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A 000	Initial Comment Annual Licensure Survey 295.2040 a) 295.4000 a) 295.4010 a) c) e) g) 2) 3) 295.4050 295.4060 h) 3) A) i) 2) B) 295.6000 a) 13) 295.9000 a) Complaint and Facility Reported Incidents: IL196817/FRI 7.24.25, substantiated, 295.4000 a) 196837/FRI 8.1.25, substantiated, no violations cited IL197539/FRI 7.17.25, substantiated, 295.6000 IL197616/FRI 9.10.25 substantiated - 295.4010 a) c) e) g) 2) 3) cited IL197539/FRI 7.17.25 substantiated - 295.5000 d) cited	A 000		
A4000	Section 295.4000 Physician/s Assessment This Regulation is not met as evidenced by: Type 3 Violation	A4000		

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A4000	Continued From page 1 Section 295.4000 Physician's Assessment a) No more than 120 days prior to admission of a resident to any establishment, a comprehensive assessment that includes an evaluation of the prospective resident's physical, cognitive, and psychosocial condition shall be completed by a physician. The physician's assessment shall include documentation of the presence or the absence of tuberculosis infection in accordance with the Control of Tuberculosis Code. At the time of admission, the physician's assessment must reflect the resident's current condition. This requirement is not met as evidenced by: Based on interview and record review the facility failed to ensure that admission assessment was completed by a physician for three (R1, R5, R6) of seven residents reviewed for physician's assessment. Findings include: R1 is an 89-year-old resident admitted to the facility on 7/1/2025 with diagnoses including but not limited to Dementia, Anxiety and Depression. R1's admission assessment is signed on 6/23/2025 by an APRN (Advanced Practice Registered Nurse) and not by a Medical Doctor. R5's medical record showed R5 moved into the establishment on 7/3/25, resides in the memory care unit, and has multiple diagnoses, including but not limited to Chronic Kidney Disease, Dementia, moderate with mood disturbance, Essential Hypertension, Osteoporosis. R5's prior to move-in Physician Assessment dated 6/30/2025 was signed by PAC (Physician Assistant, Certified) and not by a Medical Doctor.	A4000		

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A4000	Continued From page 2 R6's medical record showed R6 moved into the establishment on 6/6/25, resides in the memory care unit, and has multiple diagnoses, including but not limited to Vascular Dementia, Type 2 Diabetes Mellitus, Unspecified Convulsions, Secondary Merkel Cell Carcinoma. R6's prior to move-in Physician Assessment dated 6/4/2025 was signed by PAC (Physician Assistant, Certified) and not by a Medical Doctor. On 9/25/2025, at 1:08 PM E2 (Assisted Living Wellness Director) stated, "I thought the Nurse Practitioner could sign the initial resident assessments, change in level of care assessments and annuals. I am aware the resident assessments need to be dated."	A4000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 2 Violation Section 295.4010 Service Plan - Repeat Violation 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 the Act) The establishment shall respect and accept the resident's choices regarding the service plan. c) The service plan shall be signed and dated by all individuals involved in its	A4010		

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A4010	Continued From page 3 development. e) The service plan shall be reviewed and revised if necessary immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000). g) Service plans shall address: 2) The amount, type, and frequency of health-related services needed by the resident; 3) Staff responsible for the provisions of the service plan; This requirement was not met as evidenced by: Based on record review and interview, the establishment failed to: -revise the service plan with interventions to address fall that resulted in injury for one of 7 residents (R3) reviewed for fall incidents; -ensure service plans were signed and dated by residents or resident's representative and staff involved in its development for four of seven residents (R2, R3, R6, R7) -indicate level of services received for two of seven residents (R6, R7) reviewed for service plans. These failures have the probability to affect all residents in the establishment. This failure creates a substantial probability of harm to a resident or residents.	A4010		

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A4010	Continued From page 4 Findings include: 1. R3 is a 86 year old resident who moved into the establishment 2/3/24. R3 has diagnoses including Alzheimers disease, unspecified Dementia and Cerebrovascular disease. The prog notes dated 8/29/25 show Incident Note: E15 (NOD/nurse on duty) was notified by Safely You that R3 was on the floor. E15 watched the video to ensure that R3 did not hit his head - which R3 did not. R3 was found in the video on the floor, in an upright position, attempting to put his pants on. When CNAs (certified nurse aide) checked on R3 a few moments later, R3 had taken himself off the floor. R3 stated that he "was cold and wanted to put his pants on." R3 was unable to give a clear description on how he fell to the floor. E15 reached out to the CNA staff in Memory Care to check on R3 while E15 made her way over to the building. CNAs stated R3 was back in bed. NOD asked R3 if there was any pain which there wasn't any. Nurse checked ROM (range of motion), which was normal. The progress note dated 9/10/25 (4:42pm) shows: R3 complained of pain to left leg this shift. R3 assessed. No swelling noted. PRN (as needed) Tylenol given and ineffective. R3 reassessed and noted with swelling to left hip. When Safely You video viewed writer (E15/LPN) observed R3 had a fall. Ambulance called and transported R3 to St Joe's hospital for further evaluation. At 5:47pm E15 called the local hospital's emergency room for an update, R3 will be admitted for left hip fracture. The service plan was not revised with new	A4010		

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A4010	Continued From page 5	A4010		

interventions to address the fall that occured on 8/29/25 and 9/10/25 nor pain management for the hip fracture R3 sustained as a result of the unwitnessed fall on 9/10/25.

2. R6's medical record showed R6 moved into the establishment on 6/6/25, resides in the memory care unit, and has multiple diagnoses, including but not limited to Vascular Dementia, Type 2 Diabetes Mellitus, Unspecified Convulsions, Secondary Merkel Cell Carcinoma.

R6's Progress Notes indicated that R6 tested COVID positive on 9/24/2025. No interventions were noted in the service plan regarding type of isolation, frequency of isolation precautions, staff responsible to provide services.

3. R7's medical record showed R7 moved into the establishment on 5/26/2025, resides in the memory care unit, and has multiple diagnoses, including but not limited to Type 2 Diabetes mellitus, Gastro-Esophageal Reflux Disease, Essential Hypertension, Anorexia, Edema, Asthma, Cognitive Communication Deficit.

R7's clinical records indicate that R7 receives insulin every morning and evening and blood sugar level is monitored twice daily. Services and who's responsible to provide these services are not noted in R7's service plan.

During this annual survey, 7 resident clinical records were reviewed. It was noted that R4, R5, R6 and R7 services plans were not signed and dated by the residents,or resident's representative and staff involved in its development.

On 9/30/2025 at 12:37PM, E2 (Wellness Director)

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A4010	Continued From page 6 said that Service Plans are updated every 6 months and with every change in conditions, such as hospitalization, hospice, falls. All services are added to the Service plan, and they are signed by the POA (Power of Attorney) during our service Plan conference.	A4010		
A4050	Seciton 295.4050 Tuberculin Skin Test Procedures This Regulation is not met as evidenced by: Type 2 Violation Section 295.4050 Tuberculin Skin Test Procedures Tuberculin skin tests for employees and residents shall be conducted in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696). Section 696.140 Screening for Latent Tuberculosis Infection (LTBI) and Active Tuberculosis (TB) Disease b) Screening for Active TB Disease. The following persons shall be screened for active TB disease: 1) Persons with a documented positive TB screening test result; 2) Clients admitted to health care settings and residential care settings serving high-risk groups. C) All clients in non-acute care residential health care settings serving high-risk groups shall	A4050		

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A4050	Continued From page 7 obtain an entry TB screening according to the healthcare facility written protocol. Routine periodic screening shall be determined by completing a Department approved a risk assessment tool performed in cooperation with the local TB control authority. The TB Risk Assessment Form is available on the Department's website at https://dph.illinois.gov/content/dam/soi/en/web/idph/files/forms/tuberculosis-risk-assessment.pdf. This requirement has not been met as evidenced by: Based on record review and interview the establishment failed to screen for TB within 14 days of move-in for three (R5, R6, R7) of 7 residents reviewed for TB testing. This failure has the probability to affect all residents in Memory Care. This failure creates a substantial probability of harm to a resident or residents. Findings include: R5's medical record showed R5 moved into the establishment on 7/3/25, resides in the memory care unit, and has multiple diagnoses, including but not limited to Chronic Kidney Disease, Dementia, moderate with mood disturbance, Essential Hypertension, Osteoporosis. R5's clinical records indicated that Chest X-Ray was done 8/1/2025 R6's medical record showed R6 moved into the establishment on 6/6/25, resides in the memory care unit, and has multiple diagnoses, including but not limited to Vascular Dementia, Type 2 Diabetes Mellitus, Unspecified Convulsions, Secondary Merkel Cell Carcinoma.	A4050		

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A4050	Continued From page 8 R6's clinical records indicated that Chest X-Ray was done 6/28/2025 R7's medical record showed R7 moved into the establishment on 5/26/2025, resides in the memory care unit, and has multiple diagnoses, including but not limited to Type 2 Diabetes mellitus, Gastro-Esophageal Reflux Disease, Essential Hypertension, Anorexia, Edema, Asthma, Cognitive Communication Deficit. R7's clinical records indicated that Chest X-Ray was done 7/23/2025. On 9/29/2025 at 2:30, E2 (Wellness Director) said that they don't do TB testing unless they come from the hospital. Residents have Chest X-Ray instead. E2 was unable to provide any other documents indicating TB screening was done within 14 days of move-in.	A4050		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Type 2 Violation Section 295.4060 Alzheimer's and Dementia Programs h) An establishment that offers to provide a special program for persons with Alzheimer's disease and related disorders shall: 3) Develop and implement policies and procedures that ensure the continued safety of all residents in the establishment including, but not	A4060		

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A4060	Continued From page 9 limited to, those who: A) May wander; and i) Training requirements for individuals working in a special program 2) Staff training: B) Direct care staff must receive 16 hours of on-the-job supervision and training within the first 16 hours of employment following orientation. Training must cover: i) encouraging independence in and providing assistance with the activities of daily living; ii) emergency and evacuation procedures specific to the dementia population; iii) techniques for creating an environment that minimizes challenging behaviors; iv) resident rights and choice for persons with dementia, working with families, caregiver stress; and v) techniques for successful communication. This requirement was not met as evidenced by: Based on record review and interview the facility failed to ensure continued safety of one of seven residents (R1) reviewed for wandering. Facility also failed to provide documentation of 16 hours of on-the-job supervision and training within the first 16 hours of employment following orientation	A4060		

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A4060	Continued From page 10	A4060		

for six (E2, E3, E4, E5, E6, and E7) of six employees reviewed that to have the 16 hour dementia training. This failure creates a substantial probability of harm to a resident or residents.

Findings include:

1. On 9/25/2025, surveyor reviewed employee files. Employee files for E2 (Assisted Living Wellness Director), E3 (Memory Care Director), E4 (Licensed Practical Nurse/LPN), E5 (Caregiver), E6 (Caregiver), and E7 (Caregiver) were missing the 16-hour on-the-job supervision and training documentation.

On 9/25/25, at 11:19 AM, E1 (Executive Director/ED) stated "we do initial dementia training in Relias (online training) and in person. Staff do a physical in person dementia training before they hit the floor.

On 9/25/2025, at 1:29 PM, E1 (Executive Director) stated "I do not have in person training records for dementia. The Memory Care Director (E3 Memory Care Director) puts the trainings in Relias and verifies that staff completes. We do not have an in person sign in sheet for dementia training. E3 does do some in person trainings with staff but she inputs their attendance in Relias. It is called general dementia overview (2 hours) and connection points-neighborhood onboarding (4 hours). Those are the only two she does in person the rest are done in Relias.

On 9/29/2025, at 11:30 AM, E3 (Memory Care Director) stated, "I am in charge of the Memory Care training of all staff. We have 2 separate trainings. We have neighborhood onboarding, and we have 4 hours dementia training that I do

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A4060	Continued From page 11	A4060		

one to two times a month. The 4-hour dementia training is mandatory that everyone must complete initially and yearly and is in Relias. The initial training is in person as an in-service training with me. The neighborhood onboarding involves going over connection points, my job, dining experience, hand cleaning, family connection point, family engagement, resident connection points, spark where employee can buy something that connects them with the resident. It also goes over beacon of light which indicates someone in the community is actively transitioning so staff and families know to be courteous. This training is in our assisted living community room/classroom type of training and is done for all staff. I also just do basic in-service training like fire drills, evacuation and that kind of thing and elopement drills as well. Any other trainings we have are in Relias."

When asked by surveyor if E3 was aware of E3 supposed to do a 16 hour on the job training, E3 stated, "I am aware we are supposed to do 16 hours on the job training prior to working in memory care. Part of it is done in Relias and the other part is done in orientation and in the 1440 chat. 1440 chat goes over all regulations and that is classroom training. Orientation is also classroom training."

When asked by surveyor if any shadowing/training is done, E3 stated, "Once all classroom training is done, they will have shadowing training that takes place that is about 4 days. Our scheduler sets up the shadowing training with another caregiver. I am unsure if there is any documentation of staff or training staff signing anything regarding this training. I can ask if there is any documentation to provide you for this."

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A4060	Continued From page 12 On 9/29/2025, at 11:50 AM, E1 (Executive Director) stated, "we do not have any documentation to provide you to with signatures of staff regarding documented dementia specific on the job/shadowing training. The only thing I can provide is the schedules of the shifts they worked in training, but it is not specific to dementia training and does not include signatures." 2. R1 is an 89-year-old resident admitted to the facility on 7/1/2025 with diagnoses including but not limited to Dementia, Anxiety and Depression R1's progress note dated 7/24/2025 documents: Note Text: Earlier this shift at approx. 3:45 am R1 observed by main entrance, guarding door. At that time R1 was taken to 2nd floor tv room for safety to prevent elopement. R1 provided with snack. R1 observed by CP (care provider) to remain at tv room. Around 6:00 am, writer made aware that R1 was no longer in tv room. Writer and CP started doing room checks on 2nd floor, no door alarm was triggered, and code silver was issued. When 2nd floor sweep was completed, other facility staff started arriving at campus. Staff from outside therapy provider took picture and proceeded to go check surrounding areas. Writer made aware that 1st floor was not checked. Writer along with other CPs started checking rooms. Once writer exited shower room, code silver was cleared. Staff from Legacy located resident outside of campus by the pond/lake area. Resident accompanied by staff back to building. Upon arrival and allowing resident to rest, writer took resident to room and performed head to toe assessment. Resident observed with skin abrasion at right wrist with discoloration already developing. Resident does admit to falling	A4060		

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A4060	Continued From page 13	A4060		

and using hands to prevent fall. No other skin abrasions, discolorations, areas of redness observed. VS: 126/70, HR: 79, O2: 96% RA, RR: 18, T: 97.1 on forehead. Writer called R1's son and lvm (left voicemail) to return call to facility. Endorsing to oncoming shift to f/u with provider to obtain order for x-ray to evaluate right hand. R1 is not exhibiting s/s of pain or distress. DON (Director of Nursing) made aware of incident. Plan of care ongoing.

On 9/25/2025 at 10:20 AM E2 (Assisted Living Wellness Director) stated "regarding R1, I was here when R1 got out of the locked facility. R1 was a wanderer and was alert and not as confused as we think it is. R1 was able to get down the stairs and went to first floor and held the door handle for 15 seconds and got out of the building. Staff found R1 on the side of the building. I think R1 had been out there like 5 minutes or so. R1 was known to be a wanderer and had exit seeking behavior. The first day R1 came here she was in assisted living and was found in another resident's car. I spoke to R1's family/son and we ended up moving R1 to memory care that evening for R1's safety. The memory care is a locked unit. On the side doors if you hold the bar due to fire hazard, the lock releases. The staff is supposed to be rounding every 2 hours. When I looked at the cameras for that time period, the caregiver (E10) kind of opened the door and looked right and left but did not go outside to check. E10 has been terminated. E10 did have dementia training. I am not sure how long she worked here. Everyone gets dementia training with Relias and with the Memory Care director that is part of the orientation. I feel the reason this happened was that R1 had exit seeking behaviors and the newness of moving in, and also had a UTI as

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STORYPOINT ROMEOVILLE	600 S EDWARD DR ROMEOVILLE, IL 60446

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A4060	Continued From page 14 well, R1 has seen psychiatrist now and they changed her medications due to anxiety and not sleeping at night, and the staff member not providing proper supervision by not laying eyes on her and not doing the rounds every 2 hours like they are supposed to. We now have done a whole training for all care partners regarding rounding every 2 hours, more hands on with exit seeking residents and care partners taking shifts with exit seeking residents or residents with behaviors."	A4060		
A5000	Section 295.5000 Medication Reminders, Supervision of Self Med This Regulation is not met as evidenced by: Type 2 Violation Section 295.5000 Medication Reminders, Supervision of Self-Medication, Medication Administration and Storage d) Medication administration refers to a licensed health care professional employed by an establishment engaging in administering routine insulin and vitamin B-12 injections, oral medications, topical treatments, eye and ear drops, or nitroglycerin patches. Non-licensed staff may not administer any medication. (Section 70 of the Act) This requirement was not met as evidenced by: Based on record review and interview the facility failed to administer medications prescribed to a resident (R1) as ordered by her medical doctor from 7/1/2025 through 7/18/2025 causing	A5000		

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A5000	Continued From page 15	A5000		

resident to have decreased potassium levels and requiring a hospital visit and intravenous infusion of potassium. This failure caused harm to resident (R1).

Findings include:

R1 is an 89-year-old resident admitted to the facility on 7/1/2025 with diagnoses including but not limited to Dementia, Anxiety and Depression.

R1's signed admission orders include an order for Potassium Chloride ER Oral tablet Extended Release 20 MEQ - Give one tablet by mouth two times a day for replacement therapy with order date of 6/6/2025 and start date of 6/7/2025.

R1's Medication Administration Record for July 2025 documents that no Potassium was given from admit date of 7/1/2025 until 7/18/2025.

R1's progress note dated 7/1/2025 documents: Note Text: R1 came in with her son who is her POA (power of attorney). R1 alert and oriented x4, HOH (hard of hearing), VS WNL (vital signs within normal limits). Writer took med list and medications from POA.

R1'w progress note dated 7/16/2025 documents: Note Text: Resident has been sent to local hospital due to low potassium.

R1's progress note dated 7/16/2025 documents: Note Text: Follow up call placed to local hospital for update on resident. Resident is receiving IV potassium. Resident may be discharged depending on her potassium level. POA updated on resident conditions.

R1's hospital record dated 7/17/2025 documents

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discharge diagnosis: Acute UTI (urinary tract infection); Acute hypokalemia; generalized weakness.

Medication Administration Policy with last reviewed date of 4/11/2022 documents in part:
4. Procedure
Medications will be administered to residents as prescribed and by persons lawfully authorized to do so in a manner consistent with good infection control and standards of practice.
Administration
2. Medications are administered in accordance with written orders of the attending healthcare provider.

On 9/25/2025, at 10:20 AM, E2 (Assisted Living Wellness Director) stated, "R1 was at a rehabilitation center for rehabilitation and upon discharge the director of social service there sent us the signed medication list. We uploaded it into electronic medical record files prior to discharge. Potassium and Namenda was not on the signed med list. I think the family noticed she was not on the medication, and we did her labs." Surveyor pulled up the signed med list and showed E2 that potassium was listed on the medication list and E2 stated that there must be two medication lists in there then. E2 left the room to go look up on her computer."

On 9/25/2025, at 10:44 AM, E2 (Assisted Living Wellness Director) stated, "there were two medication lists in the EMAR (electronic medical record) for R1 the unsigned one did not have the potassium on it, and I think that is what the nurse (E11 Licensed Practical Nurse/LPN) went by when putting in the medication orders. Once the resident comes back to the community the nurse verifies the medications with the nurse

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A5000	Continued From page 17 practitioner. When I spoke to the E11 about this, E11 stated she went by the unsigned medication list not realizing there were two lists and the unsigned list was not signed. E11 stated she sent the unsigned list to the NP. The nurse practitioner gave orders for the medications on the unsigned list. The confusion was the two medication lists. My nurses should have looked at all admission documents and should have caught the two medication lists and do a medication reconciliation with the nurse practitioner and also take into account the signature on the signed medication list. This resulted in the resident not getting prescribed medications for about two weeks, lab work being off, needing to go to hospital for IV infusion of potassium. I did the in-service with all the nurses regarding safety of medication administration. All nurses were retrained again on medication policies and procedures of facility. Also, when we are going out to assess the residents, we are ensuring medications are reconciled with past medication lists."	A5000		
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	A6000		

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A6000	Continued From page 18 the following rights: 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor. This requirement is not met as evidenced by: Based on record review and interview the facility neglected to ensure safety for one resident (R1) of 7 residents reviewed for neglect. This failure creates a substantial probability of harm to a resident or residents. Findings include: R1 is an 89-year-old resident admitted to the facility on 7/1/2025 with diagnoses including but not limited to Dementia, Anxiety and Depression. R1's progress note dated 7/24/2025 documents: Note Text: Earlier this shift at approx. 3:45 am R1 observed by main entrance, guarding door. At that time R1 was taken to 2nd floor tv room for safety to prevent elopement. R1 provided with snack. R1 observed by CP (care provider) to remain at tv room. Around 6:00 am, writer made aware that R1 was no longer in tv room. Writer and CP started doing room checks on 2nd floor, no door alarm was triggered, and code silver was issued. When 2nd floor sweep was completed, other facility staff started arriving at campus. Staff from outside therapy provider took picture and proceeded to go check surrounding areas. Writer made aware that 1st floor was not checked. Writer along with other CPs started checking rooms. Once writer exited shower room, code silver was cleared. Staff from Legacy located resident outside of campus by the pond/lake area. Resident accompanied by staff back to	A6000		

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building. Upon arrival and allowing resident to rest, writer took resident to room and performed head to toe assessment. Resident observed with skin abrasion at right wrist with discoloration already developing. Resident does admit to falling and using hands to prevent fall. No other skin abrasions, discolorations, areas of redness observed. VS: 126/70, HR: 79, O2: 96% RA, RR: 18, T: 97.1 on forehead. Writer called R1's son and lvm (left voicemail) to return call to facility. Endorsing to oncoming shift to f/u with provider to obtain order for x-ray to evaluate right hand. R1 is not exhibiting s/s of pain or distress. DON (Director of Nursing) made aware of incident. Plan of care ongoing.

On 9/25/2025, at 10:20 AM E2 Assisted Living Wellness Director stated "regarding R1, I was here when R1 got out of the locked facility. R1 was a wanderer and was alert and not as confused as we think it is. R1 was able to get down the stairs and went to first floor and held the door handle for 15 seconds and got out of the building. Staff found R1 on the side of the building. I think R1 had been out there like 5 minutes or so. R1 was known to be a wanderer and had exit seeking behavior. The first day R1 came here she was in assisted living and was found in another resident's car. I spoke to R1's family/son and we ended up moving R1 to memory care that evening for R1's safety. The memory care is a locked unit. On the side doors if you hold the bar due to fire hazard, the lock releases. The staff is supposed to be rounding every 2 hours. When I looked at the cameras for that time period, the caregiver (E10) kind of opened the door and looked right and left but did not go outside to check. E10 has been terminated. E10 did have dementia training. I am not sure how long she worked here. Everyone

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A6000	Continued From page 20 gets dementia training with Relias and with the Memory Care director that is part of the orientation. I feel the reason this happened was that R1 had exit seeking behaviors and the newness of moving in, and also had a UTI as well, R1 has seen psychiatrist now and they changed her medications due to anxiety and not sleeping at night, and the staff member not providing proper supervision by not laying eyes on her and not doing the rounds every 2 hours like they are supposed to. We now have done a whole training for all care partners regarding rounding every 2 hours, more hands on with exit seeking residents and care partners taking shifts with exit seeking residents or residents with behaviors.	A6000		
A9000	Section 295.9000 Physical Plant This Regulation is not met as evidenced by: Type 2 Violation Section 295.9000 Physical Plant a) The establishment shall comply with the residential board and care occupancies chapter of the National Fire Protection Association's (NFPA) Life Safety Code (Life Safety Code) 101, Chapter 32 for new establishments and Chapter 33 for existing establishments. This requirement was not met as evidenced by: Based on record review and interview the facility failed to meet time constraints for fire drills, ensure all residents attend and participate in fire	A9000		

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drills, and list any residents unable to participate in fire drills. This failure creates a substantial probability of harm to a resident or residents.

Findings include:

On 9/24/2025 at 12:00 PM Fire drills reviewed since the last annual survey.

3/14/2025 MEMORY CARE Fire drill start time 5:30 AM - 5:45 AM. More than 13 minutes. No list of residents who attended. No list of residents who need assistance with evacuation.

4/12/2025 MEMORY CARE Fire drill start time 10:30 AM - 10:45 AM. More than 13 minutes. No list of residents who attended. No list of residents who need assistance with evacuation.

6/12/2025 MEMORY CARE Fire drill does not have start or end time. No list of residents who attended. No list of residents who need assistance with evacuation.

6/20/2025 MEMORY CARE Fire drill start time 6:00 AM with no end time. More than 13 minutes. No list of residents who attended. List of residents attached with resident names highlighted but does not state those are the residents who need assistance with evacuation.

7/15/2025 MEMORY CARE Fire drill start time 10:15 AM - 10:30 AM. More than 13 minutes. No list of residents who attended. No list of residents who need assistance with evacuation.

8/29/2025 MEMORY CARE Fire drill start time 3:00 PM - 3:15 PM. More than 13 minutes. No list of residents who need assistance with evacuation.

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A9000	Continued From page 22 9/16/2025 MEMORY CARE Fire drill start time 6:15 AM - 6:30 AM. More than 13 minutes. No list of residents who attended. No list of residents who need assistance with evacuation. Evaluation documents: Did staff know apartments where occupants need physical assistance N/A. Undated MEMORY CARE Fire drill start time 6:30 AM - 6:13 AM. No list of residents who attended. No list of residents who need assistance with evacuation. Fire Drill Policy with a last review dated of 6/10/2025 documents in part: 4. Procedure It is community policy to conduct fire drills in accordance with applicable codes and standards for that respective community. In the case of a community that has combined signals and/or houses both classifications, the higher most stringent standard will apply. All drills must engage residents along with employees. Responsibility to Conduct Drills: It shall be the responsibility of the Maintenance lead at each community to conduct fire drills that are required. Actual drills may require a combination of observers that are dedicated to evaluating all aspects during a drill. All drills must be documented, and records maintained for three years. It shall be the responsibility of the community Executive Director to make sure this process is current, and records are maintained. On 9/24/2025, at 3:00 PM - E1 Executive Director/ED stated "The last two fire drills do not have dates on them. I know we have drills for every single month in the portal so I can look up and see when they happened. We do evacuation drills every other month. We had a life safety drill	A9000		

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A9000	Continued From page 23 that we put into place a plan of correction of adding which residents participated in the drills. The lists of residents that are attached to some of the drills with highlighted residents indicate the residents who could not attend the drill. All other residents listed attended. On our fire drills we do not attach a list of residents that need evacuation to our drills. When we had our life safety drill that was not indicated that we needed to document those individuals who need evacuation. Our documentation does not include a list of residents who need assistance included in our fire drills."	A9000		