IN THE UNITED STATES BANKRUPTCY COURT FOR THE DISTRICT OF DELAWARE

In re:	Chapter 11
SC HEALTHCARE HOLDING, LLC, *et al.*,[1]	Case No. 24-10443 (TMH)
Debtors.	(Jointly Administered)

PATIENT CARE OMBUDSMAN'S INITIAL REPORT

In accordance with section 333(b)(2) of chapter 11 of title 11 of the United States Code (the "Bankruptcy Code"), Suzanne Koenig, in her capacity as the patient care ombudsman (the "Ombudsman") appointed in the above-captioned chapter 11 cases (the "Chapter 11 Cases") of SC Healthcare Holding, LLC, *et al*. (collectively, the "Debtors") submits this initial report (the "Initial Report") for the time period from April 16, 2024 through June 14, 2024 (the "Report Period").

GENERAL BACKGROUND

A. Overview of the Debtors

1. On March 20, 2024, (the "Petition Date"), the Debtors each commenced the above-captioned Chapter 11 Cases by filing voluntary petitions for relief under chapter 11 of the Bankruptcy Code.

2. The Debtors, with the exception of some inactive entities, are authorized to operate their businesses and manage their properties as debtors in possession pursuant to sections 1107(a) and 1108 of the Bankruptcy Code. No trustee or examiner has been appointed in the Chapter 11 Cases.

[1]The last four digits of SC Healthcare Holding, LLC's tax identification number are 2584. The mailing address for SC Healthcare Holding, LLC is c/o Petersen Health Care Management, LLC 830 West Trailcreek Dr., Peoria, IL 61614. Due to the large number of debtors in these Chapter 11 Cases, whose cases are being jointly administered, a complete list of the Debtors and the last four digits of their federal tax identification numbers is not provided herein. A complete list of such information is available on a website of the Debtors' claims and noticing agent at www.kccllc.net/Petersen.

3. On April 10, 2024, the U.S. Trustee filed the *Concurred in Application Regarding Order Pursuant to 11 U.S.C. § 333 and Fed. R. Bankr. P. 2007.2 Directing the Appointment of a Patient Care Ombudsman* [D.I. 136] (the "Ombudsman Application).

4. On April 10, 2024, the Court entered the *Order Pursuant to Pursuant to 11 U.S.C. § 333 and Fed. R. Bankr. P. 2007.2 Directing the Appointment of a Patient Care Ombudsman* [D.I. 137] (the "Ombudsman Order").

5. On April 16, 2024, the U.S. Trustee filed the *Notice of Appointment of Patient Care Ombudsman Under 11 U.S.C. § 333* [D.I. 160] (the "Ombudsman Appointment"), appointing Suzanne Koenig as the Ombudsman.

B. The Debtors' Corporate Structure

6. The Debtors are comprised of 141 privately held entities which the Debtors use to manage their operations and real estate business segments.

7. As of the Petition Date, the Debtors operate approximately eighty facilities (the "Facilities"), which will be subject to the Ombudsman's observations in compliance with section 333 of the Bankruptcy Code.[2]

8. The Chapter 11 cases of the following Debtors (collectively, the "Receivership Debtors") have been suspended subject to the terms of the *Order Approving Stipulation to Resolve (I) X-Caliber's (A) Motion to Dismiss, (B) 543 Motion, and (C) DIP Objection, and (II) The Debtors' MT4 Motion to Dismiss* [Dkt. No. 340]: El Paso HCC, LLC; Flanagan HCC, LLC; Kewanee AL, LLC; Knoxville AL, LLC; Legacy Estates AL, LLC; Marigold HCC, LLC;

[2] The Ombudsman is monitoring all of the Debtors' facilities. Due to the significant number of Facilities, the Ombudsman is visiting facilities on a rolling basis, in addition to monitoring all Facilities. The attachment to this Initial Report includes detailed descriptions on eleven (11) facilities which were visited during the Report Period. The Ombudsman will include detailed information on the remaining facilities on a rolling basis in subsequent reports.

Monmouth AL, LLC; Polo, LLC; El Paso HCO, LLC; Flanagan HCO, LLC; CYE Kewanee HCO, LLC; CYE Knoxville HCO, LLC; Legacy HCO, LLC; Marigold HCO, LLC; CYE Monmouth HCO, LLC; and Polo HCO, LLC. Michael F. Flanagan was appointed as receiver of the Receivership Debtors (the "Receiver"). The Receiver has appointed Walnut Creek Management Company, L.L.C. as the manager operating the Receivership Debtors' facilities. The Ombudsman is not visiting the Receivership Debtors' facilities because their bankruptcies have been suspended.

9. Mark B. Petersen ("Petersen") personally owns 100% of the following companies: Petersen Health Care, Inc.; Petersen Health Care II, Inc.; Petersen Health Systems, Inc.; Petersen Health Care III, LLC; Petersen Health Care XI, LLC; Midwest Health Properties, LLC; Petersen Healthcare VII, LLC. *See* Docket No. 44 Declaration of David R. Campbell in Support of Debtors' Chapter 11 Petitions and First Day Pleadings (the "Campbell Declaration"), Ex. C., at 2. Petersen created two parent companies, SC Holding, LLC and SABL, LLC, which are both owned in part by four entities: Petersen (personally) (41.04%), Petersen Health Care, Inc. (19.18%), Petersen Health Care II, Inc. (31.88%), and Petersen Health Systems, Inc. (7.9%). *Id*. Petersen owns 99% of the following companies: Petersen Health Quality, LLC; Petersen Health & Wellness, LLC; Petersen Health, LLC; Petersen Health Bushiness, LLC; Midwest Health Operations, LLC; and Petersen Healthcare VII to which SABL, LLC jointly owns the remaining 1%. *Id*.

10. Thirty-six (36) of the Debtors' facilities are owned, to some level, by SC Healthcare Holding, LLC and SABL, LLC. *Id*. Each facility is divided by its real estate ("RE") and healthcare organization ("HCO"). *Id.* SC Healthcare Holding, LLC is a parent within the corporate structure for the Debtor entities owning 100% of the RE of each facility and SABL, LLC is a parent within the corporate structure for the Debtor entities owning 99% of each HCO, with Petersen owning the remaining 1%. *Id.*

11. Additionally, Petersen and SABL, LLC jointly own the following facilities: Rock Falls Rehabilitation & Health Care Center, Countryview Terrace, Enfield Rehabilitation & Health Care Center, Newman Rehabilitation & Health Care Center, Sandwich Rehabilitation & Health Care Center, and Shawnee Rose Care Center. *Id.* at 1-2. Petersen owns 100% of Midwest Health Properties, LLC, which is a parent within the corporate structure for the Debtors' owning the following facilities: Cornerstone Rehabilitation & Health Care Center and Rock River Gardens, and Sauk Valley Senior Living & Rehabilitation (currently closed). *Id.* at 1. Pursuant to the GMF Loan Agreement (as defined in the Campbell Declaration), Petersen owns all of Petersen Health Systems, Inc., which is a parent within the corporate structure for the Debtors' owning facility by the name of Betty's Garden Memory Care of Kewanee. *Id.* at 3.

12. The following facilities are jointly managed by Petersen Health Care X, LLC and Petersen Health Network, LLC: Flora Gargens Care Center; Flora Gardens Care Center; Nokomis Rehabilitation & Health Care Center; Rochelle Gardens Care Center; Rochelle Rehabilitation & Health Care Center; Whispering Oaks Care Center; and Willow Rose Rehab & Health Care. *Id.* at 4. Petersen Health Care X is 100% owned by Petersen and Petersen Health Network, LLC is jointly owned by Petersen and a parent company (MBP Partner, LLC) which Petersen also owns. *Id.* Ten (10) additional facilities are owned by Petersen pursuant to the X-Caliber Loan Agreement, and are related to the Receivership Debtors. Two (2) of the ten (10) facilities are additionally funded through HUD Loans. *See id.* at 3.

13. Petersen owns 100% of MBP Partner, LLC and Petersen Health Care III, LLC which jointly manage the following facilities: Countryview Care center of Macomb; Jonesboro Rehabilitation & Health Care Center; and South Elgin Rehabilitation & Health Care Center. *Id.* at 6. Petersen personally owns Illini Heritage Rehab & Health Care Center, Roseville Rehabilitation

& Health Care Center. *Id.* Through Petersen Health Care, Inc., Petersen owns Courtyard Estates of Canton and Riverview Estates of Havana. Through CYE Girard HCO, LLC, Petersen owns Courtyard Estates of Girard. *Id.* Under Petersen Health Systems, Inc., Petersen manages Courtyard Estates of Herscher, Courtyard Estates of Farmington, Courtyard Estates of Galva, and Courtyard Estates of Green Valley. *Id.* Lastly, under Petersen Health Care II, Inc., Petersen owns Palm Terrace of Mattoon, Flora Rehabilitation & Health Care Center, Toulon Rehabilitation & Health Care Center, Mt. Vernon Health Care Center, and White Oak Rehabilitation & Health Care Center. *Id.*

14. The Facilities are divided into three regions – identified as the Northern Division, the West Region, and the Southern Division.

- Northern Division

15. The Northern Division is comprised of twenty-five facilities. Lance Tossell is the Divisional Director of Operations of the Northern Division. The Ombudsman and her representatives visited the following Facilities within the Northern Division during the Report Period: (i) Rochelle Gardens Care Center; (ii) Rochelle Rehab & Health Care Center; (iii) North Aurora Care Center; (iv) Sandwich Rehab & Health Care Center; and (v) South Elgin Rehab & Health Care Center (collectively, the "Northern Division Facilities").

16. As further described below, the Ombudsman and her representatives spent significant time at the Northern Division Facilities and have met with the appropriate members of the Debtors who are entrenched in these operations and patient care issues from an organizational perspective.

- West Region

17. The West Region is comprised of ten facilities. Cindy White is the Regional Director of the West Region. The Ombudsman and her representatives have been receiving information relevant to all of the Debtors Facilities and are conducting in-person facility visits on a rolling basis. The Ombudsman has not conducted an in-person visit within the West Region as of the date of this filing, but expects to visit West Region facilities in the near term.

- Southern Division

18. The Southern Division is comprised of thirty-six facilities. Glenna Birch is the Divisional Director of Operations of the Southern Division. The Ombudsman and her representatives visited the following Facilities within the Southern Division during the Report Period: (i) Jonesboro Rehab & Health Care Center; (ii) Rosiclare Rehab & Health Care Center; (iii) McLeansboro Rehab & Health Care Center; (iv) Willow Rose Rehab & Health Care; (v) Lebanon Care Center; and (vi) Swansea Rehab & Health Care Center (collectively, the "Southern Division Facilities").

19. As further described below, the Ombudsman monitored and worked extensively with her representatives who spent time at the Southern Division Facilities and have met with the appropriate members of the Debtors who are entrenched in these operations and patient care issues from an organizational perspectives.

C. The Debtors' Operations

20. Among their many Facilities, the Debtors provide residential healthcare services—sometimes the only available resident healthcare services in their geographical area—to some of the most rural parts of Illinois, Missouri, and Iowa. To that end, the Debtors have concentrated on multiple segments of service: (i) Independent Living, (ii) Assisted Living, (iii) Supportive Living, (iv) Skilled Nursing, (v) Memory Care, (vi) Alzheimer's Care and (vii) Rehabilitation Care.

- Independent Living: The Petersen independent living program ("Independent Living") appears to provide living arrangements by which residents are able to maintain a sense of independence, while still receiving medical and other forms of care and assistance in their daily lives. For residents who wish to purchase a villa within Petersen's retirements community, the Debtors have certain properties set aside to be sold to such interested residents.

- Assisted Living: Petersen's assisted living program ("Assisted Living") combines apartment-style housing with personal care and other services so that residents may be afforded the ability to live independently. Residents have the option to enroll in various care plans depending on their needs.

- Supportive Living: Petersen's supportive living program ("Supportive Living") provides care to residents who require more traditional nursing home care than residents in Independent Living, but less than those in Assisted Living. Supportive Living provides staff to meet various needs of its residents, including assistance with showering and dressing, moving around the community, incontinence care, dementia orientation and support, and daily nursing assessments and monitoring.

- Skilled Nursing Care: At each of its skilled nursing locations, Petersen retains on-site nurses to assist with health care needs, including rehabilitation, dementia/Alzheimer's care, around-the-clock care and others ("Skilled Nursing Care").

- Memory Care: Introduced in 2015, Petersen appears to provide therapeutic programming for residents to partake in activities that promote self-esteem and accomplishment at various levels of cognitive ability ("Memory Care").

- Alzheimer's Care: Petersen offers assistance to residents experiencing various levels of memory and function loss brought on by Alzheimer's ("Alzheimer's Care").

- Rehabilitation Care: Petersen's rehabilitation segment seeks to provide physical, occupational and speech therapies and treatment, including related care planning, through a contracted therapy provider ("Rehabilitation Care").

21. The Debtors also appear to provide care to persons with intellectual and developmental disabilities in two of their Facilities.

D. The Ombudsman's Meetings with the Debtors' Management

22. Throughout the Report Period, the Ombudsman and her representatives have sought and obtained information from, and assured open lines of communications with, the

Debtors. On April, 26th, 2024, at the South Elgin Healthcare Center, the Ombudsman met with the following individuals: Greg Wilson, the Petersen Senior Vice President of Operations of the Petersen Companies and Petersen Health Care; Lance Tossell, the Northern Divisional Director of Operations; and Kendel Brooks, the Northern Division Regional Director. The Ombudsman interviewed the corporate staff and was provided with an update on the resident services, oversight by corporate staff, and the residents' continued receipt of healthcare services from the Debtors. The Debtors responded to the Ombudsman's inquiries regarding their divisional map by region, and also provided detailed explanations of services to the Skilled Nursing Facility Division, and Assisted Living Division, by Operations Field Support, Hospital Liaisons, Clinical Finance Support staff , Regional Dietitian and Corporate Maintenance to the Ombudsman.

23. Where identified, the Ombudsman and her representatives identified any concerns with the management and the Debtors related to any necessary repairs of note. These included, for example, broken floors that could pose a tripping hazard to residents; broken windows that could create risk of injury or a lack of climate control; and unkempt driveways that required repair to achieve smooth and safe surfaces for people entering and leaving the Facilities. The staff has been particularly accommodating and cooperating with the PCO and her representatives throughout their visits.

24. In addition to resident care and facility issues, the Ombudsman and her representatives also discussed issues related to the residents' trust fund accounts, which is further discussed immediately below.

E. Trust Fund Accounts

25. Under Title 77 of the Illinois Administrative Code "A resident shall be permitted to manage his own financial affairs unless he or his guardian or if the resident is a minor, his parent,

authorizes the administrator of the facility in writing to manage such resident's financial affairs under subsections (b) through (o) of this Section."]. 77 Ill. Adm. Code 300.3260 (a), citing to the Illinois Nursing Home Care Act Section 2-102 (the "Act").

26. The Act further states that:

> The facility may accept funds from a resident for safekeeping and managing, if it receives written authorization from, in order of priority, the resident or the resident's guardian, if any, or the resident's representative, if any, or the resident's immediate family member, if any; such authorization shall be attested to by a witness who has no pecuniary interest in the facility or its operations, and who is not connected in any way to facility personnel or the administrator in any manner whatsoever.

The Act, Section 2-101(2).

27. Section 2-201(3) of the Act states that "The facility shall maintain and allow, in order of priority, each resident or the resident's guardian, if any, or the resident's representative, if any, or the resident's immediate family member, if any, access to a written record of all financial arrangements and transactions involving the individual resident's funds."

28. Finally, each resident, resident's guardian, resident's representative, or resident's immediate family member shall receive a "written itemized statement *at least quarterly*, of all financial transactions involving the resident's funds. The Act, Section 2-201(4).

29. As of the Report Period, the Ombudsman and her representatives have observed that not all of the Facilities are providing the residents (or the resident's guardian, or the resident's representative, or the resident's immediate family member) with quarterly reports related to all financial transactions involving resident funds, per the Act.

30. Notwithstanding the above, the Ombudsman and her representatives have not interviewed any residents claiming that they have not received funds upon request.

F. Reporting

31. During the Report Period, the Ombudsman and her representatives have requested, and have very recently begun receiving reporting information regarding: surveys, incident reports, and plans of correction. This request has been made by the Ombudsman for the purpose of obtaining reports more expeditiously than they otherwise may be publicly available. As a result of the Ombudsman's recent receipt of the related information from the Debtors, the Ombudsman is in the process of reviewing the reports from the Debtors that may not yet be publicly available and will include any useful information from that review in her next report.

G. Vendor Relations

32. The Ombudsman discovered that several of the Debtors' vendors ceased providing services to the Facilities due to: (i) fear of the Debtors' financial ability to pay for services, and (ii) some vendors having already extended credit beyond their limit. Below is a list that the Ombudsman understands to include current vendors as well as vendors that have recently been replaced:

- Medical Supplies: McKesson (replaced by Medline)
- Therapy Services: RehabCare (replaced by Renewal)
- Pharmacy: Omnicare
- Linens: Gem (replaced by Medline)
- Food and Supplies: Martin Bros
- Oxygen: Pel VIP
- Part B Supplies: Impact Medical
- Prism Testing Outbreak

- Staffing Services: ShiftKey Nextaff (attempting to be replaced by Petersen in-house staffing agency).

SUMMARY OF OMBUDSMAN'S MONITORING AND OBSERVATIONS

The following summarizes the Ombudsman's observations during the Report Period. Any observations regarding the facilities are based upon the visits referenced below and observations and interviews conducted during those visits as well as interviews and electronic mail communication conducted remotely with staff of the respective facilities.

A. Executive Summary

The facilities included in this Initial Report are as follows (collectively, the "Facilities"):

Exhibit	Debtor	Facility Name	Address
A	South Elgin, LLC	South Elgin Rehabilitation & Health Care Center	746 W. Spring Street, South Elgin, IL 60177
B	North Aurora HCO, LLC	North Aurora Care Center	310 Banbury Road, North Aurora, IL 60542
C	Petersen Health Care XI, LLC	Sandwich Rehabilitation & Health Care Center	902 E. Arnold, Sandwich, IL 60548
D	Petersen Health Network, LLC	Rochelle Gardens Care Center	1021 Caron Road, Rochelle, IL 61068
E	Petersen Health Network, LLC	Rochelle Rehabilitation & Health Care Center	900 North 3rd Street, Rochelle, IL 61068
F	Petersen Health Network, LLC	Willow Rose Rehab & Health Care	410 Fletcher, Jerseyville, IL 62052
G	Swansea HCO, LLC	Swansea Rehabilitation & Health Care Center	1405 North Second Street, Swansea, IL 62226
H	Lebanon HCO, LLC	Lebanon Care Center	1201 North Alton, Lebanon, IL 62254
I	Jonesboro, LLC	Jonesboro Rehab and Health Care Center	995 State Route 127 South, Jonesboro, IL 62952
J	Rosiclare HCO, LLC	Rosiclare Rehab and Health Care Center	1807 Fairview Road, PO Box 220, Rosiclare, IL 62982
K	McLeansboro HCO, LLC	McLeansboro Rehab and Health Care Center	405 W. Carpenter, McLeansboro, IL 62859

As described in further detail below, an individual report for each Facility visited during this Report Period is attached hereto as reflected in the above chart.

B. Methodology

Due to the number of Facilities operated by the Debtors, the Ombudsman developed a standardized methodology to ensure consistency in reporting among the Ombudsman's representatives visiting each location. Prior to the first visit, the Ombudsman developed materials to ensure consistency with respect to representatives' work under the statutory requirements of section 333 of the Bankruptcy Code, appropriate procedures for interviewing the professional staff, residents, and family members, and reiteration of privacy requirements mandated under the Health Insurance Portability and Accountability Act ("HIPAA") as they apply to the Facilities. The Ombudsman also created question guidelines and checklists to encompass the full scope of potential resident care concerns.

Each site visit included the Ombudsman and one of her representatives, or alternatively, at least two (2) Ombudsman's representatives, at least one (1) licensed registered nurse and at least two (2) senior living professionals[3] with significant knowledge and experience regarding assisted living and memory care operations as well as regulatory requirements. In addition, the Ombudsman personally made visits to the Facilities where possible throughout the site visit schedule. The visits to each Facility ranged from approximately four to eight hours in length depending upon the size and complexity of the Facility. During each visit, the Ombudsman and her representatives met with the executive director, licensed nursing home administrator or administrator in training of the Facility and department heads, conducted a walk-through tour of

[3] Either the Ombudsman and the Ombudsman representative, or two Ombudsman's representatives attended each visit.

each Facility and its grounds, and interviewed key professional staff as well as residents and family members where possible. The Ombudsman and her representatives also requested and reviewed Facility records as part of their assessment process.

C. Overall Impressions

For all visits, the Ombudsman and her representatives noted the following:

- Although the Debtors' administrative staff include a number of members who are new or have only been in their present roles for a short time, the Debtors' employees are generally demonstrating a strong commitment to caring for the residents in their communities. The financial distress and media coverage surrounding these facilities can be worrisome for staff and residents alike, and the administrators are continuing to work toward leading their teams forward to serve the interest of the residents in their charge.
- Several facilities have been previously cited for abuse by surveyors. Although the Ombudsman and her representatives did not find any evidence of continued noncompliance, it is essential that facilities remain vigilant for recurrence of issues that resulted in abuse citations, and that staff continues to receive appropriate in-service education to prevent recurrence.
- The Ombudsman did not find any concerns related to procurement of adequate supplies such as food, medical supplies and equipment, and other necessary items. The facilities have endeavored to cooperate with each other to share supplies and equipment as needed to prevent shortages.
- Physical plant issues remain problematic at several facilities, which they have no ability to resolve without provision of funds. However, observations indicate a

possible lack of regular environmental rounding and sanitation routines at some facilities, routines that are within the control of local management who can effect improvements going forward.

- The Ombudsman did not find evidence of problems with disbursement of trust funds to residents.

OMBUDSMAN'S MONITORING AND OBSERVATIONS BY FACILITY

The Ombudsman has provided detailed supplemental reports on each of the Facilities visited and assessed. Each report includes observations of resident care with commentary about one or more areas of assessment, including an overview of each Facility, regulatory compliance, activities and life enrichment, resident interviews, clinical services, risk management, medical records, infection control and COVID-19 protocols, dietary services, emergency preparedness, vendor relationships, maintenance, and environmental services. It should be noted that the supplemental reports will make repeated references to two key regulatory agencies for the skilled nursing facility industry: the federal Centers for Medicare and Medicaid Services, which promulgates national regulations and standards of care and is responsible for monitoring compliance of covered facilities, and the Illinois Department of Public Health, a state-level agency responsible for licensure and inspection of skilled nursing facilities for compliance with federal, state, and local healthcare regulations.

CONCLUSION

The Ombudsman did not observe any significant concerns during this Report Period. The Ombudsman will submit her next report within sixty days and will inform the Court if there are any critical concerns discovered prior to that time, as necessary.

Dated: June 14, 2024

PATIENT CARE OMBUDSMAN

By: */s/Suzanne Koenig*
Suzanne Koenig, solely in her capacity as the Patient Care Ombudsman of SC Healthcare Holding, LLC, *et al*.

Exhibit A
South Elgin, LLC
South Elgin, IL

A. Overview

South Elgin Rehabilitation & Health Care Center is operated by Debtor South Elgin, LLC (together, the "Facility"), and is located at 746 West Spring Street, South Elgin, Kane County, Illinois. There are twenty-five nursing facilities in and around the Facility including twenty-one within ten miles. The twenty-five nursing facilities collectively have a total of 2,995 available nursing home beds. The Facility is in a middle-class neighborhood with houses located on all four sides of its property. The sprawling front yard includes lighted signage and a well-manicured yard with half circle drive leading to the front of the building.

The Ombudsman visit occurred on April 25, 2024. Upon arrival at the Facility, the Ombudsman and her representatives were greeted at the entrance and shown to a conference room to meet with corporate staff from the Debtor: Greg Wilson, Senior Vice President of Operations; Lance Tossell, Division Director of Operations; and Chad Dawson, Regional Director. The Facility's administrator has been in this position since March 2024.

B. Regulatory

The Facility is licensed by the Illinois Department of Public Health (the "IDPH") and has a licensed bed capacity of 90. On date of the visit, there were 56 residents in-house. Payer sources for residents included three private pay, one hospice, two Medicare A and 50 Medicaid. The Illinois Department of Healthcare and Family Services certifies the Facility for Medicaid participation.

Required informational postings were observed to be in place and readily available to residents, staff, and visitors. The posting included a nursing home hot line poster, resident rights,

grievance plan, monthly menu and activity calendar. The Facility's license is posted and active, the Facility has a valid CLIA certificate in place.

The last annual survey was conducted on June 8, 2023; at that time, the Facility was cited as follows:

- F559 SS=D Choose/Be notified of room/roommate change
- F604 SS=D Right to be free of physical restraints
- F677 SS=D ADL Care Provided for Dependent Residents
- F686 SS=D Treatment/Services to Prevent Heal Pressure Ulcer
- F688 SS=D Increase/prevent Decrease in ROM/Mobility
- F690 SS=D Free of Accident Hazards/Supervision/Devices
- F825 SS=D Provide/Obtain Specialized Rehab Services
- F880 SS=D Infection Prevention and Control

All citations have been corrected and there are no outstanding deficiencies presently. The administrator reported that the Facility is within their survey window, the period during which the IDPH may visit the Facility to conduct their annual licensure and certification survey. The survey is generally scheduled between nine and fifteen months after the previous annual survey but can occur at any time.

C. Physical Plant and Environmental Services

The Facility is of brick and frame construction. The Ombudsman and her representatives noted that the exterior building envelope and grounds were well-maintained and generally in good repair with a few exceptions noted:

- Shrubs with dead branches should be pruned with cuttings removed.
- Wooden porch has untreated decay and requires painting.
- Rear of building has numerous trash items that should be discarded.
- Eaves and gutters around the sides and rear of building have unrepaired damage.

On an environmental tour of the Facility's interior, the Ombudsman and her representatives noted the following:

- Multiple resident rooms were noted to have cove base missing and were due to be repainted.
- Objectionable odors (stale, musty odors) were noted in multiple locations.
- Several lavatory faucets were observed to be leaking.
- Multiple bath/showers spaces were noted to have broken or missing ceramic tiles and loose grab bars. Most bathrooms had broken ceramic tiles on corner edging at ankle height, presenting a potential physical hazard for skin injuries to residents. There was standing water present around several commodes.
- Hot water accessible to residents was temperature checked at 105ºF; however, the faucets had to be left open for an extended period to achieve the hot temperature.
- 100 Wing: Several cubicles were missing privacy curtains, and several resident rooms were noted to be missing beds and/or room furnishings.
- 200 Wing: Several resident rooms required painting. Some floor areas required cleaning.

- 300 Wing: An objectionable odor in the hallway was noted. Several resident rooms were without furnishings. Some floor areas required cleaning.
- 400 Wing: An objectionable odor in the hallway was noted. Several resident rooms had unmade beds; several rooms required painting.
- Many hygiene products that have a label warning to "keep out of reach of children" were left accessible to residents.
- Beauty shop was unlocked; a chemical container with a label warning to "keep out of reach of children" was left accessible to residents.
- Exit doors were clearly signed. The base of one exit door was badly rusted allowing exposure to the outside environment.

The laundry room was noted to house a 50# washing machine and a 50# dryer. Both machines were several years old but operational. Linen is properly separated between soiled and clean items and the storage area was adequately maintained, but the laundry room floor needed cleaning. There were several unopened packages of washcloths and towels in storage. Many packages of unopened linen were stacked too close to the ceiling.

The housekeeping room was noted to have two fully stocked operational carts. Staff reported to the Ombudsman's representatives that garbage pick-up is timely each week and medical waste is scheduled for pick-up once per month, which is sufficient for the Facility.

D. Resident Observation/Life Enrichment

The Ombudsman's representatives noted that the Facility's activity calendar has not been updated; as of the tour date, the March calendar remained on display. Activities were not observed during this visit. Staffing includes a full-time activity director and social service director, both on

duty Monday through Friday each week. The calendar was reviewed for activities oriented to resident interests. The activities noted include a resident council meeting, a monthly birthday celebration, religious events, crafts, and current events. During the Ombudsman visit, many residents were observed unoccupied and not engaged in any activities.

E. Resident Interviews

One resident was interviewed as they exited a shower room in a wheelchair attended by a certified nursing aide. The resident was fully dressed and had a blanket wrapped around their shoulders to keep warm. Upon questioning, the resident did not express concerns with his shower or daily care. The resident verbalized positive comments regarding the staff and made mention of the food, which they stated is always good.

The Ombudsman's representative interviewed a second resident and reviewed the resident's chart. The resident's medications are delivered by mail from the Veteran's Administration. The resident's nurse reported that medications are sometimes delivered late and will be contacting the Facility administrator regarding this concern. The resident did not verbalize any concerns about care received. The resident reported participating in activities and verbalized enjoying several special events held by the Facility. A review of the resident's chart showed that basic assessments with timely notes were recorded and appropriately reflected the resident's care plan.

F. Clinical Services

The Facility has been without a Director of Nursing (the "DON") for several months; staff reported that a new DON will be on site in the next few weeks. The operator's registered nurse

consultant has been on site to assist with the clinical components of the Facility's operations. A wound doctor from VOHRA (wound care specialty practice focused exclusively on the post-acute sector) visits the Facility each Wednesday to review progress of residents with pressure injuries; at the time of the tour, staff reported that there were three (3) residents with a total of four (4) pressure injuries.

The Facility obtains pharmacy services from Omnicare; staff reported to the Ombudsman's representatives that there have been no interruptions in pharmacy service.

The administrator reported that all lead departmental positions are filled currently except for the Director of Nursing. The administrator reported that staffing coverage is challenging at times; Certified Nurse Aide staff is particularly difficult to obtain. The administrator reported that the Facility has four (4) agency staff contracts and can acquire staff to maintain sufficient coverage.

G. Risk Management

Staff reported that risk management meetings occur each morning with a different topic discussed per the day of the week. Interdisciplinary team members are present during each meeting. In addition, a Quality Assurance meeting is conducted quarterly with the interdisciplinary team members, the consultant pharmacist and the medical director in attendance. Currently the administrator is responsible for ensuring that these meetings take place and provides departmental staff agendas for preparation related to their department's input.

H. Medical Records

The Facility has a partial implementation of its electronic medical records system. Currently PointClickCare contains only resident care plans and Minimum Data Set (the "MDS")

data. The review by the Ombudsman's representative concluded that the care plans and the MDS records were current and reflected residents' needs. The Facility invites residents and their representatives to attend care plan sessions and the Facility maintains flexibility in meeting scheduling to accommodate individual needs.

I. Dietary Service/Kitchen

The Ombudsman and her representatives conducted a tour of the kitchen accompanied by the Facility's dining services manager. While the dietary preparation area is antiquated, equipment was functional, and a visual inspection found the area to be very clean and well-organized. The pantry area was well stocked. Martin Brothers is the food commodity supplier for the Facility. The Ombudsman's representatives noted that refrigerators contained food with proper labeling, and that equipment temperatures were logged by staff. At the time of the tour, staff was preparing lunch in accordance with the posted menu.

The resident dining area is adjacent to the Facility's front entry and lobby. Residents were observed sitting at the dining room tables. There were no seats available for guests. The illumination in the dining area was dim.

The Ombudsman's representatives interviewed the corporate registered dietitian. The dietitian reported that the Facility dietary and clinical staff members were diligent in following the dietitian's recommendations for resident care. Three residents were reported to be receiving enteral feeding. A review of the resident records indicated that weights were within normal range and the Facility follows their protocol of notifying the attending physicians of any diet or weight changes. Staff reported that weight review meetings are conducted weekly, and the Facility's menus are created by Martin Brothers with the oversight of the registered dietician.

J. Emergency Preparedness

The maintenance director and the administrator are responsible for ensuring emergency preparedness is in place and on-going. While the Facility has a partially completed assessment, fire drills and water temperature checks are both current. Several inspection reports (sprinkler system, kitchen hood "Ansul system") were not current. The administrator stated that with the changes occurring in the company, vendors related to these systems refused to provide service due to non-payment. The services have been rescheduled and the inspections are expected to be back on track soon.

K. Vendor Relationships

Staff reported to the Ombudsman's representatives that the Facility is not experiencing difficulties obtaining food or maintenance chemicals. Interviews conducted with a housekeeper and a laundry attendant indicate that chemicals have always been made available as well as paper goods including paper towels, toilet tissue, Kleenex tissues, and hand towels. The laundry attendant reported that new linen continues to be delivered. No other concerns were reported by interviewed staff.

L. Resident Trust Fund

The Facility maintains a surety bond for the resident trust funds in its custody. The Facility administrator stated that this account is balanced monthly in conjunction with the statement.

Exhibit B
North Aurora HCO, LLC
Aurora, IL

A. Overview

North Aurora Care Center operated by Debtor North Aurora HCO, LLC (together, the "Facility"). The Facility is located at 310 Banbury Road, North Aurora, IL 60542 and is a single-story building licensed as a 129-bed intermediate care facility serving residents with mental health diagnoses. The census at the time of the Ombudsman's visit was ninety-seven. Intermediate Care Facilities are defined as facilities that provide basic nursing care and other restorative services under periodic medical direction.

B. Regulatory

The Facility is licensed by the Illinois Department of Public Health (the "IDPH") and the Illinois Department of Healthcare and Family Services certifies them for Medicaid participation. On April 11, 2024, the IDPH conducted a complaint investigation survey at the Facility. The Facility received one citation related to the right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed, effecting two of three residents reviewed for room transfers in a sample of four. On April 25, 2024, the Facility submitted the corrective action for the alleged deficient practice to the IDPH. The Facility provided the Resident Notification of Room/Roommate Change form to the affected residents, along with an explanation for the room changes.

The Facility's current policies and procedures meet all state and federal guidelines. However, the administrator completed in-service training starting April 10, 2024, and will continue to do so to ensure adherence to policies and procedures. The quality assurance program will also monitor the administrator to ensure ongoing compliance. On March 14, 2024, the IDPH conducted

a complaint investigation survey at the Facility. Per the survey findings according to the Facility's policy, the facility failed to thoroughly investigate a resident's injury of unknown origin, failed to provide hourly rounding to a resident with a history of falls as ordered by the physician, and failed to implement new, individualized fall risk interventions for residents who experienced falls to prevent further falls, resulting in three citations. During a complaint investigation survey on February 28, 2024, the Facility received one citation for neglecting to provide the necessary services for maintaining good personal hygiene for three of the three residents who had their daily activities reviewed.

C. Physical Plant and Environmental Services

The Ombudsman's representatives toured the physical plant and grounds of the Facility. The entrance sign to North Aurora Facility is easy to read, and the parking area is sufficient to accommodate visitors. The front door is secured with an electronic lock and opens into the resident dining area. Required postings including the Resident Bill of Rights, the State and Local Long-Term Ombudsman contact information, and the community inspection results were displayed in prominent locations. The facility has an overall Medicare star rating of one. Data from health inspections, staffing, and quality measures combine to calculate a facility's star ratings enrolled with Medicare.

The Maintenance Director has been in the role for two years. The facility has been recruiting for a Maintenance Assistant since November 2023 and has been unable to fill this role. The Executive Director stated that this open position has delayed some projects, for example, replacing cove bases after the facility was repainted. The resident and staff interviews conducted did not indicate any maintenance concerns impacting resident care delivery. The Executive

Director stated that work orders are routinely reviewed as part of the facilities quality assurance process.

The Housekeeping and Laundry Supervisor has been at the facility for 26 years. Interviews with residents and staff did not indicate any concerns about these services. The Executive Director stated that laundry equipment is sufficient to meet current needs.

D. Resident Observation/Life Enrichment

During the initial tour of North Aurora Care Center, residents were observed eating lunch in the dining area. Residents were appropriately groomed and dressed. The communal areas were clean, provided adequate lighting, and with the exception of one hallway, were odor-free. Staff interactions with residents were cordial and mutually respectful.

E. Resident Interview

A representative for the Ombudsman, a registered nurse, interviewed a resident after obtaining appropriate consent. The resident's room was clean and included a functioning emergency call device that was readily accessible. The resident's room lacked cove base trim on the walls as was missing from all other resident rooms in the Facility. The resident did not voice any concerns about safety or rights violations. An interview with a second Facility resident revealed no care concerns. The resident expressed her anticipation for new eyeglasses, but she was uncertain about their delivery schedule. The administrator promptly addressed the resident's concern.

F. Clinical Services

A registered nurse serves as the Director of Nursing (the "DON") and oversees clinical services at North Aurora Care Center. North Aurora Care Center schedules additional nurses and nursing assistants for twelve-hour shifts to administer medication and provide direct care to residents. North Aurora Care Center does use contracted agency staff, and using current staff fills voids in scheduling. Interviews were conducted with the DON, Assistant DON, and additional clinical staff, and they reported no concerns regarding staffing shortages that could impact the delivery of care and services to residents.

North Aurora Care Center is one of six Illinois facilities that participate in the Adapt program. Adapt is a grant funded service that enhances self-esteem, empowers individuals, and promotes dignity, purpose, and pride through recovery-based care, allowing individuals to live at their highest potential within their community, regardless of symptoms they experience. Twenty-five residents currently participate in the program that provides support in the facility eleven hours a day, seven days a week.

Staff reported to the Ombudsman's representative that the Facility's medical staff regularly conducts scheduled visits, providing timely psychiatric, podiatry, dental, and optometry services. During the Ombudsman's representative, an interview with one of the North Aurora Facility's psychologists revealed no issues with the care or services offered.

The North Aurora Care Center has contracted with Renewal Therapy to replace the previous therapy provider, but the start date is pending due to challenges with therapy staff recruitment. Meanwhile, the North Aurora Facility is referring residents to outpatient therapy services. According to the DON interviewed, this has not affected resident care, but transport costs have increased.

G. Risk Management

Staff at North Aurora Care Center conduct daily risk meetings to review accidents and incidents, resident behavioral concerns, skin impairment, and clinical documentation. North Aurora Care Center does accept residents who smoke cigarettes. For these residents, North Aurora Care Center allows outdoor staff to supervise smoking in a designated area. Residents are assessed for smoking safety and compliance with smoking rules. The Ombudsman's representatives observed that receptacles for discarding smoking materials are readily available and in good working condition, and that the smoking area was clean and free of inappropriately discarded items.

H. Medical Records

Staff interviews indicated that a hybrid medical record is maintained for each resident, consisting of paper records located at each nurse station and electronic health records utilizing the PointClickCare electronic medical records system. Staff were observed minimizing laptop screens in public areas to ensure the confidentiality of records. The Ombudsman's representatives conducted a review of medical records. The residents' records contained advanced directives, assessments of physical and mental status, assistance requirements for daily living activities, physician orders, diet, medication administration records, and laboratory results. A review of care plans by the Ombudsman's representative indicated adequate information was present to provide appropriate resident care and services.

I. Dietary Service/Kitchen

North Aurora Care Center furnishes three meals a day, served in the main dining area adjacent to the front entrance. Due to space constraints, the facility serves meals to residents at two separate seating times. Monthly menus were observed posted in the dining area. North Aurora Care Center provides alternative food choices and offers daily snacks. A tour of the kitchen with the dietary manager found staff wearing appropriate hair nets and gloves to prevent food-borne illnesses, and infection control standards were displayed. Food stored in the refrigerator, freezer, and dry storage areas was organized and appropriately dated, and a visual inspection indicated that North Aurora Care Center maintained sufficient food supplies to meet residents' nutritional requirements. The Ombudsman's representative also observed that: (a) the kitchen equipment and cooking utensils were clean and in working order; (b) temperature logs for the refrigerator, freezer, and dish machines were regularly updated; (c) staff maintained current routine equipment service and maintenance logs; and (d) staff posted cleaning schedules with appropriate supplies available.

Residents interviewed during lunch did not report any concerns with the amount or quality of food provided during meals and confirmed that alternate choices and snacks are provided when requested.

J. Emergency Preparedness

Responsibility for the oversight of the emergency management plan is designated to the Administrative Team. Review of preventative maintenance for the fire suppression system logs revealed no areas of concern. The Ombudsman examined the Facility's emergency preparedness manual, which detailed the locations of emergency exits, disaster and evacuation plans, and the methods for maintaining care continuity to guarantee resident safety.

K. Vendor Relationships

The administrator, the DON, and dietary director reported to the Ombudsman that vendor relationships are stable, with supplies and services delivered timely. Staff reported that the Facility recently switched vendors for medical supplies from McKesson to Medline as a result of the bankruptcy, and that no service delays have been experienced.

L. Resident Trust Fund

No records were available for review during the Ombudsman's representative's visit. There were no concerns reported from residents regarding their ability to access funds from resident trust accounts.

Exhibit C
Petersen Health Care Xl, LLC
Sandwich, IL

A. Overview

Sandwich Rehabilitation & Health Care Center, operated by Debtor Petersen Health Care Business Xl, LLC (together, the "Facility"), is located at 902 E. Arnold, Sandwich, IL 60548. The Facility is a single-story building licensed as a skilled nursing facility with sixty-three beds. The census was twenty-six at the time of the Ombudsman's visit. Interviews with the Facility's administrative staff indicated that there are no vacant positions and no contracted agency staff usage.

B. Regulatory

The Facility has an overall Centers for Medicare and Medicaid Services (the "CMS") star rating of one. Data from health inspections, staffing, and quality measures combine to calculate a facility's star ratings enrolled with Medicare. The Facility has recently been cited for resident harm or potential harm for abuse or neglect as evidenced by the display of an abuse icon, a white hand surrounded by a red circle, on the Facility's web page at the CMS nursing home compare consumer website. The Facility submitted a written plan of correction to the IDPH for the alleged deficient practice, and the Ombudsman did not find evidence of ongoing noncompliance at the Facility.

A review of the complaint investigation conducted by the IDPH on March 1, 2024 for incident reporting and an investigation into an incident that occurred in February 2024 complies with the survey's requirements for long-term care institutions with no citations issued. The IDPH completed an annual licensure and certification survey on January 25, 2024. The Facility received citations for:

- Developing and implementing policies related to abuse and neglect. Observation, interview, and record review revealed that the Facility neglected to complete resident background checks for three out of five residents.
- Based on observation, interview, and record review, the Facility did not ensure the completion of initial and weekly wound assessments, nor did it implement interventions to address the refusal of care and behavior of two of the three residents. The Facility provided treatment and services aimed at preventing and healing pressure ulcers.
- Based on observation, interview, and record review, the Facility failed to ensure a physician-ordered dressing was in place for one of four residents reviewed for pressure ulcers.
- Bowel/Bladder Incontinence, Catheter, UTI. Observation, interview, and record review revealed that the Facility neglected to change an indwelling catheter as instructed and failed to keep it off the floor for one of the two residents under review.
- Nutrition/Hydration Status Maintenance. Based on observation, interview, and record review, the Facility failed to implement interventions for a resident experiencing a significant weight loss of 19.47% in two months, and one of the four residents reviewed had a one-day time frame.
- Respiratory and tracheostomy care and suction observation. Interview and record review revealed that the Facility did not guarantee the proper administration of oxygen to a patient under review for oxygen services.
- The interview and record review revealed that the Facility lacked licensed nursing coverage for twenty-four hours a day. The facility employs nurses for eight hours daily, seven days

a week. Based on the interview and record review, the Facility failed to ensure a registered worked at least 8 hours a day.

- According to observation, interview, and record review, the Facility failed to ensure that one resident's medication was not left at the bedside.
- According to observations, interviews, and record review, the Facility failed to ensure that the bucket used for wiping down the dining room tables had the correct amount of chemical level to achieve sanitation.
- The Facility neglected to maintain food temperatures at 135 degrees Fahrenheit or higher before serving, failed to prevent cross-contamination during lunch meal service, and neglected to complete temperature and sanitation logs.
- According to the interview and record review, the Facility did not continue testing residents and staff for COVID-19 until there were no positive cases for fourteen consecutive days, nor did it notify the local health department of a COVID-19 outbreak. The interview and record review revealed that the Facility neglected to include immunization status information in the electronic or paper charts for two out of the five residents undergoing immunization reviews.

The Ombudsmen's facility tour, record review, and observations found no signs of ongoing alleged noncompliance.

C. Physical Plant and Environmental Services

The Ombudsman’s representative conducted a tour of the exterior and interior of the Facility. The sign at the entrance to Sandwich Rehabilitation and Health Care Center is easy to read, and the parking area is sufficient to accommodate visitors. The grounds surrounding the building were well maintained. An electronic lock secures the Facility's front door, which leads to

a lobby area. The Facility prominently posted the resident bill of rights, the State and Local Long-Term Ombudsman contact information, and the community inspection results.

During interviews, residents reported no concerns about the facility's housekeeping or laundry services. According to staff, the Facility reviews maintenance requests and work orders daily. Interviews with the administrative team confirm that the contracted preventative maintenance services were completed on time.

D. Resident Observation/Life Enrichment

The Ombudsman's representative observed residents actively engaged in an activity program in the main dining area during the initial tour. The residents were well-groomed and dressed appropriately. The observed interaction between staff and residents was respectful and reciprocal.

E. Resident Interview

Observations by the Ombudsman's representative indicated that informal interactions with the Facility residents were pleasant and conversational. The residents asked questions of the Ombudsman's representatives to learn why they were at the facility. During the formal interviews, the residents did not verbalize any complaints or concerns regarding the care and services provided at the Facility. The residents reported they were aware of someone to whom they could voice any concerns or complaints. The Ombudsman's review of the Facility resident council meeting minutes revealed that there were no unaddressed resident concerns or suggestions.

F. Clinical Services

A registered nurse serves as the director of nursing (the "DON") and oversees clinical services at the Facility. Staff reported that the Facility does use contracted agency staff and current staff to fill voids in scheduling. Interviews were conducted with the DON and other clinical staff; they reported no concerns regarding staffing shortages that could impact the delivery of care and services to residents.

G. Risk Management

The interdisciplinary team conducts weekly reviews of resident care areas that include accidents and incidents, infection control and prevention, weight loss, residents with behavioral concerns, and psychotropic medication usage. Processes are in place to complete a root cause analysis of identified concerns and update resident records as indicated. The Facility conducts risk analysis as part of the quality assurance process, no concerns were observed or reported during the Ombudsman's visit.

H. Dietary Service/Kitchen

The Ombudsman's representative noted monthly menus posted in the dining area and other areas of the facility. Interviewed residents did not report any concerns with the quality or availability of choice in the meals offered at the Facility. A tour of the Facility's kitchen did not identify any issues with the cleanliness of equipment, food preparation, or storage areas. The Ombudsman's representative observed staff wearing appropriate hair nets and gloves to prevent food-borne illnesses; infection control standards were prominently displayed. The Ombudsman's

representative reviewed cleaning and temperature logs and found they contained the appropriate documentation.

I. Emergency Preparedness

Responsibility for the oversight of the emergency management plan is designated to the Administrative team and reviewed annually. The Ombudsman's representative examined the Facility's emergency preparedness manual, which detailed the locations of emergency exits, disaster and evacuation plans, and the methods for maintaining care continuity to guarantee resident safety. Review of preventive maintenance logs for the fire suppression system did not reveal any areas of concern.

J. Vendor Relationships

The administrative team reported that contracted preventive maintenance services are completed timely. According to Facility staff, there have been no service interruptions with delivery of resident care supplies or food commodities.

K. Resident Trust Fund

Resident trust account records were not available for review during the Ombudsmen representative visit. No residents reported concerns related to accessing personal funds managed by the Facility.

Exhibit D
Petersen Health Network, LLC
Rochelle, IL

A. Overview

Rochelle Gardens Care Center is operated by Debtor Petersen Health Network, LLC (together, the "Facility"). The Facility is located at 1021 Caron Road, Rochelle, IL 61068 and is licensed by the Illinois Department of Public Health (the "IDPH") for 74 beds. The resident census on the day of the tour was 56. The administrator is relatively new in their role, having started at this location in January 2024. The administrator reported that communication and support from corporate regional staff is good.

B. Regulatory

The facility has an overall Centers for Medicare and Medicaid Services (the "CMS") star rating of one. Data from health inspections, staffing, and quality measures combine to calculate a facility's star ratings enrolled with Medicare. The Facility has recently been cited for resident harm or potential harm for abuse or neglect as evidenced by the display of an abuse icon, a white hand surrounded by a red circle, on the Facility's web page at the CMS nursing home compare consumer website. The Facility submitted a written plan of correction to the IDPH for the alleged deficient practice, and no evidence of ongoing noncompliance was identified by the Ombudsman.

The IDPH completed the investigation of a facility-reported incident on April 30, 2024, and the Facility received citations for its failure to report alleged violations. Based on the interview and record review, the Facility failed to immediately report an injury of unknown origin to the abuse coordinator or administrator for one of three residents reviewed for injuries of unknown origin. According to the interview and record review, the Facility failed to thoroughly assess a

resident following an injury of unknown origin. This failure resulted in a delay in identifying and obtaining medical treatment for one resident.

On April 4, 2024, the IDPH completed a complaint investigation and based on observation, interview, and record review, cited the Facility for neglecting to inform a resident's family or contact person about two falls, leading to the resident's transfer to a nearby hospital for injury assessment. Observation, interview, and record review revealed that the Facility neglected to send a resident on anticoagulant therapy to a local hospital for evaluation following a fall that resulted in a head injury. The Facility failed to store medications in a locked medication cart or in a locked medication room, according to observation, interview, and record review.

On February 28, 2024, the IDPH completed a complaint investigation and cited the Facility for pain management. According to the interview and record review, the Facility failed to obtain physician orders to ensure that a resident received his pain medication. This failure caused one resident to miss 41 days and 123 potential doses, resulting in uncontrolled pain for one of the three residents reviewed. The Facility was issued an additional citation for failing to ensure a physician supervised one resident's care. The interview and record review revealed that the Facility did not ensure that a primary care physician was supervising one of the three residents reviewed for physician services. The Facility submitted a written plan of correction to the IDPH for the alleged deficient practices, and no evidence of ongoing noncompliance was identified by the Ombudsman's representative.

C. Physical Plant and Environmental Services

The Facility is a one-story building with sections covered in part with a flat roof or peaked with an attic. Resident room configurations vary with some having their own bathrooms while

others use shared facilities located on the hallway. The Ombudsman noted significant damage to door jams and walls that may be the result of wheelchair traffic. There was notable ceiling damage in the Facility's therapy room.

During the environmental tour, the Ombudsman's representatives noted numerous mattresses, wheelchair armrests, and seats were visibly worn and in need of repair. A certified nursing aide, the housekeeping supervisor and administrator verbalized that mattresses are an immediate need in the Facility. Staff reported that supply levels are adequate for the Facility. The Ombudsman noted that a new packaged terminal air conditioning ("PTAC") unit is needed in a common area. The housekeeping supervisor has been with the Facility for ten years. The Facility is fully staffed for housekeeping and laundry services at present.

D. Resident Observation/Life Enrichment

During the initial tour, the Ombudsman's representatives observed residents engaged in self-directed activities.

E. Resident Interviews

The Ombudsman's representatives conducted an interview with the resident council president, who stated that resident council meetings are held monthly on the third Tuesday. The resident has lived in the facility for seventeen months. The resident stated that staffing is "okay" and that call lights are answered. The resident indicated that food quality could be improved and that they can request sandwiches occasionally. According to the resident, the activities that are offered to residents include games and crafts.

A second resident who was interviewed verbalized that the food could be better and stated that they "can't get a grilled cheese when I want it." The resident stated that the Facility staff are nice and respond to residents.

A third resident was interviewed who stated that the food was good, and staff are nice to residents. The resident verbalized that they experience aches and pains and that the nurses come help her when needed.

F. Clinical Services

Clinical services are overseen by the director of nursing (the "DON") but was not present in the community at the time of the Ombudsman visit. According to the social services director and other staff, Facility nurses work a mix of eight- and twelve-hour shifts. Certified nursing aides work typically work twelve-hour shifts. The Facility staffs two nurses on the day and evening shifts and one nurse for the overnight shift. The Facility schedules three to four aides during the day and evening shifts, and two for the overnight shift. Staff reported they were unaware of any grievances and that the Facility did not have any external agency staff at present. However, the corporate operator has its own internal agency pool and both nurses working during the Ombudsman's visit were provided through this entity.

G. Risk Management

Staff reported to the Ombudsman that the interdisciplinary team conducts weekly reviews of resident care areas that include accidents and incidents, infection control and prevention, weight loss, residents with behavioral concerns, and psychotropic medication usage. Processes are

reportedly in place to complete a root cause analysis of identified concerns and update resident records as necessary.

H. Medical Records

A hybrid medical record consisted of electronic and paper-based documentation is maintained for each resident. The Ombudsman's representative review of the clinical records found that they included physicians' orders and functional assessments necessary to create individualized care plans for residents. The Facility staff reportedly updates the care plan information to align with the evolving needs of the resident. Interviews were conducted with clinical staff, and they reported no concerns regarding staffing shortages that could impact the delivery of care and services to residents.

I. Dietary Service/Kitchen

The Facility furnishes three meals a day with a snack available. The Ombudsman's representatives observed the lunch meal service and noted that residents were served meals on paper dinnerware. Visual observation indicated that food portions were large and appetizing. Residents verbalized that the meal was good. The Facility has a storage room designated for personal snacks and is accessible to the activities director and aides. The Facility offers an afternoon snack cart with fruit, deli sandwiches, peanut butter and jelly sandwiches, cookies, pudding and applesauce. The dietary manager gave notice just prior to the Ombudsman visit and the Facility will need to recruit a replacement. The Facility administrator reported that the resident census was not experiencing any weight loss issues.

J. Emergency Preparedness

No information was provided to the Ombudsman regarding emergency preparedness plans, generator maintenance logs, fire drill logs, disaster response logs, elopement drill logs or similar documentation.

K. Vendor Relationships

The administrator reported that there have been no supply issues since the Facility changed vendors to Medline. Furthermore, the administrator indicated that the Facility could borrow supplies and equipment from other facilities if needed. There were no other supply concerns reported to the Ombudsman.

L. Resident Trust Fund

The Ombudsman's representatives interviewed the business office manager, who is new to the facility. Both the administrator and business office manager are reviewing the representative payee list and process, and the collection letters that are to be issued. The Facility did not provide current documentation for resident trust funds being held for residents. There were no issues reported to the Ombudsman that residents are unable to access their funds.

Exhibit E
Petersen Health Network, LLC
Rochelle, IL

A. Overview

Rochelle Rehabilitation and Health Care Center is operated by Debtor Petersen Health Network, LLC (together, the "Facility"). The Facility is located at 900 North 3rd Street, Rochelle, IL 61068 and is licensed by the Illinois Department of Public Health (the "IDPH") for 50 beds. The administrator, a registered nurse with experience as a Minimum Data Set data coordinator, began their role at the Facility in April 2024. The administrator verbalized that the Facility team is the largest positive aspect of the community.

B. Regulatory

On April 25, 2024, the IDPH completed its Annual Licensure and Certification Survey of the Facility. Citations are summarized as follows:

- The Facility received citations for Medicaid, Medicare Coverage, and Liability Notice violations. The interview and record review revealed that the Facility had neglected to provide residents with an advanced beneficiary notice before therapy discharge. The Facility reviewed all three residents for an advanced beneficiary notice.
- The interview and record review revealed that the Facility did not follow instructions to refer a resident to a heart specialist, and it did not record an assessment of a new skin condition for two out of the two residents under review.
- The Facility should be free from accidents, hazards, supervision, and devices. Based on observation, interview, and record review, the Facility failed to implement

interventions to minimize the risk of elopement for 1 of 4 residents reviewed for elopement.

- Based on observation, interview, and record review, the Facility failed to ensure a resident with a feeding tube had placement checked prior to administration of medications and feedings. The Facility also failed to ensure a resident with a feeding tube had a nutritional assessment on admission.
- According to observation, interview, and record review, the Facility did not administer oxygen as ordered for one of the residents under review.
- According to observations, interviews, and record reviews, the Facility failed to ensure the availability of prescribed medications for one of the residents under review.
- Observation, interviews, and record review revealed that the Facility neglected to lock the treatment cart when the nurse on duty was not present, failed to double-lock controlled medications in the medication cart, and failed to prevent residents and staff from accessing the medication cart's keys.
- The procurement, storage, preparation, and serving of food must be done in a sanitary manner. According to the observation interview and record review, the Facility failed to ensure that the ceiling over the serving window and the dishwashing area were free from damage and falling debris.
- The Facility neglected to place a thermometer in one of the refrigerators to ensure proper operation and keep food at a safe temperature. The Facility did not use a thermometer that measures internal food temperatures or obtain temperature readings prior to serving. The Facility also neglected to ensure that staff were

accurately recording food temperature logs and monitoring the dish machine's chemical sanitation levels in accordance with their policies and procedures.

- According to the interview and record review, the Facility did not provide therapy services as ordered for one of the residents reviewed for therapy.
- Based on observation, interview, and record review, the Facility failed to ensure enhanced barrier precautions were in place, failed to implement their Legionella program, and failed to test facility water for Legionella.

At the time of the Ombudsman's visit, the Form 2567 "Statement of Deficiencies and Plan of Correction" had not yet been received by the Facility. However, the Facility reported they were initiating their plan of correction based on exit conference findings provided by the survey team.

The facility has an overall Centers for Medicare and Medicaid Services (the "CMS") star rating of one. Data from health inspections, staffing, and quality measures combine to calculate a facility's star ratings enrolled with Medicare. The Facility has previously been cited for resident harm or potential harm for abuse or neglect as evidenced by the display of an abuse icon, a white hand surrounded by a red circle, on the Facility's web page at the CMS nursing home compare consumer website. The Facility submitted a written plan of correction to the IDPH for the alleged deficient practice, and no evidence of ongoing noncompliance was identified by the Ombudsman's representative.

C. Physical Plant and Environmental Services

Staff reported that physical plant deficiencies is the biggest challenge faced by the Facility, and that support from corporate is needed in this area. The Ombudsman and her representatives toured the physical plant and grounds of the Facility. The following concerns were noted:

- There is a water leak at the kitchen passthrough window over the steam table. As a result, the kitchen is performing tray service only until this has been repaired.
- Multiple exterior doors were noted with visible (e.g. boiler room, dry storage, hallway near salon).
- Pest control logs were reviewed and there were no concerns. Staff interviewed denied there were pest concerns. However, the last pest control consultants visit occurred on February 23, 2024 and there were no further records available for review.
- Drywall damage visible in resident rooms near beds and around doors. Flooring patched with different materials in multiple places.
- Room 148 window glass was cracked and covered with duct tape. The window cannot be closed.
- Missing tile outside of the beauty shop could be a trip hazard.

The Laundry department has one commercial washer and dryer set; one residential washer was added to accommodate increased volume. The Ombudsman did not find any concerns in this area.

D. Resident Observation/Life Enrichment

The activities director was unavailable to meet while the Ombudsman and her representatives were present in the Facility. The activity calendar was posted and based upon review, appears to meet regulatory requirements. According to the activity calendar, programming ends daily at 3:30 pm. The last activity on most days is a snack service. Residents utilize paper packets for activities for two days of the week. Staff were observed interacting with residents in the common areas and residents were engaged in self-directed activities.

E. Resident Interviews

One resident interviewed by the Ombudsman verbalized that there is "always something going on" and that "staff are nice."

F. Clinical Services

Clinical services are overseen by the director of nursing (the "DON"). Nurses work 12-hour shifts and there is at least one nurse on duty 24 hours daily. Certified nurse aides work eight-hour shifts with three aides on duty during day and evening shifts, and two aides on night shifts. The Facility is fully staffed and is not currently using agency personnel.

The medical director and a second physician are in the Facility on a regular basis. Ancillary services are available for residents; the podiatrist is in house and other services are coordinated with outside providers. VOHRA provides wound care services. One resident has a house-acquired pressure wound and is on hospice care. The Ombudsman reviewed a dietitian report on the resident from April 19, 2024 with no weight loss noted. Based upon interviews, the clinical team excels at tracking quality assurance data, and the medical director attends participates in quality assurance meetings.

Renewal Therapy is contracted to provide therapy services is on site weekday mornings. During the visit, a therapist was interviewed and stated that communication with the DON was good. The certified nurse aide supervisor schedules and oversees restorative direct care with aides carrying out the programs and the activities department performs range-of-motion exercises with residents. Residents that smoke are allowed to do so under supervision.

The DON verbalized that durable medical equipment needs are met by sharing with other facilities under the corporate organization. Impact is the Facility's part B supplier. The medical

supply budget is approximately $3000 per month and together with the part B supplies, the Facility can meet resident needs.

The Ombudsman noted during the tour that the medication cart and treatment cart were unlocked. In addition, the medication room door was left open with the medication refrigerator unlocked.

G. Risk Management

Interviews with the DON indicated that excellent processes related to risk management including incidents, skin areas and infection control are in place. Quality assurance tracking data was produced immediately for the Ombudsman and appeared to be complete with all necessary information. The DON verbalized processes related to monitoring for trends and monitoring effectiveness of interventions. Fall incidents and infections are tracked on a paper-based ledger in addition to the its electronic medical records ("EMR") system. The Facility uses the EMR's infection control module. The Ombudsman's representative reviewed the infection log and did not note any trends or concerns.

The fall incident log indicated there were seven falls in April 2024 with no injury, and four falls in May 2024 to date with one minor injury. The Ombudsman did not have any concerns related to fall incidents and Facility tracking processes.

H. Medical Records

Resident records are maintained with a hybrid system that uses both electronic and paper-based documentation. The Facility has PointClickCare for its EMR system, used widely in the skilled nursing industry. The DON and a nurse were interviewed regarding recording processes

and based on the discussion the processes seemed appropriate. Both the nurse and the DON verbalized similar processes and the nurse was observed by the Ombudsman entering notes into resident record at the time of the visit. A caregiver was observed documenting care notes related to a shower that had been given to a resident.

I. Dietary Service/Kitchen

The Ombudsman met with the dietary manager, who had been with the Facility for two weeks. The dietary manager stated they don't have a sanitation certificate but has worked in kitchens with a background in restaurant and hotel environments. The administrator and dietary manager verbalized their plan to have certificate within sixty days to meet the requirement. One of the staff members has over twenty years of longevity in the Facility and is supporting the dietary manager. The dietary manager reported that residents are receiving tray service only until a ceiling leak over the steam table is repaired.

Visual inspection determined that the kitchen is clean and that foodstuffs are properly dated. A review of temperature logs indicated they are well maintained and up to date. Staff were observed wearing appropriate hair nets in the kitchen.

J. Emergency Preparedness

The maintenance director provided information to the Ombudsman regarding emergency preparedness planning and activities. The Ombudsman reviewed the Facility's binder and it appeared to be complete. The maintenance director reported that the annual life safety inspection had been completed the week prior to the Ombudsman visit. The maintenance director stated that

a fire drill was held the week prior and that a tabletop disaster exercise was planned for Friday of the current week on heat emergency procedures. A tornado drill was anticipated to be held soon.

K. Vendor Relationships

No concerns were reported by staff to the Ombudsman regarding any vendor or supply issues except for the delivery of light bulbs, which were delayed and caused an outage of light in the therapy room. Supplies continue to flow into the Facility, and the staff reported that equipment and supplies can be borrowed from other Debtor facilities as needed. The dietary manager reported that food deliveries are continuing as orders are placed.

L. Resident Trust Fund

The administrator began duty in April 2024 and was unable to provide information regarding the resident trust fund administration, indicating that the information was managed at the corporate level.

Exhibit F
Petersen Health Network, LLC
Jerseyville, IL

A. Overview

Willow Rose Rehab & Health, operated by Debtor Paterson Health Network, LLC (together, the "Facility") is a 98-bed skilled nursing home located at 410 Fletcher Street, Jerseyville, IL 62052. There were thirty-seven residents in-house during the Ombudsman's visit. A Skilled Nursing Facility (SNF) is a certified establishment that provides nursing care to residents who require either short-term rehabilitative treatments or long-term nursing care, with periodic medical supervision. Skilled nursing facilities are licensed by the Illinois Department of Public Health (the "IDPH") and certified for Medicare/Medicaid participation by the Illinois Department of Healthcare and Family Services.

B. Regulatory

The Facility has an overall one-star rating on the Centers for Medicare and Medicaid Services (the "CMS") five-star rating system. This system is used to compare and evaluate facilities and health plans based on performance in three areas: health inspections, quality metrics, and staffing. The ratings for all skilled nursing facilities in the United States are published through the CMS web site, https://www.medicare.gov/care-compare/.

The Facility's rating is calculated based on a health inspection rating of one star, a staffing rating of two stars, and a quality measures rating of three stars. The IDPH conducted a recertification investigative survey at the Facility on November 8, 2023. The facility was cited in two areas: the provision of incontinent care and food storage. The IDPH did not report other issues regarding the care provided to the residents. Despite the citation for a malfunctioning freezer door, the temperature remained within the expected range of 0 to -10 degrees Fahrenheit and was not

noted to have had any adverse effects on resident care. No further examinations by the IDPH have been conducted at the facility since November 8, 2023.

C. Physical Plant and Environmental Services

The Ombudsman's representatives arrived at Willow Rose Rehab & Health Care on May 22, 2024. The grounds were well maintained and there was adequate parking available for both personnel and visitors. The Facility's walkway was in disrepair as evidenced by several areas of uneven surfaces and sections of missing concrete.

The entrance is equipped with an electronic lock and leads into a small vestibule. Signage for the Resident Bill of Rights and the contact details for the State and Local Long-Term Ombudsman were prominently displayed in the resident all-purpose area. Survey findings were supplied upon request.

Willow Rose Rehab & Health Care has a workforce of forty-eight employees, which includes a management team with a combined longevity of 60 years' experience. The staff consists of thirty clinical personnel, eight dietary employees, seven cleaning and maintenance employees, one social service employee, an activity staff member, and one administrative staff member. Currently, there is no Business Office Manager available, but the administrative staff is temporarily fulfilling the role on a part-time basis. Staff reported to the Ombudsman's representatives that no changes were expected to the current staffing. . The facility is engaged in active recruitment efforts to fill the available positions.. During the tour of the physical facility, the Ombudsman's representatives noted that housekeeping supplies were not properly secured. After reporting the concern to Facility staff, the issue was promptly rectified and did not pose any danger to the residents. In addition, the Ombudsman's representatives noted that milk jugs containing used razors in the shower area. Staff corrected this issue upon notification. The

Ombudsman's representatives observed secure doors lacked a warning sign indicating a fifteen (15) second delay when opening.

D. Resident Observation/Life Enrichment

During the initial visit to the Facility, residents were observed participating in an activity. The residents were well-groomed and dressed appropriately, and they actively engaged in the provided activity. The Ombudsman's representatives observed dining services during lunch, with the entire staff actively participating. Dining services were provided appropriately, with all residents at the tables served simultaneously and dishes taken from the serving tray and placed before the resident. Food palatability was good as evidenced by its pleasant odor and resident remarks indicating their satisfaction with the taste of their portions. The Facility's common spaces were orderly and had sufficient illumination. The Ombudsman's representatives observed staff interactions with residents as being amicable and mutually respectful.

E. Resident Interviews

The Ombudsman's representatives conducted interviews with several residents. The residents verbalized positive comments when asked about whether the institution met their care needs. The residents did not voice any concerns regarding their care. The residents reported that the care they received was adequate to fulfill their needs and expressed a sense of security within the Facility.

F. Clinical Services

The Director of Nursing (the "DON") of Willow Rose Rehab & Health Care is a registered nurse who is responsible for supervising clinical services. The Facility schedules both eight and

twelve-hour work shifts for nurses and nursing assistants. Primary staff responsibilities include administering medication and providing direct care to residents. The DON reported that Willow Rose Rehab & Health Care does not utilize contracted agency services and has not done so for several years. The current workforce effectively addresses schedule gaps. The DON and another clinical staff member were interviewed, and they stated that there were no concerns about staffing shortages that could affect the provision of care and services to residents.

The Ombudsman's representative reviewed visit reports for the Facility's medical personnel, including psychiatric, podiatry, dental, and optometrist treatments. No concerns were noted in obtaining these services.

The Willow Rose Rehab & Health Care facility has entered a contract with Renewal Therapy to replace the previous therapy provider. Beth, a Certified Occupational Therapy Assistant (COTA), acts as the Director of Rehabilitation (DOR), and it was reported that the therapy services are now being provided.

G. Risk Management

Staff reported that they conduct a daily meeting to assess and analyze potential risks. This review reportedly encompasses accidents, events, resident behavioral issues, skin, weight issues, wound healing progress, and clinical documentation.

Willow Rose Rehab & Health Care accommodates residents who engage in cigarette smoking. For these residents, the institution reports it has personnel to oversee smoking activities in a designated location. Director of Social Service evaluates residents to determine their adherence to smoking regulations and ensure their safety regarding smoking. During the Ombudsman's representatives' visit, the smoking area was observed to be clean and devoid of any improperly disposed objects and a ceiling fan present.

H. Medical Records

The medical records system at the Facility utilizes a hybrid approach. The administrator stated to the Ombudsman that Minimum Data Set data is utilizing PointClickCare software, but the other departments are still relying on paper-based systems.

I. Dietary Services

Willow Rose Rehab & Health Care provides three daily meals, which are served in the main dining hall located next to a common activity space.

Monthly menus that include alternate food options are posted in the dining room. Residents were observed consuming snacks. The dietary manager led the Ombudsman's representatives on a tour of the kitchen, where staff members were observed wearing hair nets and gloves. Infection control regulations to prevent the occurrence of food-borne illnesses were prominently posted. The food held in the refrigerator, freezer, and dry storage facilities was systematically arranged and accurately labeled with dates. Visual inspection of the inventory indicated sufficient food supplies to fulfill the nutritional needs of the residents. The Ombudsman's representative noted the kitchen equipment and cooking utensils to be in a clean and functional condition. However, the freezer door mentioned in the IDPH November 2023 recertification survey continued to be in a state of disrepair. The observed temperature during the Ombudsman's tour was within the typical acceptable range. A review of the temperature logs indicated that temperatures were being maintained in an acceptable range and that the temperature and maintenance logs for the refrigerator, freezer, and dish machines were periodically updated in accordance with regulations.

Residents interviewed at lunch by the Ombudsman's representatives expressed no grievances regarding the quantity or quality of food served during meals and affirmed that alternative options and snacks are offered upon request.

J. Vendor Relationships

The Administrator and the DON reported that the connections with vendors are secure, and they consistently provide goods and services in a punctual manner. Visual inspection of the inventories indicated that the Facility was well stocked with supplies.

K. Resident Trust

Willow Rose Rehab & Health Care reported to the Ombudsman's representatives that it manages resident trust funds using a paper-based system. Funds are deposited at the Jerseyville branch of Royal Banks of Missouri, located nearby. Two staff within the facility are authorized to handle funds for the residents. During the interview, the Administrator affirmed that there were no difficulties in acquiring funds for the residents when requested. The Administrator indicated that the trust account's current balance was approximately $45,000. The Administrator reported that an evaluation of the surety bond recommended an increase in the bond coverage from its current amount of $25,000.

L. Emergency Preparedness

The responsibility for emergency preparedness is shared between the maintenance director and the nursing home administrator. The Ombudsman's representatives reviewed the emergency preparedness manual and determined it complies with the criteria established by the IDPH. It encompasses fire drills, elopement drills, and essential policies and procedures that will be assessed during a life safety inspection. The drills mentioned in the manual were determined to be current. The audits included assessments of water temperature and fire drills

Exhibit G
Swansea HCO, LLC
Swansea, IL

A. Overview

Swansea Rehabilitation & Health Care Center is operated by Debtor Swansea HCO, LLC and affiliated with Debtor Swansea RE, LLC (collectively, the "Facility"). The Facility is located at 1405 North Second Street, Swansea, IL 62226. The facility is licensed by the Illinois Department of Public Health (the "IDPH") as ninety-four bed skilled facility. The census at the time of the Ombudsman's representative visit was 39.

B. Regulatory

Upon arrival, the Ombudsman's representatives conducted a tour of the building and noted that the resident bill of rights, the State and Local Long-Term Ombudsman contact information, and the community inspection results all were posted in prominent locations. The facility has an overall the Centers for Medicare and Medicaid Services star rating of one. Data from health inspections, staffing, and quality measures combine to calculate a facility's star ratings enrolled with Medicare.

The IDPH conducted a compliant investigation at Swansea Rehab on April 8, 2024, and found the facility to be in compliance with the requirements for long-term care facilities.

The IDPH completed a complaint investigation of the Facility on February 22, 2024. The Facility received citations for quality of care, which is defined as a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. The interview and record review revealed that the Facility did not

guarantee the completion of treatment for one of the three wound care residents in the sample of seven. On February 21, 2024, the Facility's staffing schedule failed to record registered nurse coverage every day for 8 consecutive hours over the previous 14 days. In the area of staff qualifications, the Facility must employ, on a full-time, part-time, or consultant basis, those professionals necessary to carry out the requirements. Professional staff must be licensed, certified, or registered in accordance with applicable state laws. Observation, interviews, and record reviews revealed that the Facility did not ensure the certification of a qualified and licensed administrator in accordance with applicable state laws for overseeing the daily operations of the Facility. The Facility submitted a written plan of correction to the IDPH.

The nursing staff was instructed by the director of nursing (the "DON") to provide adequate prevention techniques and documentation for the completion of treatments. The regional director provided training to the administrator on how to order supplies to meet the needs of all residents. The alleged deficient practice has the potential to affect all residents who received treatment. The Facility has implemented systematic measures to prevent the alleged deficient practice from recurring. Nursing management will monitor all residents with a treatment plan and provide weekly skin assessments and documentation to ensure wound treatment is completed. During morning meetings, the Quality Assurance Committee will review nursing monitoring of treatment completion and documentation to ensure compliance. The Facility staff reported that they will rectify any identified issues through additional education and ongoing monitoring, if necessary.

The IDPH conducted a complaint investigation on January 18, 2024. According to observation, interview, and record review, the Facility failed to provide the services of a registered nurse for at least eight hours daily, seven days per week. During the Ombudsmen's visit no registered nurse was present in the Facility.

C. Physical Plant and Environmental Services

Swansea Rehabilitation is a single-story brick building attached to a two-story building used for facility storage. The entry is secured with an electronic lock. The grounds surrounding the building were appropriately maintained. During the initial tour of the facility the hallways were free from clutter and there were no objectionable odors detected.

Interviewed residents reported no areas of concern related to housekeeping or laundry services provided at the Facility. Staff reported that maintenance requests and work orders are reviewed daily. Interviews with the administrative team affirmed timely completion of contracted preventative maintenance services.

D. Resident Observation/Life Enrichment

During the initial tour, the Ombudsman's representatives observed residents participating in an activity in the main dining area. Residents were appropriately groomed and dressed, and they actively engaged with the staff. The Ombudsman's representatives noted that the community had posted activity calendars on bulletin boards in several locations.

E. Resident Interview

The Ombudsman's representative interviewed three residents regarding their experiences with care and other aspects of resident life while residing at the Facility. The residents did not verbalize any concerns about the quality of care and services provided to them.

F. Clinical Services

The regional DON is providing temporary support for the vacant DON position at the Facility. Interviews were conducted with clinical staff, and they reported no concerns regarding staffing shortages that impact the delivery of care and services to residents.

G. Quality Assurance/ Risk Management

The interdisciplinary team conducts weekly reviews of resident care areas that include accidents and incidents, infection control and prevention, weight loss, residents with behavioral concerns, and psychotropic medication usage. Processes are in place to complete a root cause analysis of identified concerns and update resident records as indicated. Residents are assessed for smoking safety and compliance with smoking rules. Receptacles for discarding smoking materials are readily available and in good working condition. The smoking area was clean and free of inappropriately discarded items.

H. Medical Records

A hybrid medical record is maintained for each resident, with portions of the record maintained electronically as well as through paper-based documentation. A review of the clinical record included written advanced directives, physicians' orders and functional assessments needed to create individualized care plans for residents. Based upon the selected review by the Ombudsman's representatives, the Facility staff updates the care plan information to align with the needs of the residents. Incident, accident, and wound care logs are up-to-date and provide documentation of interventions implemented at the time of occurrence.

I. Dietary Service/Kitchen

The Facility furnishes three meals a day, offers an alternative meal selection, and a snack. The Ombudsman noted that the Facility posted menus in the main dining room and other areas. Residents interviewed by the Ombudsman's representatives voiced no complaints or concerns regarding the quality of meals or available snacks. The tour of the kitchen revealed an adequate supply of food. The documentation on the temperature and cleaning logs was inconsistent.

J. Emergency Preparedness

Responsibility for the oversight of the emergency management plan is designated to the Administrative team and reviewed annually. The Ombudsman's representative examined the Facility's emergency preparedness manual, which detailed the locations of emergency exits, disaster and evacuation plans, and the methods for maintaining care continuity to guarantee resident safety. The fire suppression monitoring and routine maintenance logs were up to date.

K. Vendor Relationships

According to interviews with the administrator and clinical staff, vendor relationships are stable, with supplies and services delivered on time. The Facility is equipped with an adequate inventory of supplies to provide resident care.

L. Resident Trust Fund

The administrator reported that the corporate office manages resident funds, but no reviewable information was available. The Ombudsman's Representative interviewed the residents of the Facility, but they did not report any difficulties accessing personal funds upon request.

Exhibit H
Lebanon HCO, LLC
Lebanon, IL

A. Overview

Lebanon Care Center is operated by Lebanon HCO, LLC (together, the "Facility"). The Facility is located at 1201 North Alton, Lebanon, IL 62254 and is a single-story building licensed as a 90-bed skilled Facility. The census at the time of the Ombudsman's visit was fifty-seven.

B. Regulatory

The Resident Bill of Rights, the State and Local Long-Term Ombudsman contact information, and the community inspection results were posted in prominent locations in the main hallway. The Facility has an overall Centers for Medicare and Medicaid Services (the "CMS") star rating of two. Data from health inspections, staffing, and quality measures combine to calculate star ratings for facilities enrolled with Medicare. The Facility has been cited previously for resident harm or potential harm for abuse or neglect as evidenced by the display of an abuse icon, a white hand surrounded by a red circle, on the Facility's web page at the CMS nursing home compare consumer website. The Facility submitted a written plan of correction to the Illinois Department of Public Health (the "IDPH") for the alleged deficient practice, and no evidence of ongoing noncompliance was identified by the Ombudsman's representative during the visit.

The IDPH conducted a complaint investigation at Lebanon Care Center on May 1, 2024, and found the Facility to be in compliance with the requirements for long-term care facilities.

The IDPH conducted a complaint investigation survey on April 10, 2024, and the Facility received two citations. The interview and record review revealed that the Facility failed to document a discharge in the medical record and did not provide the necessary information for the discharge of one of the three residents in the sample of five. Based on the interview and record

review, the Facility failed to follow discharge requirements for one of the three residents reviewed for discharge in the sample of five. The Lebanon Care Center submitted a written correction plan to the IDPH, indicating that the staff received in-service training on the transfer and discharge requirements and policy, the necessary documentation for transfers, the paperwork for the transfer packet, and the policy itself. The Facility will conduct daily quality assurance meetings to ensure that the necessary transfer documentation is present in the medical chart and transmitted to the receiving Facility.

The IDPH conducted a compliant investigation survey on March 29, 2024, and received one citation. Based on the interview and record review, the Facility failed to prevent staff to resident verbal abuse for one of five residents reviewed for abuse in the sample of six. Lebanon Care Center terminated the employee involved in the abuse allegation and submitted a written plan of correction to the IDPH. The staff reported that the Facility implemented systematic measures to ensure the alleged deficient practice doesn't recur. Upon hiring, all staff receive training on abuse and addressing residents. The quality assurance team reported it will monitor compliance and review any reportable incidents, including abuse, during the quarterly quality assurance meetings to address any areas requiring additional training beyond the ongoing scheduled in-service.

C. Physical Plant and Environmental Services

The sign at the entrance to Lebanon Care Center is easy to read, and the parking area is sufficient to accommodate visitors. The front door of the Facility opens to a reception area with seating visible from the Administrator’s office. The Ombudsman’s representative did not observe any issues with the maintenance of the building exterior or grounds that would impact resident care.

Residents have not reported any issues or concerns with the cleaning or laundry services offered at the Facility. The administrator reported that the Facility has a daily process to review and attend to maintenance requests. The administrative staff reported that a vendor provides preventive maintenance services for selected building infrastructure and that the vendor service performance has been timely and in accordance with the contract requirements.

D. Resident Observation/Life Enrichment

During the initial tour, the Ombudsman's representatives noted residents were completing a pre-meal activity. The staff and resident interaction were observed to be respectful. Staff escorted residents requiring assistance with transportation within the building.

E. Resident Interview

The Ombudsman's representatives interviewed four residents to learn their opinions on their experiences with residence at the Facility. The feedback received indicated that the residents are pleased to live at the Facility and that staff promptly and respectfully meets each resident's personal care needs. All of the interviewed residents participate in the monthly resident council meetings and reported that the Facility staff promptly addressed any issues or concerns brought forward in the meetings.

F. Clinical Services

At the time of the Ombudsman's representative visit, the Director of Nursing (the "DON") position was vacant. The administrator reported that they are actively recruiting a new nurse to fill the DON position, and that the Regional DON is providing clinical support to the Facility in the

interim. The Ombudsman's representatives reviewed the direct care staff schedule and determined that the number of staff available to provide care to residents is appropriate. Staff reported that ancillary service providers continue to provide routine care services at the Facility.

G. Risk Management

The Facility reported that it has an interdisciplinary team ("IDT") that conducts weekly reviews of resident care areas, which include accidents and incidents, infection control and prevention, weight loss, residents with behavioral concerns, and psychotropic medication usage. The IDT performs a root cause analysis of identified concerns and subsequently updates resident records as necessary.

Lebanon Care Center permits outdoor supervised smoking for residents in a designated area. Residents are assessed for smoking safety and compliance with smoking rules. Observations by the Ombudsman's representatives noted that receptacles for discarding smoking materials are readily available and in working condition, and the smoking area was clean and free of inappropriately discarded items.

H. Medical Records

The Lebanon Care Center maintains a hybrid medical record for each resident. The Ombudsman's representatives pulled a sample of clinical records to review the contents and found they contained physicians' orders, advanced directives, and functional assessments necessary for the development of personalized care plans for residents. Based upon the review, it appears that staff regularly updates the care plan information to reflect changes in the residents' conditions. Staff reported that resident medical records are reviewed as part of the quality assurance process for accurate and current information.

I. Dietary Service/Kitchen

The Ombudsman's representatives toured the dining facilities and kitchen. The representatives noted that the dining area has the monthly menus prominently displayed and that the Facility offers alternative food choices and daily snacks. Staff were observed assisting residents who needed help with meals. No complaints were voiced about the quality, temperature, or taste of the food.

During the kitchen tour with the dietary manager, staff were observed wearing appropriate hair nets and gloves to prevent food-borne illnesses. Postings with infection control standards were on display, the food preparation areas were clean, and the equipment was in working order. Food stored in the refrigerator, freezer, and dry storage areas were observed to be well organized and appropriately dated, and it appeared that they maintained enough food supplies to meet residents' nutritional requirements. The temperature and cleaning logs available for review contained appropriate documentation.

J. Emergency Preparedness

Skilled nursing facilities are required to establish a comprehensive emergency management plan that addresses many potential hazards and emergency circumstances. The Facility's administrative team bears the responsibility for the oversight of the emergency management plan and is expected to conduct an annual review. The Ombudsman's representative examined the Facility's emergency preparedness manual, which detailed the locations of emergency exits, disaster and evacuation plans, and the methods for maintaining care continuity to guarantee

resident safety. Fire suppression system and preventative maintenance record were current. Fire drills were documented as conducted monthly.

K. Vendor Relationships

According to interviews with the Facility's administrative team there were no current issues with receiving supplies to provide resident care. The Facility received a medical supply delivery during the Ombudsman's representative's visit. The delivered supplies were placed in a locked storage area.

L. Resident Trust Fund

Resident trust records were unavailable for review at the time of the Ombudsman's representatives visit. Residents did not verbalize any complaints about accessing their money from the funds held by the Facility

Exhibit I
Jonesboro, LLC
Jonesboro, IL

A. Overview

Jonesboro Rehab and Health Care Center is operated by Debtor Jonesboro, LLC (together, the "Facility"), and is located at 995 State Route 127 South, Jonesboro, IL 62952. It is a single-story building licensed as a 77-bed skilled nursing facility. The census at the time of the Ombudsman's visit was twenty-seven. The Facility does not actively market its services and relies on its referral sources for admissions.

The Facility has thirty-eight employees, including a management team with 45 years of experience. There are twenty clinical personnel, five dietary employees, eight cleaning and maintenance employees, one social service employee, an activity staff member, and two administrative staff members. The administrator stated there were no plans to change any personnel.

B. Regulatory

The facility has a three-star rating on the Centers for Medicare and Medicaid Services nursing home compare website. This is based on a four-star health inspection rating, one star staffing rating, and three-star quality measures rating. During a tour, the Ombudsman's representatives noted that the resident bill of rights, as well as contact information for the State and Local Long-Term Ombudsman, were prominently displayed in the resident all-purpose area. Survey findings were published but were not up to date. The missing findings were provided upon request.

On December 7, 2023, the IDPH performed a recertification survey at Jonesboro Rehab and HCC. The facility received six citations:

- F661 SS=D: Discharge Summary
- F684 SS=D Quality of Care.
- F727 SS=F RN Coverage Hours/7 Days/Week, Full-time DON
- F883 SS=E Influenza and pneumococcal Immunizations
- F887 SS=E: COVID-19 Immunizations
- F912 SS=B Bedrooms measure at least 80 square feet per resident.

Currently, there are no outstanding citations with the IDPH.

C. Physical Plant and Environmental Services

The Ombudsman's representatives toured the physical plant and grounds at the Facility. Landscaping was slightly overgrown, and the roof was noted to be in disrepair as evidenced by fallen shingles that had been piled against the building. The Facility's main door is electronically locked and opens onto a large dining/multi-purpose space. There are three hallways with resident rooms and one central nursing station that has a clear view of the hall.

During the tour, the following concerns were noted by the Ombudsman's representatives:

- A musty odor permeated the entire facility.
- Numerous resident restrooms had only had one working lightbulb; several commodes were found to have water valves running; several lavatories were temperature checked and found to be producing water exceeding the allowable level; many wall vent fans were found to be inoperative or excessively noisy.

- Water heater in a room adjacent to the clean linen room was found to lack a self-closing door.
- Utility rooms found with loose cove base, missing or loose floor tiles, floor soiled, supplies placed on the floor, and broken carts kept next to the water heater. Cabinet doors were missing.
- A bathroom accessible to residents had unlocked cupboards containing products labeled "keep out of reach of children."
- Hallway wall coverings were observed to be worn.
- The laundry facility had one washing machine and two dryers, one of which was malfunctioning.
- Window seals noted with damaged paint, cracked or missing caulking.
- Resident room air conditioning units were found to have sullied filters that needed to be cleaned or replaced.
- Many fire extinguishers did not have current inspections. The linked inspection cards reviewed have not been updated since February 1, 2024.

A resident was seen tumbling from a toileting chair in their room. An Ombudsman intervened and shortly after a nurse aide arrived to assist. The aide reported the facility lacked sufficient wheelchairs and had left the resident unattended to find a chair. The Ombudsman present informed the nurse on duty about the situation.

The Facility has a gas-powered generator that serves a number of outlets near the nurse station as well as some lights in the 100 Hall but is not configured to serve the entire building.

D. Resident Observation and Life Enrichment

During the visit, residents were observed participating in activities in the dining room/all-purpose area. Residents were properly groomed and dressed, and they were actively engaged in the organized activity. The community facilities were noted to be clean and had appropriate lighting. Interactions between staff and residents were pleasant and respectful.

E. Clinical Services

The director of nursing (the "DON") supervises clinical services at the Facility. The DON reported the Facility is short-staffed and is acquiring a part-time registered nurse to supplement management. The Facility is reportedly meeting its staffing requirement with the incumbent the DON due to the low census. Weekend coverage remains problematic.

A nurse reported that the Facility has not had problems obtaining supplies, but staffing is an issue because the present employees cover the majority of open shifts. The nurse stated that the department heads frequently assist with floor coverage as three employees currently hold CNA certification.

The medical supplies storage space was found to be well-stocked. The medication room was found to be disorganized with numerous unopened cardboard boxes in the cupboards. Medication carts were locked with narcotics properly secured. A review of medication administration records found them to be up to date, with no indications of missed medications or nurses failing to sign off. Treatment carts were found to contain a few ointment tubes with no distinguishing resident names.

There are four residents with house acquired pressure injuries. Resident records were reviewed, and each has adequate documentation in place, including weekly assessments/clinical

notes and follow-up with the attending physician. There are no residents in isolation presently. There are no residents with catheters at present.

F. Risk Management

Staff reported that they review risk issues daily. This review covers accidents, events, resident behavioral issues, skin impairment, weight concerns, wound healing progress, and clinical documentation. The Facility accepts residents who use cigarettes. There is a designated smoking area for these residents. The director of social services assesses residents' smoking safety and compliance with smoking restrictions. The smoking area was noted to be clean and clear of improperly discarded materials.

G. Dietary Services/Kitchen

The Dietary Manager has been at the Facility for three years. A registered dietitian visits the Facility monthly to assess menus and any substantial changes in the caloric demands of the residents.

The Ombudsman’s representatives toured the kitchen and dining room. The kitchen including preparation areas were clean, and all employees were noted to be wearing hairnets and gloves. While the equipment is outdated, it is functional and well-maintained. Food in refrigerators and freezers was observed to be properly stored and labeled.

Resident lunch service was observed. Dietary and nursing staff were joined by the department manager who took part in lunch delivery in a "all hands on deck" style. The served meal followed the posted menu and alternate options are offered. All residents at each table were served together with plates removed from the serving tray and placed in front of the residents. The

food had a pleasant odor and resident enjoyed their meals as evidenced by the diner's comments to the Ombudsman's representatives.

H. Vendor Relationships

According to interviews with the administrator and DON, vendor relationships are reliable, with medical supplies (Medline) and food (Martin Brothers) arriving on schedule. Visual inspection of supply inventories found the Facility to be well stocked.

I. Resident Trust

The Facility manages resident trust funds using an internal paper ledger system. Staff reported that funds are deposited in a local bank. Two individuals within the facility have the authority to obtain money for the residents. During the interview, the administrator stated that there were no challenges in obtaining funds to fulfill resident requests. The Facility maintains a surety bond. The Facility does not currently provide quarterly statements to residents and has not done so since a past security breach incident.

J. Resident Interviews

A resident was interviewed as they were seated in a sunlit area adjacent to the entrance of a resident courtyard. During the interview, the resident was engaged in solving a puzzle. The Ombudsman's representative inquired about the resident's experience throughout their time in Jonesboro. The resident expressed satisfaction with lunch today and mentioned they were engrossed in the jigsaw puzzle, a favorite activity. The resident expressed enjoyment of group activities but specified that today was dedicated to solving puzzles. The resident expressed

satisfaction with the nurses at Jonesboro Rehab and Healthcare Center, stating that they effectively cater to the resident's requirements and that "everyone is nice in this place."

K. Medical Records

The medical records system at the Facility utilizes a hybrid approach. The administrator reported to the Ombudsman that the Minimum Data Set data, social services, and dietary departments are utilizing PointClickCare software, but the other departments are still relying on paper-based systems.

L. Emergency Preparedness

The responsibility for emergency preparedness is shared between the maintenance director and the nursing home administrator. The Ombudsman's representatives reviewed the emergency preparedness manual and determined it complies with the criteria established by the IDPH. It encompasses fire drills, elopement drills, and essential policies and procedures that will be assessed during a life safety inspection. Drills cited in the many were determined to be current. The audits conducted included assessments of water temperature, fire drills, elopement drills, and room temperatures.

Exhibit J
Rosiclare HCO, LLC
Rosiclare, IL

A. Overview

Rosiclare Rehab and Health Care Center is operated by Debtor Rosiclare HCO, LLC and affiliated with Debtor Petersen Health Care Business, LLC (collectively, the "Facility"), and is located at is located at 1807 Fairview Drive in Rosiclare, Hardin County, Illinois. The facility is licensed by the Illinois Department of Public Health (the "IDPH") as a skilled nursing facility with 62 licensed beds. On the date of the Ombudsman's visit, the Facility had a census of 40 comprised of 5 private pay, 29 Medicaid and 6 Medicare A residents. The Facility is the only licensed nursing home in the county while other nursing homes are over thirty minutes away. Hardin County General Hospital is the main referral source for admissions.

B. Regulatory

The IDPH completed the Facility's Annual Licensure and Certification Survey on February 1, 2024. The following areas were noted with concerns:

- Quality of care. The facility received citations for the lack of assistance with activities of daily living specific to provision of showers not being given, call lights being answered timely, and the lack of assistance during meal service.
- Incontinent care. Based on observations, incontinent care was not always provided timely by staff as monitored by the surveyors.
- Nutrition/Hydration. Records and survey observations failed to ensure supplements were administered as ordered per physician orders.

- Sufficient nursing staff. Based on record review, the facility failed to ensure staffing numbers were sufficient to provide necessary services to two residents during the survey.
- Menus meet resident needs. Based on observation, interview, and record review the facility failed to ensure menus were followed.
- Resident allergies. Upon record review, the facility failed to follow residents' preferences in food service to include assistance during meals. Staff did not assist residents requiring meal set up and/or assistance with feeding.

C. Physical Plant and Environmental Services

The Ombudsman's representatives toured the physical plant and grounds of the Facility. The roof and exterior of the building appear to be well-maintained and there is ample street parking for visitors. The front porch and landscaping present an attractive appearance.

The Facility entrance is controlled with an electronic lock. The one-story building has a small day area near the entrance leading to the dining room, with the nurse's station and three resident room wings adjacent to it. Hallways were clear of equipment or other obstacles. The dining room was well furnished and resident rooms were noted to be very clean and well organized. Some rooms were personalized with family photos and other personal belongings. Walls were painted and none were observed to be in disrepair. Furnishings appeared to be in good condition. The temperature in the resident rooms was comfortable, but a couple of window air-conditioning units needed to have their partition panels secured properly.

The Ombudsman's representatives noted the following issues:

- Cove base was not attached to the walls in several areas.

- A fluorescent light shield was missing in a resident's room.
- Protective door coverings were missing from four resident doors.
- Broken ceramic tile was noted in the shared showers, accessible to residents. In addition, several personal cleaning items and razors were observed in the shower rooms.
- The beauty shop was noted to be unlocked and products were accessible to residents that clearly stated to keep out of reach of children.

The Laundry department is housed in a building across the street from the Facility. Inspection found that clean and soiled linen was appropriately separated. Machines were operable and the staff was well organized. Linen and resident clothing is carted back and forth from the facility to be laundered by staff. Laundry staff explained that the turnaround time for laundering resident clothing is short, and that staff never fall behind. Chemicals were readily available, and staff stated they've never had issues with receiving supplies. Unopened packages of wash cloths, pillowcases, and sheets were noted to be shelved in the laundry department.

D. Resident Observation / Life Enrichment

Residents were observed engaging in activities throughout the Ombudsman's visit. Upon arrival, several residents were observed socializing and watching television near the lobby area. Residents were seen in the dining room engrossed in an activity. The activities director reported that planned activities were developed to meet the interests of the residents. A review of the activity calendar indicated it was comprehensive and featured a variety of resident activities designed to appeal to both men and women. Activities included religious events as well as a resident council meeting.

Review of the grievance log found few incidents documented; incidents tended to focus on locating misplaced clothing or other personal items, but there did not appear to be any issues rising to a substantial concern.

E. Resident Interview

A resident's family member was interviewed. The interviewee expressed concern regarding the future of the nursing home but had no plans to move their loved one to another facility as the staff have been so good in providing care for them. The family member stated that the food quality is good, the nurses work hard, and they've always called with any changes in loved one's condition. The family member stated her loved one residing in the home is content and is very satisfied with the facility overall.

F. Clinical

The administration reported that there wasn't a director of nursing at the time of the visit but anticipates hiring a candidate soon. The Facility schedules three or four nurses per a twelve-hour shift pattern dependent upon the census. Certified nurse aides work eight hour shifts with two on midnight shift, four scheduled on days and four on evenings. The nursing department does not utilize agency services to cover shift openings. The Facility reported that it has used the same medical director for years and is always prompt and available.

The medication and treatment carts were observed to be locked with the contents well organized and very clean.

The Facility currently has two house acquired stage 2 pressure injuries that are being treated and monitored by a wound physician. Care plans for both residents were reviewed and the

plans adequately address the resident's care needs. Currently the Facility does not have any residents with a catheter and the overall acuity of the resident census is very low.

Renewal Therapy provides therapy services to the residents. During the Ombudsman visit, there were very few pieces of therapy equipment on hand and there were no therapist present.

G. Dining Services/Kitchen

Inspection of the kitchen found it to be very clean, with floors clear of debris, the garbage can with a sealed lid, and bins clearly labeled. The dietary manager was on hand for the Ombudsman's tour and stated that one double door freezer unit was not working; contents were being discarded because the temperature was not maintained overnight. All other refrigeration units were operable with temperature logs posted and contents appropriately stored and labeled. The pantry area was well-stocked, The dietary manager stated that she had not experienced any problems with vendor service.

Residents were observed at lunch time and appeared to enjoy the meal service. The posted menu was being followed by the kitchen.

H. Vendor Relationships

Visual inspection of storage areas indicated that the facility was well stocked. Staff members stated there had been no interruption of service or difficulties obtaining supplies.

I. Resident Trust Fund

The resident trust fund is balanced by the corporate office. As resident checks arrive at the Facility, they are sent to the corporate office and deposited into the trust fund. Cash is on hand to

fulfill resident requests and staff assists residents with making purchases. Receipts are on hand and each expenditure is documented with a co-signature of the resident requesting the purchase. These records were thoroughly reviewed and documented expenditures appropriately. According to the administrator, the Facility does have a surety bond but there was no copy of the bond in the Facility. The administrator requested a copy to be forwarded to the Facility.

J. Risk Management

Staff reported that daily stand-up meetings are conducted where topics are reviewed including falls, pressure injuries, catheters, weight loss concerns, psychotropic medication reduction plans, and similar clinical issues. Staff indicated that these meetings are productive and attended by members of the interdisciplinary team.

K. Medical Records:

Clinical documentation is paper based. The Facility does utilize an electronic medical records system for the Minimum Data Set data, care plans and resident weight measurements. A review of the charts and medical records determined they were accurate and reflective of the residents' overall needs. The medication administration and treatment records were current with no missing "sign-out." Medication and treatment carts were observed to be clean, stocked and well maintained.

L. Emergency Preparedness

Previous issues with certain vendor relationships delayed required inspections such as the kitchen hood Ansul system and sprinkler systems but according to the administrator, these are now scheduled and will be current within the next week. A review of the logs indicated that the fire

alarm drills, disaster drills, water temperature checks, door alarms checks, and emergency lighting checks are all current. The Facility assessment is current and in good condition. As part of staff orientation, new employees receive training in disaster preparedness as evidenced by audited in-service records.

Exhibit K
McLeansboro HCO, LLC
McLeansboro, IL

A. Overview

McLeansboro Rehab & Healthcare Center, operated by Debtor McLeansboro HCO, LLC (together, the "Facility"), is a single-story building located at 405 West Carpenter, McLeansboro, IL 62859. It is licensed by the Illinois Department of Public Health (the "IDPH") as a 43-bed skilled nursing Facility. Thirty-two residents were in house at the time of the Ombudsman's visit. This Facility is certified for Medicaid participation by the Illinois Department of Healthcare and Family Services.

A recent storm caused significant damage to a nearby Facility, Enfield, that is related to the Debtor. Fourteen Enfield residents were evacuated to the McLeansboro Facility, and several Enfield staff transferred to the Facility to support the additional residents. Enfield staff members reported that they believe they and the transferred residents would return to the Enfield Facility after repairs are completed; however, there has been no official communication on the status of repair work nor any date certain for returning.

Fifty-four employees are at the Facility, including thirty-seven clinical employees, five dietary employees, nine sanitation and maintenance employees, one social service employee, an activity staff member, and one administrative staff member. There were no vacant leadership positions at the time of the Ombudsman visit.

B. Regulatory

The Ombudsman's representatives noted that the contact information for the State and Local Long-Term Ombudsman as well as the resident bill of rights were prominently displayed in

the resident area. The health inspection survey results were made available upon request, as the ones that were previously published were not current.

The Centers for Medicare and Medicaid Services Nursing Home Care website has assigned the Facility an aggregate rating of two stars. This rating is the result of a three-star health inspection, a one-star staffing rating, and a two-star quality measures rating.

A self-report/complaint investigation survey was conducted by the IDPH at the Facility on May 7, 2024 for a self-report dated April 14, 2024. Three citations were issued to the Facility:

- F609 SS=D Failure to disclose abuse within the designated timeframe results in the failure to implement abuse policies.
- F600 SS = G Free from neglect and maltreatment
- F610 SS=D Examine/Prevent/Correct Alleged Violation

The Facility provided a plan of correction to the IDPH, which was subsequently approved. The Facility was restored to conformance following the inspection team's subsequent visit. Based upon interviews, the Facility has been reporting in a timely manner since and has implemented a system to more effectively identify cases of abuse since the deficiency.

C. Physical Plant and Environmental Services

The Ombudsman’s representatives toured the physical plant and grounds of the Facility. Observations did not identify any issues of concern for the grounds or building exterior. The front entrance is controlled with an electronic lock and leads to an area for common activities and dining. The dining and entry area have tiled floor coverings while the remainder of public spaces are carpeted. Carpeting is old and worn but very clean.

The environmental tour of the interior found the Facility to be free of objectionable odors and the public spaces were maintained at a comfortable temperature within allowable levels. Furnishings and equipment appeared to be in excellent condition. The hallways were uncluttered, and the exits were not obstructed. Resident rooms were found to be in satisfactory condition. In the laundry areas, the spaces were clean and there was an appropriate separation of clean and soiled items.

The Ombudsman's representatives noted several issues:

- In the Facility's shared bathing areas, there were a few fractured ceramic tiles exposed to residents, which present a risk of skin tears.
- A previous pipe leak had damaged plaster walls in the restroom in two shower stalls. Repairs were attempted but the results were unsatisfactory.
- Offices throughout the Facility were noted to be unkempt and cluttered, with a disorganized accumulation of crates and items on top of desks and filing cabinets, as well as directly on the floor.
- Backup power generators are not available at the Facility. The staff disclosed that the Facility has acquired at least three portable generators, all of which have been stolen.

D. Life Enrichment/Resident Observation

During the initial tour of the Facility, the Ombudsman's representatives observed residents enthusiastically participating in an activity. Residents were noted to be appropriately groomed and dressed. Adequate illumination was provided in the common areas, which were also clean. Staff interactions with residents were cordial and characterized by mutual respect.

E. Resident Interview

A resident was interviewed by the Ombudsman's representatives regarding their care experiences. The resident verbalized favorable comments regarding the Facility's ability to fulfill their care needs. The resident did not voice any concerns during the interview; the resident was completing a puzzle, an activity which they indicated was enjoyable. The resident commented that they experienced a sense of security within the Facility.

F. Clinical Services

The director of nursing (the "DON") at the Facility is a registered nurse responsible for the supervision of clinical services. The Facility arranges for nurses and nursing assistants to work twelve-hour, and eight-hour shifts to administer medication and provide direct care to residents. The personnel and the residents they care for reported satisfaction with the staffing schedule's combination of shifts. Staffing agencies are not used, and scheduling gaps are filled by the current staff. The DON and an additional clinical staff member were interviewed, and they expressed no concerns about personnel shortages that could potentially affect the provision of care and services to residents.

Inspection of the medication room revealed several personal items belonging to staff stored in a cabinet. These included items such as purses, bags, and backpacks. Otherwise, cabinets were secured as necessary, and no expired medications were discovered. The medication and treatment trolleys were confirmed to be locked and their contents to be appropriate for their expected use. Medication administration and treatment records were current and comprehensive.

The Facility has limited space for storage of medical supplies. Many crates were stored in the medication room and the clean utility room as a result. The oxygen cylinders were placed on

secure stands, and signage indicated whether the tanks were full or empty. Emergency equipment was found to be updated and readily available. Suction devices were noted to be accessible to staff in the dining room, at the nursing station, and in storage.

Currently, no residents are in isolation nor is COVID-19 infection present in the Facility. The Facility has not experienced a COVID-19 outbreak in the past year. Wounds are monitored on a weekly basis at the Facility. There are two residents with active pressure injuries; one resident was hospitalized with a stage 2 infection that was acquired in-house while the second resident was admitted with a stage 2 infection.

Renewal Therapy has been contracted by the Facility to replace the previous therapy provider. Physical therapy, occupational therapy, and speech therapy services all are available to residents.

G. Risk Management

Staff conducts a daily risk evaluation meeting; this review encompasses clinical documentation, wound healing progress, weight concerns, skin impairment, accidents, incidents, and resident behavioral concerns. The Ombudsman's representatives reviewed the process, documentation, and audits, and did not identify any concerns.

Residents are permitted to smoke cigarettes. The Facility assigns personnel to supervise smoking in a designated area for smokers. Residents are evaluated by the director of social services for safe usage and their compliance with smoking regulations. The partially covered smoking area was observed to be clean and devoid of inappropriately discarded items and had a secure means for cigarette disposal.

H. Dietary Services/Kitchen

During the Facility visit, the Ombudsman's representatives inspected the kitchen and observed a meal service. Dining staff stated that all residents are encouraged to consume their meals in the dining room. Tables are positioned at the appropriate height for residents, improving their experience. During lunch, staff were observed interacting with residents and providing support as needed. The meal service was timely, and a few residents even expressed their satisfaction with the cuisine without prompting. The Ombudsman's representatives noted that the posted menu was followed by the kitchen and that residents had alternatives available to them.

Kitchen equipment was found to be antiquated but operational, except for the waste disposal which, according to the staff, has been inoperative for an extended period. The kitchen exhaust vent has not been inspected as required, reportedly due to lack of funds. Food was appropriately stored and labeled, as evidenced by inspection of the freezers and refrigerators. The pantry areas were well-stocked, and the cabinets had ample space for commodities.

The kitchen area was noted to be well maintained, and food service personnel were equipped with required hairnets and gloves. The dietary manager is fully accredited to assume the role of manager, and all dietary employees possess the Servsafe Food Handler Certification. Staff promptly cleaned the dining room following lunch, paying attention to the chairs, tables, and the floor.

The Ombudsman's representatives observed dinner service. The entire staff participated in serving residents, transferring plates from the serving tray to the table, with all diners at a table served concurrently. The residents commented on the enjoyable flavor of the meal and the appetizing aroma.

I. Vendor Relationships

The administrator and the DON reported that vendor relationships are stable and supplies and services are delivered promptly to the Facility. Visual inspection of supply inventories confirmed these statements. Furthermore, the dietary staff reported that services service and the delivery of food and chemicals have not been interrupted.

J. Resident Trust

The resident trust process is managed by the Facility through an internal paper ledger process. Funds are deposited at People's Bank, a nearby banking location. Two staff members have been authorized to obtain funds for residents. During the interview, the administrator confirmed that the residents were able to obtain funds upon request without any difficulties. The administrator was unable to furnish a surety bond. Although the business office manager wase able to provide the residents with copies of the ledgers that were used, they were unable to provide a formal quarterly statement.

K. Medical Records

McLeansboro employs a hybrid system for managing medical records. The records for the eighteen permanent residents residing in McLeansboro Rehab and Healthcare Center are maintained using PointClickCare, an electronic medical records (the "EMR") system. Records for the fourteen residents who originated from Enfield Rehab and Health Care Center are paper-based with the exception of data related to the Minimum Data Set (the "MDS"), which are maintained in the EMR system. The MDS is part of the federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes.

CONCLUSION

As stated above, the Ombudsman is monitoring all facilities, visited eleven facilities and did not observe any significant concerns during this Report Period. The Ombudsman will submit her next report within sixty days and will inform the Court if there are any critical concerns discovered prior to that time, as necessary. The Ombudsman will submit detailed information on additional facilities on a rolling basis as she continues to monitor all of the Facilities.