizations of suicidal ideations on 02/23/26 or 02/26/26.

On 04/23/26 at 11:15 AM, E2 (Director of Nursing) verified she could not provide documentation confirming that Z1 was notified when R1 verbalized suicidal ideations on 02/23/26 and on 02/26/26. E2 stated, "If it is not documented, then it has not been done."

On 04/22/26, Z1 (R1's Son/Power of Attorney) provided the following email communication regarding concerns with R1's falls: "(R1 fell at the establishment) Date unknown (occurred Between February 5, 2026, and February 13, 2026). Fall disclosed by my mother (R1) at her general practitioner's office. On February 13, 2026, my mother had a follow-up appointment with her general practitioner to check the wound sustained on February 4, 2026, and, if appropriate, to have the staples removed from her scalp; the latter was completed. Upon arriving at (establishment), I noticed rugburn/rug rash on my mother's nose and chin. It did not occur to me at the time that

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A2030	Continued From page 4	A2030		

this was the result of a subsequent fall; I was under the impression that it occurred during the fall on February 4, 2026. Whilst speaking with the practitioner who performed the exam, my mother was asked about the rugburn, noting that she had fallen again. According to my mother, this fall was witnessed by a member of senior staff, (E3, Community Relations Director), who then called for the nurse."

On 04/22/26 at 11:55 AM, Z1 (R1's Son/Power of Attorney) confirmed the details in the above noted email and stated, "My mother was asked how she had gotten the injury on her face, and she told her practitioner that she had fallen yet again after the 02/04/26 fall that required staples to repair the laceration on her head. She stated she reported this subsequent fall to (E3, Community Relations Director)." Z1 stated he was never notified of R1 falling at the establishment between 02/05/26 - 02/13/26. Z1 then stated, "My mom has fallen at least seven times, and I do not believe I have not been notified after all of her falls."

On 04/22/26 at 03:20 PM, E3 (Community Relations Director) stated she recalls R1 reporting a fall to her, "a few months back." E3 stated, "I was rounding and checking in on the residents and (R1) was standing at her doorway. I do recall (R1) had told me that she had just fallen, but she was already standing so she must have gotten herself up. I asked her if she had told anyone and she told me 'No.' So I believe I went and told a nurse. I have an old brain, and I believe I recall one of the Resident Aides was also present. If I wasn't the person that reported (R1's) fall to the nurse, the Resident Aide was." E3 stated she could not recall who the nurse was that was informed when R1 self-reported a fall, or the Resident Aide that was present and involved

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A2030	Continued From page 5 at the time R1 reported this fall. R1's medical record has no documentation of R1 falling at the establishment between 02/05/26 - 02/13/26, or documentation that Z1 (R1's Son/Power of Attorney) was notified of R1 falling during this time frame. On 04/22/26 at 03:25 PM, E2 (Director of Nursing) stated she does not have record of R1 reporting a fall to E3 (Community Relations Director) at any point in time throughout R1's stay at the establishment. E2 stated, "We should be documenting all resident falls that occur in the building, and the POA (Power of Attorney) should be notified any time a resident has fallen."	A2030		
A4000	Section 295.4000 Physician/s Assessment This Regulation is not met as evidenced by: Violation Section 295.4000 Physician's Assessment b) At least annually, once a resident has moved into the establishment, a comprehensive assessment shall be completed by a physician. Based on interview, observation and record review, the establishment failed to ensure a Physician's Assessment was completed annually by a Physician for one of three residents (R2) reviewed for Physician's Assessments in the sample of three. This failure creates a substantial probability of harm to a resident or residents.	A4000		

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A4000	Continued From page 6 Findings include: The establishment's current Resident Roster documents R2 was admitted to the establishment on 11/02/21. R2's current medical record documents that R2's most recent Physician's Assessment was completed by Z2 (Nurse Practitioner) on 03/25/25. On 04/23/26 at 11:00 AM, E2 (Director of Nursing) confirmed that R2's most recent Physician's Assessment had not been completed within the past year and was not completed and signed by a physician.	A4000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 1 Violation 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 the 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,	A4010		

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A4010	Continued From page 7 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; C) special accommodations for the resident; 2) The amount, type, and frequency of health-related services needed by the resident; 3) Staff responsible for the provisions of the service plan; h) The service plan shall include all support services provided or arranged for by the establishment. Based on interview and record review, the establishment failed to revise a service plan to accurately reflect resident falls, assistive devices, medication administration, and resident behaviors for three of three residents (R1-R3) reviewed for service plans in the sample of three. This failure creates a substantial probability of severe harm to a resident or residents. Findings include: The establishment's 'Procedures for Resident Change in Condition Form' policy (revised 03/18/25) documents the following: "If the change in condition results in the resident needing additional care needs that are not reflected in the current service plan, the Director of Nursing will conduct an assessment and update the service	A4010		

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A4010	Continued From page 8	A4010		

plan to include the care services needed."

1. R1's current Service Plan (dated 09/09/25) documents the following: "Focus: Medication Management. Interventions: Resident needs medication administered by a licensed nurse (eye drops only), Resident needs medication reminders for self-administered medications; Focus: Ambulation. Interventions: Resident is independent with ambulating; Focus: Behavior Management. Interventions: Provide calm environment for resident, Provide person-centered care to decrease behaviors."

R1's Progress Note (dated 02/12/26) documents, "It was reported to this writer by therapy that the resident stated she had fallen in the hallway and gotten herself back up. Resident stated she had left her room to go to the front and wait for her son. As she was walking to the front she realized she had forgotten her walker and turned around to go back to her room she 'must have tripped on her own two feet.' She stated she did not hit her head but did hit her mouth. Resident stated that she was not in any pain."

R1's Medication Administration Record (dated 01/01/26 - 04/23/26) document R1's medications have been prepared and administered by a licensed nurse during this time frame.

On 04/23/26 at 11:00 AM, E2 (Director of Nursing) stated R1 ambulates with the assistance of a walker and her current Service Plan is inaccurate and should mention that R1 utilizes a walker when ambulating. E2 then stated R1's service plan is also inaccurate because all of R1's medications are prepared and administered by the licensed nurses at the establishment.

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R1's Fall Investigations document R1 fell at the establishment on the following dates: 09/20/25, 10/28/25 at 10:15 AM, 10/28/25 at 10:29 AM, 11/04/25, 01/02/26, and 02/04/26.

R1's current Service Plan has no mention of R1's falls on 09/20/25, 10/28/25 at 10:15 AM, 10/28/25 at 10:29 AM, 11/04/25, and 01/02/26, or any fall prevention interventions that were implemented following these falls.

On 04/23/26 at 11:10 AM, E2 (Director of Nursing) confirmed that R1's Service Plan had not been revised to reflect R1's falls on 09/20/25, 10/28/25 at 10:15 AM, 10/28/25 at 10:29 AM, 11/04/25, and 01/02/26, and R1's Service Plan does not document any interventions that were implemented following these falls.

R1's Progress Notes document that R1 has verbalized suicidal ideations on multiple occasions throughout her residency at the establishment.

R1's current Behavior Management Plan has no mention of R1's verbalizations of suicidal ideations.

On 04/23/26 at 11:15 AM, E2 (Director of Nursing) verified that R1's current Service Plan has no mention of R1's verbalizations of suicidal ideations and stated, "This should be noted on her Service Plan."

2. R2's Fall Investigations document R2 fell at the establishment on 11/26/25, 01/30/26, and 03/29/26.

R2's current Service Plan has no mention of R2's falls on 11/26/25, 01/30/26, and 03/29/26, or any

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A4010	Continued From page 10 fall prevention interventions implemented after these falls. On 04/23/26 at 11:20 AM, E2 (Director of Nursing) stated R2's Service Plan had not been revised to reflect R2's falls on 11/26/25, 01/30/26, and 03/29/26. E2 then stated, "So we have to revise the service plan every time someone falls? Even if they are not sent out to the hospital?" 3. R3's Fall Investigation (dated 02/18/26) documents R3 slipped out of bed and sustained a skin tear. R3's Service Plan has no mention of R3's 02/18/26 fall, or any fall prevention intervention implemented following R3's 02/18/26 fall. On 04/23/26 at 11:25 PM, E2 (Director of Nursing) verified that R3's Service Plan had not been revised after R3's fall at the establishment on 02/18/26.	A4010		
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:	A6000		

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A6000	Continued From page 11 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; 16) The right of access and the right to review and copy the resident's personal files maintained by the establishment, during normal business hours or at a time agreed upon by the resident and the establishment; Based on interview and record review, the establishment neglected to address a change in a resident's condition for one resident (R1) and implement fall prevention interventions to prevent further falls for three of three residents (R1 - R3) reviewed for change in condition in the sample of three. The establishment also failed to provide medical records in a timely manner upon request for one of three residents (R1) reviewed for medical records in the sample of three. These failures create a substantial probability of severe harm to a resident or residents. Findings include: 1. R1's Fall Investigations document that R1 fell at the establishment on the following dates: 09/20/25, 11/04/25, 10/28/25 at 10:15 AM, 10/28/25 at 10:29 AM, 11/04/25, 01/02/26, and 02/04/26. R1's Fall Investigations (dated 09/20/25, 11/04/25, 10/28/25 at 10:15 AM, 10/28/25 at 10:29 AM, 11/04/25, and 01/02/26) do not document any new fall prevention	A6000		

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interventions were implemented following R1's falls at the establishment on these dates.

R1's current Service Plan (dated 09/09/25) has no mention of R1's falls at the establishment on 09/20/25, 11/04/25, 10/28/25 at 10:15 AM, 10/28/25 at 10:29 AM, 11/04/25, and 01/02/26. This same service plan has no documentation of any fall prevention interventions that were implemented following R1's falls on these same dates.

On 04/22/26 at 01:30 PM, E2 (Director of Nursing) stated that no fall prevention interventions were implemented after R1's falls on 09/20/25, 11/04/25, 10/28/25 at 10:15 AM, 10/28/25 at 10:29 AM, 11/04/25, 01/02/26, and therefore, R1's Service Plan has no mention of these falls.

R1's Admission Contract (dated 09/01/25) documents the following: "Emergency Contact: At any time there is a significant change in condition to the resident, or any situation that the Residence deems as an 'emergency situation,' the resident's designated representative will be notified in a timely manner."

On 04/22/26, Z1 (R1's Son/Power of Attorney) provided an email communication that includes the following concerns regarding notification of changes with R1: "Unless (E2, Director of Nursing) failed to print off certain documents, my mother's medical record is incomplete and not reflective of her current condition; and if true, the lack of documentation is terrifying. Absent of the records provided to me are: Communications regarding my mother vocalizing several times to one of her therapists that she wants to 'kill herself'. Neither myself or my aunt were

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contacted about these statements. Note: My Aunt and I are both aware of my mother acting out while in our respective company; however, neither of us were consulted by (establishment). My mother is very appearance-oriented and has tried to hide things for years- she has, colloquial speaking, a Pollyanna Complex, in that perfect appearances override everything, including asking for help. Other relatives are clueless as to this behavior. While in our company, the tone and tenor of her actions are that of an adolescent/teen throwing a tantrum. However, the fact that she said this to someone who is neither my aunt or me is medically relevant in that it shows, at a minimum, deterioration in impulse control."

On 04/22/26 at 11:55 AM, Z1 (R1's Son/Power of Attorney) confirmed the details in the above noted email and stated, "My mother has verbalized statements of suicide in the past, but I was not notified of the increase verbalizations she was exhibiting to the staff. If I would have been made aware of these statements, I would have had her taken to the hospital to be evaluated."

R1's Physical Therapy Note (dated 02/26/26) documents the following: "Patient seen for skilled Physical Therapy Evaluation at moderate complexity secondary to three or more functional limitations related to decreased independence with gait, transfers, and increased risk for falls, Patient referred to skilled Physical Therapy due to recent falls and decline in functional mobility. Also this date, patient reports she 'wants to kill herself.' Nursing made aware and states patient has been having suicidal ideation. Patient does not have a plan..."

R1's Progress Notes do not document that Z1 (R1's Son/Power of Attorney) was notified of R1's

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verbalizations of suicidal ideations during her therapy evaluation on 02/26/26.

R1's Progress Note (dated 02/23/26) documents, "Resident very anxious tonight, resident states she wants to kill herself and doesn't want to be here anymore, resident states she spoke with her sister and her sister told her to make sure to take this medication tonight. Resident seems fixated on incontinence episode that occurred early morning on 02/22/26, writer has tried to assure her that it happens to everyone at times, resident continues to state she does not want to be here anymore." This progress note does not document that R1's Power of Attorney, Z1, was ever notified of R1's verbalizations of suicide, or that R1's Physician was notified of her change in condition.

On 04/22/26 at 11:55 AM, Z1 (R1's Son/Power of Attorney) stated he was never notified of R1's verbalizations of suicidal ideations on 02/23/26 or 02/26/26.

On 04/23/26 at 11:15 AM, E2 (Director of Nursing) verified she could not provide documentation confirming that Z1 was notified when R1 verbalized suicidal ideations on 02/23/26 and on 02/26/26. E2 stated, "If it is not documented, then it has not been done." E2 also confirmed that R1 was not sent out for an evaluation after R1 exhibited a change in condition following her verbalization of suicidal ideations on 02/23/26 or 02/26/26.

2. R2's Fall Investigations document R2 fell at the establishment on 11/26/25, 01/30/26, and 03/29/26. These same investigations do not document that any fall prevention interventions were implemented after R2's falls.

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R2's current Service Plan has no mention of R2's falls on 11/26/25, 01/30/26, and 03/29/26, or any fall prevention interventions implemented after these falls.

On 04/23/26 at 11:20 AM, E2 (Director of Nursing) stated R2's Service Plan was not updated with any fall prevention interventions after R2's falls on 11/26/25, 01/30/26, and 03/29/26 because no new fall prevention interventions were implemented following R2's falls. E2 then stated, "So we have to revise the service plan every time someone falls? Even if they are not sent out to the hospital?"

3. R3's Fall Investigation (dated 02/18/26) documents R3 slipped out of bed and sustained a skin tear. This investigation has no documentation of a new fall prevention intervention implemented following R3's fall.

R3's current Service Plan has no mention of R3's 02/18/26 fall, or any fall prevention intervention implemented following R3's 02/18/26 fall.

On 04/23/26 at 11:25 PM, E2 (Director of Nursing) verified that R3's Service Plan had not been revised after R3's fall at the establishment on 02/18/26 because a new fall prevention was not implemented at that time.

4. On 04/22/26, Z1 (R1's Son/Power of Attorney) sent the following email communication: "Medical Records Request: February 27, 2026 (Friday): I made an in-person request to (E4, Business Office Manager) for all financial and medical records related to my mother's residency; including any preadmission documents, the time period covered by this request was September 2, 2025 (move-in day) to the then-present date. I

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stated that purpose of my request was two-fold: one, I needed my mother's financial records for tax purposes; and two, that I needed hardcopies of (establishment's) medical records to add to my personal file to better enable me to communicate with her physicians, specifically those who are located out of town. After explaining this to (E4), she fulfilled the request for financial records but stated that the medical records could not be printed at that time due to the unavailability of (E2, Director of Nursing). (E4) further stated that she would pass along the request to (E2), and the request would be promptly handled. I told (E4) that I would check back during the following week for expected pickup. March 5, 2026 (Thursday): I drove to (establishment) to pick up the requested medical records. It should be noted that I arrived at approximately 8:15 AM; at this time the leadership team was conducting its daily morning meeting, and therefore unavailable; and that after waiting for 10 (ten) minutes, I had to leave to continue with my day. March 6, 2026 (Friday): I called (establishment) to inquire about the status of my mother's medical records. The call was transferred from the front desk to (E2's) direct line, which she answered and subsequently discussed with me the request. (E2) stated that she 'had not received said request,' and that '...we have a lot of sick people [right now], so I cannot get to it.' I then asked (E2) by/on what date they would be ready, to which she replied "Wednesday [March 11, 2026]. I told (E2) that the proposed date was acceptable and that I would pick up the records on that day. March 10, 2026 (Tuesday): At 4:28 PM, (E2) sent me an email with (establishment's) Medical Release Form attached. The email read: '...we will need you to complete the attached Medical Records Release Form and send it back before we can release her records.' This caught me off guard, as this was

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the first time that this form had been mentioned; I am my mother's registered POA (Power of Attorney), and while I understand the importance of both documentation and procedural/statutory compliance, the fact that this form was not given at the time of initial request or any time thereafter was more than surprising. At 7:47 AM on March 12, I acknowledged receipt, returned the completed form, and told (E2) that I would drop off hard copies for her files. March 12, 2026 (Thursday): I drove to (establishment) to hand deliver two copies of the above-referenced Medical Release Form; the copies were enclosed in a security envelope with the intended recipient and the envelope's contents; the envelope was marked 'hand-deliver.' I personally handed the envelope to (E2), told her of its contents, and asked her if the email and the hardcopies were sufficient to fulfill the request or if the letter needed to be sent via certified mail; (E2) responded to my question with 'No, this is sufficient.' (E2) then placed the envelope on a medication/rounding cart before saying that she would fulfill the request (original ready by date expired, no new date promised). Note: My interaction with (E2) was (or should have been) captured by video surveillance. The interaction took place in the main foyer, adjacent to the reception desk. (E2) was speaking with a clinical employee at the time of this interaction. March 23, 2026 (Monday): I afforded (E2) the following full business week to fulfill the request; due to the delays and the fact that my mother had a medical appointment on this date; if (E2) had done what she promised, the records should have been ready and waiting for pickup by this date. However, they were not. Upon returning to (establishment), I asked to speak to (E2). She approached me as if she had no idea why I wanted to speak to her. I told her that I was there

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to pick up my mother's medical records per my formal request. The following is an accurate accounting of this exchange: 'Me: Hi. I am here to pick up my mother's medical records; (E2): Oh? Well, they are not ready; Me: This is unacceptable. The records were requested multiple times; delivery was promised by a certain date; and you have not fulfilled the request. When will the records be ready?; (E2): Sorry. I do not know. I am working the floor and am the only person who can print out medical records; Me: Again, this is unacceptable. What happens if you, for any reason, are gone for an extended period of time and someone needs medical records?; (E2): I do not know. (looked completely dumbfounded). It should be noted here that neither I nor (E2) spoke with hostility; (E2), while appearing to be dumbfounded, listened to what I said without becoming overly defensive or rude. After speaking with (E2), I requested to speak with (E1, Executive Director). (E1) accommodated my request with a short wait. The conversation with (E1) could be called an exercise in sophomoric futility, which has been common with communicating with (E1). The conversation was as follows: Me (condensed): I detailed the discussion that I had with (E2) regarding my mother's medical records, covering each significant date, comment, deliverable, etc. I voiced my concern that (E2) was the only person in the building who had the adequate permissions to login to (establishment's) print out records; (E1): That is not true. I have the ability to print out records. Also, requests for medical records have to be sent off for approval by corporate, which can take up to thirty days, Me: Reflexively laughed at (E1) contradicting (E2's) assertion that she was the only person at the facility who could print records, as well as her previous statement that she, herself, could print out records; (E1):

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Okay. Stop right there. You are being passive aggressive, and I am going to leave this conversation (we were in her office, mind you); Me: No, (E1), I am not being passive aggressive. I am presenting you with facts, and if I react to something that you said in a reflexive manner, I cannot help it. You literally said two things that contradict with what was said by (E2); (E1): Okay. Well, look Bud (said to infantilize and reclaim the power dynamic); Me: Pardon me?; (E1): Oh, I am sorry. I should have never said that. It was wrong of me. Me:...paused; (E1): I am going to say something and you are not going to like it: You are making a mountain out of a molehill (re: the unfulfilled records request); Me: I disagree. Given all that has happened (e.g., poor communication, numerous falls - both undocumented and documented, deterioration in my mother's condition/functional ability, etc.), I think that it is quite relevant, and I want to know what you are doing for my mother."

This same email communication also documents, "After leaving (E1's) office, I passed by the front desk where (E2, Director of Nursing) was seated and working on a laptop. (E2) grabbed my attention, asking me to wait for a minute, stating '[she was] almost finished printing your mom's records...[and was] looking for one more thing/note. (E2) did not find the document, but did hand me a stack of pages, claiming it to be my mother's full medical record. I took possession of the copies and left the facility."

On 04/22/26 at 11:55 AM, Z1 (R1's Son/Power of Attorney) confirmed the details in the above noted email and stated, "I was given notes from my mother's medical record regarding three of the falls that my mother has had at the establishment. So, they are either concealing

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A6000	Continued From page 20 some of her falls, or they did not provide me with my mother's entire medical record as they have claimed they have done. My mother has fallen at least seven or eight times since living at (establishment)." On 04/22/26 at 11:30 AM, E2 (Director of Nursing) stated she did not provide Z1 with R1's entire medical record after he had requested it. E2 stated, "I tried to print everything in a hurry. I know I did not provide all of (R1's) progress notes, and I know I did not give him (R1's) notes from therapy. (Z1) has not been given R1's entire medical record."	A6000		
A7000	Secton 295.7000 Resident Records This Regulation is not met as evidenced by: Type 2 Violation Section 295.7000 Resident Records b) An establishment shall maintain a resident's record that contains at least the following: 9) Notation of known accidents, incidents or injuries; Based on interview and record review, the establishment failed to document a fall in the resident's medical record for one of three residents (R1) reviewed for falls in the sample of three. This failure creates a substantial probability of harm to a resident or residents.	A7000		

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A7000	Continued From page 21 Findings include: The establishment's Fall/Injury Processes policy (revised 03/18/26) documents the following: "The nurse should be notified in all occasions of all resident falls or injuries. The nurse, once notified, will assess the resident at time of fall/injury and will determine the next steps. Fall without injury. If the resident does not have an injury, the nurse will: Notify the POA (Power of Attorney)/Responsible party; Notify the Director of Nursing, Complete an Incident/Accident Report, Document Nursing Note in Medical Record; Fall with Injury. If the resident does have an injury, the nurse will: Notify the POA/Responsible Party, Send the resident out for evaluation (if warranted), Notify the Director of Nursing, Complete an Incident/Accident Report, Document Nursing Note in the Medical Record, Complete the State Reportable if sent out for Urgent/Emergent services." R1's Fall Investigation (dated 02/04/26) documents the following: R1 fell at the establishment and sustained a laceration to the back of her head; R1 was sent to a local hospital for evaluation and treatment at which time staples were placed to repair the laceration. On 04/22/26, Z1 (R1's Son/Power of Attorney) provided the following email communication regarding concerns with R1's falls not being investigated: "(R1 fell at the establishment on) Date unknown (occurred Between February 5, 2026, and February 13, 2026). Fall disclosed by my mother (R1) at her general practitioner's office. On February 13, 2026, my mother had a follow-up appointment with her general practitioner to check the wound sustained (during a fall) on February 4, 2026, and, if appropriate, to	A7000		

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have the staples removed from her scalp; the latter was completed. Upon arriving at (establishment), I noticed rugburn/rug rash on my mother's nose and chin. It did not occur to me at the time that this was the result of a subsequent fall; I was under the impression that it occurred during the fall on February 4, 2026. Whilst speaking with the practitioner who performed the exam, my mother was asked about the rugburn, noting that she had fallen again. According to my mother, this fall was witnessed by a member of senior staff, (E3, Community Relations Director), who then called for the nurse."

On 04/22/26 at 11:55 AM, Z1 (R1's Son/Power of Attorney) confirmed the details in the above noted email and stated, "My mother was asked how she had gotten the injury on her face, and she told her practitioner that she had fallen yet again after the 02/04/26 fall that required staples to repair the laceration on her head. She stated she reported this subsequent fall to (E3, Community Relations Director)."

On 04/22/26 at 03:20 PM, E3 (Community Relations Director) stated she recalls R1 reporting a fall to her, "a few months back." E3 stated, "I was rounding and checking in on the residents and (R1) was standing at her doorway. I do recall (R1) had told me that she had just fallen, but she was already standing so she must have gotten herself up. I asked her if she had told anyone and she told me 'No.' So I believe I went and told a nurse. I have an old brain, and I believe I recall one of the Resident Aides was also present. If I wasn't the person that reported (R1's) fall to the nurse, the Resident Aide was." E3 stated she could not recall who the nurse was that was informed when R1 self-reported a fall, or the Resident Aide that was present and involved

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A7000	Continued From page 23 at the time R1 reported this fall. R1's medical record has no documentation of R1 falling at the establishment between 02/05/26 - 02/13/26. On 04/22/26 at 03:25 PM, E2 (Director of Nursing) stated she does not have record of R1 reporting a fall to E3 (Community Relations Director) at any point in time while R1 has resided at the establishment. E2 stated, "We should be documenting all resident falls that occur in the building."	A7000		