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A 000	Initial Comment Annual Licensure Survey was conducted in conjunction with an FRI/IL00197300 of September 1, 2025. Annual Licensure Survey: No Violations Cited FRI/IL00197300 of September 1, 2025: Section 295.6000 a) 13) Resident Rights Section 295.6010 a) 2) b) Abuse, Neglect, and Financial Exploitation, Prevention and Reporting	A 000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 1 (Repeat) Validation Section 295.6000 Resident Rights (a) (13) a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor. These requirements were not met, as evidenced by: Based on observation, interview, and record review, the facility failed to: 1. Provide supervision and monitoring to R1	A6000		

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identified to have history of fall and at high risk for fall.
2. Conduct a thorough assessment and investigation to identify the possible root causes of R1's fall incidents.
3. Implement individualized interventions based on the identified needs of R1 to prevent additional fall incidents.
This failure creates a substantial probability of severe harm to a resident or residents.
These failures resulted in R1's incidents of falls with resulting major injuries as follows:

1. On August 23, 2025, R1 sustained a left-sided facial laceration requiring six stitches, with swelling around the right orbital area and discoloration on the left hand.
2. On September 1, 2025, R1 was diagnosed with a closed hip fracture requiring surgery.
3. On October 8, 2025, R1 was placed under hospice care.
This is for one (R1) of three residents reviewed for sustaining fall incidents.

The findings include:

R1 moved into the establishment on July 3, 2025, with diagnoses to include Parkinson's disease, Alzheimer's, and dementia with behavioral disturbance.
R1's admission nurses notes dated July 3, 2025, show R1 as: oriented times two (with cognitive problem) and with moments of forgetfulness. R1 ambulates with a rolling walker and requires a one-person assist and frequent monitoring.
On October 29,2025, at 9:46 AM, E3 (Memory Care Director), described R1 as a confused and disoriented resident due to the diagnosis of Alzheimer's disease. R1 was said to ambulate with a walking device [walker] and have an

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unsteady gait. E3 also described R1 as at high risk for falls due to Parkinson's disease and requiring one physical assistance from the staff with activities of daily living.
E3 also stated, "At times R1 is non-compliant with the use of the walker. R1 was noted at times to be pushing the walker over onto the ground. This incident was documented in R1's nurse's notes on August 11, 2025. At 4:13 PM, the document shows: "Pushing (R1's) walker to the ground and walking without the walker during programs or during transfer from one program to another. Able to redirect easily. R1 also observed taking off footwear and socks and ambulates barefoot."
On October 29, 2025, during this survey, E2 (Director of Nursing), E3 (Memory Care Director) and E4 (LPN), agreed R1 was at "high risk for fall" and explained this (risk) is due to dementia, behavior (not utilizing the ambulation device at times), and Parkinson's disease.
R1's initial service plan dated July 3, 2025, was presented by E2 (Director of Nursing) on October 29, 2025, at 10:00 AM. R1's service plan identified the following:
- Mild impairment of both short- and long-term memory; difficulty remembering and using information. Staff to provide direction and reminding to support residents' safety.
- With mild to moderate visual impairment, uses glasses.
- With minimal wandering and with history of disruptive, aggressive, verbal, or socially inappropriate behavior.
- Mobility, ambulation and transferring requiring minimal assistance. May require cueing, reminder to use assistive device. Requires verbal prompts, cues to use assistive device. Staff to ensure assistive device is always within arm's reach and when seated alone.
- Fall potential:

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R1 has fallen within the last 90 days.
1-2 falls in the last 90 days. Fell out of bed between bed and nightstand within 7 days (no dates provided).
There were no interventions listed on any of R1's identified risk factors. This finding was discussed with E2 (Director of Nursing) on October 29, 2025, at 12:01 PM. E2 confirmed and stated, "Our computer program won't allow us to add interventions!"
On October 29, 2025, at 1:00 PM, E2 presented the change of condition service plan dated October 8, 2025. E2 stated, "This is because R1 was admitted to hospice."
R1's change of condition service plan (dated October 8, 2025) identified R1 requiring extensive assistance (from one physical assistance) with activities of daily living.
On October 29, 2025, at 10:30 AM, R1 was in the main dining room during activity. R1 was noted sleeping while seated in an adult reclining chair.
R1's mobility service plan read as follows:
- R1 requires staff hands on assistance while ambulating with assistive device.
- Staff to ensure assistive device is always within arm's reach when seated alone.
At 2:00 PM, E3 said, "No, R1 can't walk anymore, R1 is now using a wheelchair (high back-adult reclining chair). The staff needs to push the wheelchair."
Both R1's initial (dated July 3, 2025) and change of condition's service plan fails to include any interventions, including providers or the frequency of the services needed by R1. At 2:07 PM, E2 explained, "Our computer program does not allow us to add any of those."
At 3:10 PM, E3 (Memory Care Director) stated, "I am not involved in the development of any of the residents service plan."
R1's nurses notes show the following incidents:

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A6000	Continued From page 4 a. On July 22nd, 2025, at 1:34 PM, attempted to sit at the edge of the bed and missed and slowly slid to the floor. b. July 27, 2025, R1 was found sitting on the floor. "Unable to tell exactly what happened. R1 verbalized 'Help me help me!'" No injury was documented for this incident. c. On August 23, 2025, at 4:45 PM, a voice calling for help was heard coming from the common dining room. R1 was noted lying on the floor, blood was noted from a laceration on the left side of the head. R1 was sent to emergency room. R1 was readmitted into the establishment with six stitches on left side of the face, swelling around the right orbital area and discoloration on the left hand. d. On August 30, 2025, at 6:52 AM, was walking without the ambulation device (walker), fell backwards. e. On September 1, 2025, at 8:47 AM, R1's observed on the floor in a side lying position. R1 kept complaining of pain and rubbing the left thigh and hip area. R1 was sent to the hospital and was diagnosed close hip fracture requiring surgery. On October 29, 2025, at 1:07 PM, E2 (Director of Nursing) stated, "I went and visited R1 while at the Rehab Center (dated September 15, 2025, in the nurses notes), R1 had a big decline. Not eating, still at risk for fall because still trying to stand up unassisted. We [the establishment] recommended the family to have a Private Care Giver and R1 is now is in hospice care."	A6000		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr This Regulation is not met as evidenced by:	A6010		

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A6010	Continued From page 5 General Violation (Repeat) Section 295.6010 Abuse, Neglect, and Financial Exploitation Prevention and Reporting a) 2) b) a) When the establishment has a reasonable belief that a resident has been the victim of abuse, neglect, or financial exploitation, the establishment shall: 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. 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	A6010		

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A6010	Continued From page 6 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. These requirements was not met as evidenced by: Based on interview and record review of the facility failed to: 1. Conduct an investigation related to R1's fall incidents. 2. Submit an investigation (14 days after the incident date) to identify the possible root causes and to rule out neglect. These failures resulted R1's unwitnessed fall incidents with resulting injuries: a. On August 23, 2025, R1 sustained a left side facial laceration requiring six stitches, swelling around the right orbital area and discoloration on the left hand. b. On September 1, 2025, R1 was diagnosed with close hip fracture requiring surgery. This is for one (R1) of three residents reviewed for investigation and reporting incidents. The findings include: On October 29, 2025, at 10:30 AM, R1 was in the main dining room during activity. R1 was noted sleeping while seated in an adult reclining chair. E3 (Memory Care Director) described R1 as "R1 needs cuing and monitoring due to confusion and disorientation (diagnosed with dementia, Alzheimer's and Parkinson's disease), can talk but softly and hard to understand. R1 requires total assistance with all of activities of daily living and is now a hospice resident. R1 used to ambulate independently with walker. Yes, R1 sustained falls and declined after the fracture	A6010		

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(incident on September 1, 2025)."
R1's nurses notes show the following incidents:
a. On August 23, 2025, at 4:45 PM, a voice calling for help was heard coming from the common dining room. R1 was noted lying on the floor, blood was noted from a laceration on the left side of the head. R1 was sent to emergency room. R1 was readmitted into the establishment with six stitches on the left side of the face, swelling around the right orbital area, and discoloration on the left hand.

This incident was reported to the Department on August 24, 2025, at 7:28 PM as follows:
PM nurse on duty, heard a voice calling for help from the common dining area ... noted R1 lying on the floor ... R1 was unable to explain what happened, bleeding was noted from the laceration on the left side of the head. 911 was called ... R1 returned to the community with six stitches to the left side of the face.

b. On September 1, 2025, at 8:47 AM (from R1's nurses notes) read: R1 observed on the floor in a side lying position ...R1 kept complaining of pain and rubbing the left thigh and hip area ...911 was called ...
On September 1, 2025, admitted to the hospital for closed hip fracture.
On September 2, 2025, family confirmed R1 will have surgery for closed hip fracture ...
The establishment reported this incident to the Department on September 2, 2025, at 11:39 AM.
On October 29, 2025, at 11:16 AM, E1 and E2 confirmed the establishment had not conducted any investigations regarding R1's incidents and also acknowledged that the establishment only submit an initial report to the Department. E1 and E2 stated they were not aware that they have to conduct an investigation and unaware of the

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A6010	Continued From page 8 submission of a final report.	A6010		