STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL 510546	A. BUILDING: _____ B. WING _____	C 10/21/2025

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ARBOR TERRACE HIGHLAND PARK	1000 CENTRAL AVENUE HIGHLAND PARK, IL 60035

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A 000	Initial Comment Complaint Investigation 2517467/IL196880 Entity Reported Incident of 7/25/25/IL196897-295.4010e) Entity Reported Incident of 8/24/25/IL197170-295.4010e), 295.2050a)b) Entity Reported Incident of 9/25/25/IL198051-295.4010e), 295.2050a)b) & 295.6000a)13)	A 000		
A2050	Section 295.2050 Incident and Accident Reporting This Regulation is not met as evidenced by: Type 3 Violation 295.2050a)b) Section 295.2050 Incident and Accident Reporting a) An establishment shall report to the Department any serious incident or accident. For the purposes of this Section, "serious" means any incident or accident that causes physical or emotional harm or injury to a resident. A change in an individual's (resident's) condition that is due to health or medical decline is not a reportable incident or accident. b) The report shall be made by contacting the Department of Public Health Division of Assisted Living via email at DPH.LTCAL@illinois.gov or as requested by the Department within 24 hours after the occurrence of the incident or accident.	A2050		

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A2050	Continued From page 1 This requirement is NOT MET as evidenced by: Based on interview and record review, the establishment failed to report a significant incident(s) within 24 hours for 2 of 3 residents (R3, R4) reviewed for accidents and incidents in the sample of 6. The findings include: 1. R3's Progress Notes dated 7/25/25 at 10:02 PM show R3 was found on the floor in his bathroom on 7/25/25 at 6:00 PM. R3 was unable to move his right leg and complained of right hip pain. R3 was sent to the hospital and treatment around 6:30 PM. R3 was later admitted to the hospital with a right hip fracture. The establishment's Assisted Living and Shared Housing Incident and Accident Report shows a fax confirmation of the incident dated 7/28/25 at 3:19 PM. R3's Progress Notes dated 9/25/25 at 7:59 AM show R3 was found on the floor of his living room around 3:10 AM. R3's left elbow was bleeding. Paramedics transported R3 to the hospital. R3's Progress Notes dated 9/25/25 at 8:38 AM show R3 was diagnosed with a left hip fracture. The establishment's Assisted Living and Shared Housing Incident and Accident Report regarding this incident was emailed to IDPH on 9/26/25 at 3:34 PM. 2. R4's Progress Notes do not document anything regarding R4 having fallen on 6/21/25. The facility's Assisted Living and Shared Housing Incident and Accident Report shows R4 was found on her bedroom floor on 6/21/25 at 6:25 PM. R4 reported that she lost her balance and hit her head on the floor. R4 was sent to the hospital	A2050		

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A2050	Continued From page 2	A2050		

and was diagnosed with a subdural hematoma. The Transmission Report regarding this incident shows it was sent to IDPH on 6/24/25 at 7:30 PM. The facility's Incident Report dated 8/6/25 shows the nurse on duty heard R4 yelling at 7:05 PM and found R4 on the floor with bleeding to the back left side of her head.

R4's Progress Notes do not document anything regarding R4 having fallen on 8/6/25, however R4's Progress Notes dated 8/9/25 at 1:55 PM show R4's staples are intact with no signs or symptoms of infection. The facility's Assisted Living and Shared Housing Incident and Accident Report shows R4 was heard screaming on 8/6/25 and was found on the floor at 7:05 PM with her head bleeding. R4 was sent to the hospital and was diagnosed with a closed head injury. R4 required staples to close a laceration to her head. The Transmission Report regarding this incident shows the report was sent to IDPH on 8/7/25 at 10:08 PM.

R4's Progress Notes dated 9/17/25 at 9:04 PM show R4 fell sideways at 6:46 PM and landed on her right shoulder. R4 had excruciating pain and R4 was sent to the hospital. R4's Progress Notes dated 9/17/25 at 9:59 PM show R4 was diagnosed with a right humerus fracture and would likely be admitted (to the hospital). The establishment's Incident Report regarding incident of 9/17/25 at 6:46 PM shows State Report was not completed.

On 10/20/25 at 1:52 PM, E5, Resident Care Director Assisted Living, said incidents need to be reported (to IDPH) within 24 hours of occurrence. E5 said they follow the regulations for reporting. On 10/20/25 at 3:44 PM, E5 said the fax machine was not working at the time of R4's fall on

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A2050	Continued From page 3 9/17/25. Confirmation that the establishment reported R4's fall of 9/17/25 to IDPH was not provided as requested on 10/16/25. Another request was made via email on 10/20/25 for the establishment's confirmation that R4's fall on 9/17/25 had been reported to IDPH. E5's response on 10/20/25 at 4:27 PM via email shows she could not find record of confirmation for R4's fall of 9/17/25 being reported to IDPH. The establishment's Incident Reporting Policy (approved 4/2015) shows state guidelines for reporting incidents to state regulatory authorities are followed.	A2050		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 2 Violation 295.4010e) Section 295.4010 Service Plan 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. This requirement is NOT MET as evidenced by: Based on observation, interview, and record	A4010		

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A4010	Continued From page 4 review, the facility failed to revise resident service plans after resident falls for 3 of 6 residents (R2, R3, R4) reviewed for service plans in the sample of 6. This failure creates a substantial probability of harm to a resident or residents. The findings include: 1. R2's Face Sheet shows she moved into the facility on April 18, 2025 with diagnoses including anxiety, dementia, diabetes, right femur fracture, and right humerus fracture. R2's Service Plan shows R2 is a fall risk and shows R2's last fall happened in the gym. No falls in the last 30 days. "Nurse/Med Aide/resident care director will follow the community's fall protocol, and the nurse will communicate with the family and physician. 911 in an emergency." R2's Electronic Progress Notes shows she had a fall on August 30, 2025, September 6, 2025, and September 13, 2025. On October 20, 2025 at 10:24 AM, E5 Resident Care Director said R2's Service Plan was last updated on May 23, 2025. E5 said Service Plans should be updated with each resident fall. E5 said specific fall prevention interventions are added to the service plan. The facility's Fall Management Guide approved on November 2014 shows, "Update resident plan of care/service plan accordingly and include any interventions suggested by Resident's physician and/or family. Specific resident interventions will be identified to assist the resident in potentially reducing the risk of falls. The interventions must be specific to the resident as to the reason the resident is falling or at risk for falling."	A4010		

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A4010	Continued From page 5	A4010		

2. R3's Progress Notes dated 7/25/25 at 10:02 PM show R3 was found on the floor in his bathroom on 7/25/25 at 6:00 PM. R3 was unable to move his right leg and complained of right hip pain. R3 was sent to the hospital and treatment around 6:30 PM. R3 was later admitted to the hospital with a right hip fracture.

R3's Progress Notes dated 9/25/25 at 7:59 AM show R3 was found on the floor of his living room around 3:10 AM. R3's left elbow was bleeding. Paramedics transported R3 to the hospital. R3's Progress Notes dated 9/25/25 at 8:38 AM show R3 was diagnosed with a left hip fracture.

R3's current Service Plan dated 10/14/25 was updated after his fall on 9/25/25, but R3's previous Service Plan was dated 5/22/25 and it was not updated after his fall on 7/25/25.

3. The facility's Assisted Living and Shared Housing Incident and Accident Report shows R4 was heard screaming on 8/6/25 and was found on the floor at 7:05 PM with her head bleeding. R4 was sent to the hospital and was diagnosed with a closed head injury. R4 required staples to close a laceration to her head. R4's Progress Notes dated 8/23/25 at 4:23 AM show R3 was found on the floor next to her bed on 8/23/25 at 1:30 AM. The facility's Assisted Living and Shared Housing Incident and Accident Report shows R4 was found lying on the ground bleeding from her head on 8/24/25 at 5:00 PM. She was sent to the hospital where she was diagnosed with a laceration to her scalp and treated with sutures. R4's Progress Notes dated 9/2/25 at 6:32 PM show R4 was found on the floor with bleeding from the back of her head. R4 was transported to the hospital. R4's Progress Notes dated 9/2/25 at 10:34 PM show R4 returned to

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A4010	Continued From page 6 the establishment with a diagnosis of traumatic injury to head and a dry, intact dressing. R4's Progress Notes dated 9/17/25 at 9:04 PM show R4 fell sideways at 6:46 PM and landed on her right shoulder. R4 had excruciating pain and R4 was sent to the hospital. R4's Progress Notes dated 9/17/25 at 9:59 PM show R4 was diagnosed with a right humerus fracture and would likely be admitted. R4's Progress Notes dated 10/5/25 at 1:15 PM show R4 fell in the TV room at 12:45 PM and sustained a laceration to the top of her head. R4's most recent Service Plan is dated 7/14/25 and has not been updated since then. On 10/20/25 at 1:52 PM E5 said R3 had his Service Plan updated 5/22/25 and 10/14/25. E5 said R3's Service Plan was not updated after his fall and hip fracture on 7/25/25. E5 said R4 has had multiple falls and her Service Plan was last updated 7/14/25. E5 said all updates should be put on the Service Plan after a change in condition.	A4010		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 2 Violation 295.6000a)13) 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	A6000		

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A6000	Continued From page 7 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; This requirement is NOT MET as evidenced by: Based on interview and record review, the establishment neglected to respond to a resident's call light in a timely manner for 1 of 6 residents (R3) reviewed for resident rights in the sample of 6. This failure resulted in R3 falling and sustaining a hip fracture. This failure creates a substantial probability of harm to a resident or residents. The findings include: R3's Progress Notes dated 9/25/25 at 7:59 AM show R3 was found on the floor of his living room around 3:10 AM. R3's left elbow was bleeding. Paramedics transported R3 to the hospital. R3's Progress Notes dated 9/25/25 at 8:38 AM show R3 was diagnosed with a left hip fracture. The establishment's Assisted Living and Shared Housing Incident and Accident Report regarding this incident on 9/25/25 at 3:15 AM shows R3 has a private alarm system in place which notifies the local Emergency Medical Services (EMS). Responders to the private alarm placed a call to the facility regarding fall detection for R3. EMS transported R3 to the Emergency Department (ED). The establishment's investigation of the incident included a Summary of Events (undated) and it shows R3 called for assistance at 2:44 AM. R3 no longer wanted to wait for assistance, he got out of bed and fell while getting a glass of	A6000		

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A6000	Continued From page 8	A6000		

water. The glass broke causing R3's left elbow to bleed. R3 had an independent alert system that was activated upon impact from the fall. The independent alert system called the facility and 911. The establishment's investigation of the incident also included a Resident Assistant Care Timeline (undated) which shows that E6, Resident Assistant, reported seeing R3 at 3:30 AM when R3 was found on the floor. E6 went to R3's room because of EMS presence. The establishment's Coaching Record dated 9/25/25 of E6 shows it is a "situation of possible neglect." Resident called on call light and staff never answered. Resident subsequently had a fall with injury.

On 10/20/25 at 10:24 AM, E5, Resident Care Director of Assisted Living, said there was corrective action taken regarding R3's fall on 9/25/25 due to call lights not being answered in a timely manner. E5 said R3 triggered his call light and eventually tired of waiting. R3 wanted some water and dropped the glass. As he tried to pick up the glass, he fell, and his private alert system detected the fall and sent EMS. E5 said the establishment found out R3 had fallen when EMS arrived at the facility. E5 said E6 could not explain why she had not answered R3's call light. E5 said she pulled the call light log and there were no other call lights alarming at the time R3's call light was triggered. E5 said the most recent call light had been triggered 40 minutes prior to R3 triggering his call light. E5 said call lights should be answered within 15 minutes. E5 said R3 triggered his call light at 2:46 AM and when EMS arrived at 3:15 AM, R3's call light was still alarming.

On 10/21/25 at 7:40 AM, E6 said R3 must have been walking around his room and collapsed (on

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A6000	Continued From page 9 9/25/25) because R3 was on the floor when she responded and there was broken glass by his kitchen area. R3 said she cannot recall how long R3's call light had been alarming. E6 said R3 had already triggered EMS when she responded. E6 said when she got to R3's room, EMS was already there and R3 was on the floor. E6 said call lights are supposed to be answered as soon as possible. The establishment's Nurse Call System Policy (not dated) provided by the establishment on 10/17/25 at 2:38 PM shows all PET (personal alert transmitter) alerts should be considered priorities until the care staff responds and determines the appropriate course of action.	A6000		