STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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INDIGO AT BARTLETT (THE)	1035 SOUTH ROUTE 59 BARTLETT, IL 60103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comment Complaint Investigation: #2485887/#IL176044 - Not substantiated. No deficiencies written. FRI (Facility Reported Incident): #IL177118 - Substantiated. FRI (Facility Reported Incident): #IL181204 - Substantiated. FRI (Facility Reported Incident): #IL181841 - Substantiated. FRI (Facility Reported Incident): #IL181965 - Substantiated. FRI (Facility Reported Incident): #IL182122 - Substantiated. FRI (Facility Reported Incident): #IL185247 - Not determined as rising to the level of neglect.	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 2 Violation Section 295.4010 Service Plan a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of	A4010		

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A4010	Continued From page 1 the Act) The establishment shall respect and accept the resident's choices regarding the service plan. b) The service plan shall be developed by: 1) The resident, resident's representative or any individual requested by the resident. 2) The manager or manager's designee; and 3) A registered nurse, if the resident is receiving nursing services or medication administration or is unable to direct self-care. c) The service plan shall be signed and dated by all individuals involved in its development. d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act) e) The service plan shall be reviewed and revised, if necessary, immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000). This requirement is not met as evidenced by: Based on interview and record review the establishment failed to update the fall interventions in the residents' service plans after	A4010		

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A4010	Continued From page 2	A4010		

each fall incidents in the establishment. They also failed to conduct fall root cause analyses of these fall incidents upon which to base the updates/changes in the fall interventions.

These failures contributed to these residents' ER visits for evaluation and treatment due to injuries, and substantial probability of harm with diagnoses of contusion of knee and low back pain (R2), head injury (R3), subdural hematoma (R4), bump to right forehead (R5), closed head injury, syncope, collapse, and hospital admission (R8).

This applies to 5 (R2, R3, R4, R5, R8) residents reviewed for facility reported fall incidents in the sample of 5.

Findings include:

The establishment's Resident Face Sheet showed R2 is an 84-year-old female resident admitted to the establishment on May 23, 2024 with diagnoses of CVA history; dementia, unspecified; seizures; UTI.

R2's Incident/Accident Report and Nurses Notes dated August 18, 2024 at 11:30 PM showed resident was found on the floor lying supine next to the bedside table. Resident was assessed and was alert, verbally responsive, neuro intact and within normal limits. Resident complained of pain to right leg, bruise to right knee, right elbow skin tear, cut lip noted. Unable to perform ROM to right leg due to pain. 911 was called to send to the hospital for further evaluation...came back to the community on August 19, 2024 at 4:05 AM via EMS with diagnoses of contusion of knee and low back pain. No findings noted.

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A4010	Continued From page 3	A4010		

R2's Service Plan with effective date of August 13, 2024 and modified on October 15, 2024 showed R1 has been assessed as a Fall Potential. Fall interventions were listed as: ensure resident is wearing proper footwear, walkways are free of clutter, remind resident to call for assistance if needed. Resident does not have any other environmental safety issues in her apartment.

The establishment's Resident Face Sheet showed R3 was a 65-year-old female resident admitted to the establishment on October 21, 2023 with diagnoses of hypothyroidism, GERD, chronic pain, carpal tunnel syndrome, alcohol dependence with alcohol-induced persisting dementia.

The establishment's Incident/Accident report for R3 dated August 16, 2024 at 7:40 PM showed, "During rounds resident was observed on the floor in a sitting position. Resident was unable to bear weight alone. EMS notified and agreed with nurse that resident should be further evaluated in the ER. Resident stated that she did hit her head. Resident was sent to the hospital for further evaluation with diagnoses of fall, head injury."

The establishment's follow-up Incident/Accident report for R3 showed, "Resident returned to the community on August 17, 2024 with diagnosis of head injury and dementia."

R3's Service Plan with last modified date/effective date of October 9, 2024, and last assessed date of August 26, 2024 showed R3 was assessed as Fall Potential with fall interventions listed as: ensure resident is wearing proper footwear, walkways are free of clutter, remind resident to

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A4010	Continued From page 4	A4010		

call for assistance if needed. Environmental safety issue: resident does not have any other environmental safety issues in apartment.

There are no fall root cause analyses conducted and no changes/updates made to the fall interventions listed in R2 and R3's Service Plans after their fall incidents. The updates to the interventions should be based on the root cause analyses determined after each fall incidents.

The establishment's Resident Face Sheet showed R4 is a 90-year-old female resident admitted to the establishment on March 3, 2024 with diagnoses of dementia, UTI, hyperlipidemia, insomnia, HTN, unspecified mood disorder, GERD, and cough.

The establishment's Incident/Accident Report and Progress Notes for R4 dated November 16, 2024 were reviewed. Both showed R4 was found by two RAs outside of her bedroom door in the hallway in the entrance of another resident's room face down crying for help bleeding from her nose. She was fully assessed for face and nose injury and was sent to the hospital. She was admitted to the ICU with diagnosis of subdural hematoma.

R4's Progress Notes showed she was discharged from the hospital back to the facility accompanied by her daughter on November 20, 2024.

The same Progress Notes showed R4 had a witnessed fall in the shower area of her bathroom on November 20, 2024 with her daughter with her. She hit her head and had a wound at the back of her head. Wound site was bleeding. She was sent to the hospital and was discharged back to the community on November 21, 2024 with 3 staples to the back of her head.

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A4010	Continued From page 5 R4's Service Plan with effective date of October 30, 2024 and last assessed date of September 23, 2024 assessed R4 as Fall Potential with interventions listed as: ensure resident is wearing proper footwear, walkways are free of clutter, remind resident to call for assistance if needed. However, the fall incident on November 16, 2024 and November 20, 2024 were not addressed in the service plan. There were no fall root cause analyses conducted for both fall incidents to base the changes to the initial fall interventions in place. The establishment's Resident Face Sheet showed R5 is a 69-year-old female resident of the establishment admitted to the establishment on October 29, 2024 with diagnoses of unspecified dementia, migraine, anxiety, and depression. The establishment's Incident and Accident Report and Nursing Notes for R5 dated November 25, 2024 were reviewed. R5's Nursing Notes showed resident was observed on the floor in the community living room at Villa Olivia neighborhood after an unwitnessed fall. Resident was in right side lying position and unable to verbalize pain but was grimacing. A contusion was observed on the right side of the forehead. Ice was applied immediately. NOD notified POA. 911 was contacted and resident was sent to CDH for further evaluation. ED, DON, POA, and provider notified who ordered to discontinue scheduled lorazepam 1 mg by mouth twice daily. Resident returned to the community the same day by the POA. Tests at the hospital were negative. The same Progress Notes showed other fall incidents happened on November 19, 2024 at	A4010		

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A4010	Continued From page 6	A4010		

2235 (Observed on floor next to bed, no injuries), November 19, 2024 at 1500 (observed on the floor in supine position next to a chair, no injuries), November 25, 2024 at 4:17 PM (witnessed fall, while walking into the dining room, lost her balance and fell. Gait unstable and lethargic, no injuries).

R5's Service Plan with effective and last assessed date of December 11, 2024 showed R5 as fall potential with fall interventions listed as: ensure resident is wearing proper footwear, walkways are free of clutter, remind resident to call for assistance if needed. Environmental safety issues are listed as: resident has all types of cords in apartment, wears improper shoes, inadequate lighting in apartment, clutter in apartment, throw rugs in apartment. However, R5's fall incidents were not addressed in the service plan. There were no changes/updates that were made in the fall interventions. There were no fall root cause analyses conducted after each fall incident.

R8 is a 68-year-old female resident admitted to the establishment on October 08, 2024 with diagnoses of unspecified dementia, mild; essential (primary) hypertension, and iron deficiency anemia.

The establishment's Incident/Accident Report, nursing notes, and Service Plan for R8 were reviewed.

The Incident/Accident Report and Nursing Notes dated January 27, 2025 showed that during a routine round and AM medication pass, nurse (E5) observed R8 with a bruise on her forehead and an abrasion near her left eyebrow. R8 stated she fell in the shower the day before, hitting her

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A4010	Continued From page 7	A4010		

head on the toilet. Resident also stated she informed a caregiver after the fall, but no one came to assess her. R8 cannot recall if she lost consciousness. R8 was transported to the hospital and admitted with diagnoses of close head injury, syncope, and collapse.

The establishment's Incident/Accident Report and Progress Notes for R8 dated January 25, 2025 showed R8 had a prior unwitnessed fall incident in the establishment in the dining room. R8 stated she got dizzy as she was in the kitchen and fell. R8 was assessed and did not seem at base line. She started to shake and seemed more confused than usual. 911 was called due to resident stating she hit her head, and she was in severe pain. POA was made aware.

The establishment's Service Plan for R8 with effective date of November 10, 2024 showed R8 has been assessed as Fall Potential with initial fall interventions of staff to monitor gait; ensure resident is wearing proper footwear, walkways are free of clutter, remind resident to call for assistance if needed. R8 was also assessed as minimal assistance for transferring and toileting. The same Service Plan showed R8's level of assistance for bathing as minimal. She can bathe without physical assistance but require reminding and standby assistance. For mobility/ambulation, R8's Service Plan detail showed resident is independent with mobility/ambulation or stand by assist if needed. R8's Service Plan detail for mobility/ambulation also showed minimal resident assistance. Resident may require prompts/cues for safety, standby assistance from staff. If requires walker, will determine as needed.

R8's fall incident on January 25, 2025 was not addressed in the service plan. There were also

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A4010	Continued From page 8 no changes made to the fall interventions in the Service Plan after R8's fall incident on January 25 which led to an unwitnessed fall incident as verbalized by R8, and hospitalization on January 25, 2025. E1 (Community Director/Executive Director) will make sure the incoming Healthcare Coordinator will conduct fall analyses and update the fall interventions in the Service Plans of residents after each fall incident in the establishment.	A4010		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 2 Violation Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 5) The right to receive the services specified in the service plan, to review and renegotiate the service plan at any time; and to be informed of the cost of the changes. 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor.	A6000		

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A6000	Continued From page 9	A6000		

These requirements are not met as evidenced by:

Based on interview and record review, the establishment failed to prevent misappropriation of residents' (R6, R7) narcotic medications paid for by these residents. They also failed to follow a resident's (R8) service plan regarding safety and injury prevention.

The failure to follow a resident's service plan regarding safety contributed to R8's 2nd fall incident in the establishment within two days from a prior fall incident. It resulted in hospitalization with diagnoses of closed head injury, syncope, and collapse.

Findings include:

E1 (Community Director/Executive Director) said R6 is still a resident of the establishment during this investigation. E1 confirmed the missing narcotic medicine incident happened and the medicine Alprazolam was not found. A search of the med cart, interviews and drug tests for the nurses involved in the count were conducted. Both tests were conducted and yielded negative results. It was reported to the Regional Director of Nursing who conducted an internal investigation also. A police report was filed. The police came and investigated and said there is nothing they can do unless someone witnessed it.

The establishment's Incident and Accident Report was sent to the Department on December 1, 2024 and a final report was sent as a 14-day follow-up report. It corroborated E1's statement.

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A6000	Continued From page 10 A written statement from the incoming night shift nurse, E3 (LPN) showed during the change of shift narcotic count, all narcotics were accounted for except for one resident (R6). R6's bingo card was off by 1 pill. E3 and the outgoing day shift nurse, E2 (LPN) double checked the locked narcotic box but there were no loose pills inside the narcotic box. E3 wrote that E2 signed off on R6's narcotic sheet as a wasted pill for the one missing from the bingo card, and she signed off on the narcotic count sheet acknowledging the completion of the narcotic count at the end of the shift and the start of E3's shift. A written statement from the outgoing day shift nurse, E2 (LPN) showed during counting of narcotics with the night shift nurse, they found that R6's narcotic medicine was missing a pill of Lorazepam on her bingo card. E2 wrote she had not realized it earlier in the day count because it was a small tear in the bingo card. It looks like the card may have been punctured and the pill came out. Both of them (E2 and E3) looked in the narcotic box and did not find any loose pills. E2 marked on the narcotic count sheet the pill was wasted and signed it. E1 (Community Director/Executive Director) said R7 is no longer a resident of the community. E1 confirmed a missing narcotic medication Morphine incident happened in the establishment in November of last year. The establishment's Incident/Accident Report to the Department dated November 27, 2024 showed that on November 27, 2024, it was reported to the Executive Director/Community Director by one of the overnight nurses, that on	A6000		

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A6000	Continued From page 11 November 10, 2024, the Morphine count for a resident (R7) was off by 5.75 ml. According to the narcotic sheet there should have been 13.75 ml of Morphine left in the bottle, and there was only 8 ml remaining at shift change when overnight nurse came onto shift. Overnight nurse stated the discrepancy was first reported to the HCC on November 10, 2024. E1 said an in-service regarding Narcotic administration and Narcotic Count was conducted for all the nurses in the building. R8 is a 68-year-old female resident admitted to the establishment on October 08, 2024 with diagnoses of unspecified dementia, mild; essential (primary) hypertension, and iron deficiency anemia. The Incident/Accident Report and Nursing Notes dated January 27, 2025 showed that during a routine round and AM medication pass, nurse (E5) observed R8 with a bruise on her forehead and an abrasion near her left eyebrow. R8 stated she fell in the shower the day before, hitting her head on the toilet. R8 cannot recall if she lost consciousness. R8 was transported to the hospital and admitted with diagnoses of close head injury, syncope, and collapse. The establishment's Incident/Accident Report and Progress Notes for R8 dated January 25, 2025 showed R8 had a prior unwitnessed fall incident in the establishment in the dining room. R8 stated she got dizzy as she was in the kitchen and fell. R8 was assessed and did not seem at base line. She started to shake and seemed more confused than usual. 911 was called due to resident stating she hit her head, and she was in severe pain.	A6000		

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A6000	Continued From page 12 POA was made aware. The establishment's Service Plan for R8 with effective date of November 10, 2024 showed R8 has been assessed as Fall Potential with initial fall interventions of staff to monitor gait; ensure resident is wearing proper footwear, walkways are free of clutter, remind resident to call for assistance if needed. R8 was also assessed as minimal assistance for transferring and toileting. The same Service Plan showed R8's level of assistance for bathing as minimal. She can bathe without physical assistance but require reminding and standby assistance. For mobility/ambulation, R8's Service Plan detail showed resident is independent with mobility/ambulation or stand by assist if needed. R8's Service Plan detail for mobility/ambulation also showed minimal resident assistance. Resident may require prompts/cues for safety, standby assistance from staff. If requires walker, will determine as needed. The services in R8's Service Plan regarding safety with her ADLs were not followed as no caregiver reported this fall incident beforehand to the nurse on duty until the nurse found out about the fall herself as relayed by R8. R8 must have taken a shower by herself without any standby assistance as resident said she fell in the shower and no caregiver reported it to the nurse on duty.	A6000		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr This Regulation is not met as evidenced by: Type 2 Violation	A6010		

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A6010	Continued From page 13 Section 295.6010 Abuse, Neglect, and Financial Exploitation Prevention and Reporting Section 295.200 Definitions: Neglect - a failure by the establishment to provide services, as outlined in the service delivery contract; a failure to notify the appropriate health care professional that an assessment is necessary in accordance with the service plan; a failure to modify a service plan, as appropriate, based on a new physician's assessment; or a failure to terminate the residency of an individual whose needs can no longer be met by the establishment, which failure results in an avoidable decline in function. a) When the establishment has a reasonable belief that a resident has been the victim of abuse, neglect, or financial exploitation, the establishment shall: 1) Notify the Department within 24 hours after receiving the allegation, by contacting the Assisted Living Complaint Registry by telephone, fax, or other electronic means. The establishment shall document this report and maintain documentation on the premises for 12 months after the date of the report. 2) Investigate and develop a written report within 14 days after the initial report. The establishment shall send the written report to the Department within 24 hours after it is completed and shall maintain a copy of the written report on the premises for 12 months after the date of the report.	A6010		

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	ASL510493	A. BUILDING: _____ B. WING _____	C 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIGO AT BARTLETT (THE)	1035 SOUTH ROUTE 59 BARTLETT, IL 60103

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A6010	Continued From page 14 b) A written report of the investigation conducted pursuant to subsection (a)(2) shall contain at least the following: 1) Dates, times, and description of the alleged abuse, neglect, or financial exploitation. 2) Description of any injury to the resident. 3) Description of any change in the resident's physical, cognitive, functional, or emotional condition. 4) Any actions taken by the licensee. 5) A list of individuals and agencies interviewed or notified by the establishment. 6) Names of witnesses to the alleged abuse, neglect, or financial exploitation; and 7) If the abuse, neglect, or financial exploitation is substantial, a description of the action to be taken by the establishment to prevent the abuse, neglect, or financial exploitation from occurring in the future. c) Establishment employees and volunteers are obligated to report abuse, neglect, or financial exploitation of a resident to the establishment management and to the Department. d) When the establishment has a reasonable belief that abuse, neglect or financial exploitation occurred, the perpetrator, if an employee or volunteer, shall be removed from direct contact with residents.	A6010		

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A6010	Continued From page 15 These requirements are not met as evidenced by: Based on interview and record review, the establishment failed to ensure the circumstances regarding a resident's (R7) missing narcotic medication (Morphine) was investigated and reported to the Department in a timely manner upon the initial report by the nurse. The establishment also failed to investigate and consequently report to the Department an allegation of neglect by a resident (R8) related to her fall incident in the shower. They also failed to follow their policy regarding misappropriation of property/diversion of medications, and resident's allegation of neglect in the area of investigation and reporting. These failures created a substantial probability of harm to the residents in the establishment. Findings include: E1 confirmed a missing narcotic medication Morphine incident happened in the establishment in November of last year. She also confirmed the discrepancy was reported to the previous Healthcare Coordinator (HCC) but she neither reported it nor did an investigation regarding the missing narcotic. She resigned her position effective immediately via email on December 1, 2024. The establishment's Incident/Accident Report to the Department dated November 27, 2024, written statements by the night shift and day shift nurses, Narcotic administration and Narcotic Count in-services, narcotic policy, and resignation email of the former health and wellness	A6010		

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A6010	Continued From page 16 coordinator were reviewed. The establishment's Incident/Accident Report to the Department (dated November 27, 2024) showed that on November 27, 2024, it was reported to the Executive Director/Community Director by one of the overnight nurses, that on November 10, 2024, the Morphine count for a resident (R7) was off by 5.75 ml. According to the narcotic sheet there should have been 13.75 ml of Morphine left in the bottle, and there was only 8 ml remaining at shift change when overnight nurse came onto shift. Overnight nurse stated the discrepancy was first reported to the HCC on November 10, 2024. The HCC did not report missing narcotic of Morphine to the ED, nor to the Regional Director of Nursing (RDN). ED immediately reported to the Regional Director of Operations. The Regional Director of Nursing, and Regional HR Support. The HCC was placed on suspension, pending investigation, on November 27, 2024. ED requested written statements from the nurses regarding the discrepancy. The RDN completed a thorough investigation and determined the missing Morphine. The two nurses in question (when the narcotic count was off by 5.75 ML) were drug tested on December 4, 2024. Both were negative for Morphine. ED initiated in-servicing with the Wellness Department/Nurse on Narcotic Administration and Narcotic Count. The Police Department was contacted on December 5, 2024 and police report filed at 2:00 PM. Prior to the completion of the internal investigation, the HCC resigned on December 1, 2024 at 9:17 PM effective immediately. E1 (Community Director/Executive Director) said R8 is still in their current census as a resident of	A6010		

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A6010	Continued From page 17	A6010		

the community. However, she is currently at the hospital after the reported fall incident on January 27, 2025.

R8 is a 68-year-old female resident admitted to the establishment on October 08, 2024 with diagnoses of unspecified dementia, mild; essential (primary) hypertension, and iron deficiency anemia.

The Incident/Accident Report and Nursing Notes dated January 27, 2025 showed that during a routine round and AM medication pass, nurse (E4) observed R8 with a bruise on her forehead and an abrasion near her left eyebrow. R8 stated she fell in the shower the day before, hitting her head on the toilet. Resident also stated she informed a caregiver after the fall, but no one came to assess her. R8 cannot recall if she lost consciousness. R8 was transported to the hospital and admitted with diagnoses of close head injury, syncope, and collapse.

There was no documentation of an investigation presented during the survey by the establishment to determine who was the supposed caregiver R8 allegedly informed after her fall so she could be assessed by a nurse. The establishment did not show their effort by conducting an investigation to determine whether the resident's allegation really happened or not.

E1 (ED) said R8 was sent to the hospital right away after the fall incident so they did not get the chance to find out who the caregiver the resident talked about. They were not very sure too if it took place as R8 was exhibiting symptoms of confusion the past days as documented in the Nursing Notes.

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A6010	Continued From page 18 The establishment's Abuse, Neglect, and Injuries of Unknown Origin Policy and Procedure with effective/revised date of March 15, 2022 was not followed regarding investigation. The Policy showed, "It is the policy of the community to prevent abuse, neglect, and injuries of unknown sources and to report the same...Each staff member must communicate any such incidents to a Supervisor, regardless of whether a staff member witnessed an incident firsthand or was made aware of allegations of the incident...all allegations of abuse will be treated as serious and will be investigated, documented and reported. Failure to follow a serious violation of one's employee responsibilities, and will result in disciplinary action, up to, and including, termination. The same Policy showed Abuse: Potential abusive incidents that must be communicated are included in the following definition of abuse...substantial disregard of resident's rights or a caregiver's duties and obligations to a resident...Neglect...through substantial carelessness or negligence substantially disregards a resident's rights or a caregiver's duties and obligations to a resident...Diversion of Medications is...not limited to withholding medications but also misuse of medication or stealing of medication property. Investigation: If a team member suspects or has witnessed potential abuse, neglect, or misappropriation of property...the team member must notify the Director/Designee immediately. The Director /Designee shall immediately investigate any reports or allegations of abuse, neglect, misappropriation of property...maintain documentation of the investigation and outcome.	A6010		