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	ASL510341	A. BUILDING: _____ B. WING _____	C 10/16/2025

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SUMMIT OF UPTOWN	10 N SUMMIT PARK RIDGE, IL 60068

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A 000	Initial Comment Complaint Investigation Survey 2589516/IL197812 Type 1 Violations 295.2000 a) 295.4060 c)	A 000		
A2000	Section 295.2000 Residency Requirements This Regulation is not met as evidenced by: Type 1 Violation Section 295.2000 Residency Requirements a) No individual shall be accepted for residency or remain in residence if the establishment cannot provide or secure appropriate services, if the individual requires a level of service or type of service for which the establishment is not licensed or which the establishment does not provide, or if the establishment does not have the staff appropriate in numbers and with appropriate skill to provide such services. (Section 75(a) of the Act) This requirement was not met as evidenced by: Based on interview and record review the facility failed to ensure a resident had one to one supervision to prevent her from walking around unassisted, falling to the floor, hitting her head and sustaining a subdural hematoma. This applies to 1 of 3 residents (R1) reviewed for residency requirements in the sample of 3. This failure creates a substantial probability of severe harm to a resident or residents.	A2000		

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A2000	Continued From page 1 The findings include: R1's Nurse's Notes dated 9/15/25 state, "Writer nearby in MC (Memory Care) living area, heard a loud noise from dining room area. Writer arrived to dining area and observed resident lying on the floor on her right side. Upon assessment resident awake, alert and oriented to residents baseline, resident unable to voice how the fall happened, resident noted with bleeding from right side head area, writer applied pressure to control bleeding until paramedics arrived. Vitals: T-98.6, BP 129/67, P 70, RR 18, O2stat 96%. 911 called, paramedics arrived at 7:26pm, transported resident to (Local hospital) via ambulance for further evaluation. POA daughter notified. MD notified. MCD (memory care director) notified. Location: Dining Room Day & Time: 09/15/2025 7:20 PM " R1's Nurse's Notes dated 9/13/25 state, "Caregiver saw resident wandering in the dining room by herself and went to redirect her back to the TV room" and 9/6/25 state, "Resident was given scheduled sleeping med but noted woke up and was walking in the dining room and TV room." On 10/16/25 at 11:45 AM E3 (LPN) stated, "It was in the evening. Dinner was over and I was in the middle of medication pass. I had seen (R1) about 10 minutes before that with (E4-CNA) he had walked with her and sat her in a chair between the living and the dining area. I heard a loud noise from the dining room and I went to the dining room and found (R1) on the floor bleeding from the right side of her head. I applied pressure and told the staff to call 911. There were other residents around but no staff in the dining room.	A2000		

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A2000	Continued From page 2	A2000		

There was one staff in the living area and 2 staff in the hallway providing care to other residents. (R1) was constantly walking around and she was a high fall risk. We tried to always have her where staff could see her. We tried to supervise her as much as possible. I called (R1's) daughter and told her that (R1) fell and hit her head and I was sending her to the hospital. Her daughter asked where (R1) was when she fell and I told her (R1) was in the dining room and her daughter sounded like she was busy and she said she was going to see if she could find someone to go to the hospital and meet her there."

On 10/16/25 at 12:30 PM E4 (CNA) stated, "I took (R1) to the bathroom and when I brought her back to the chair the nurse was right there and another caregiver was in the living room. (R1) closed her eyes and went to sleep. I took another resident to the bathroom and within 5-7 minutes I came back and (R1) was on the floor in the dining room. (R1) got up all the time but the nurse was right there when I left her."

On 10/16/25 at 11:00 AM E5 (CNA) and E6 (Resident Assistant) stated, "(R1) loved walking around- she was not steady on her feet and she walked with her eyes closed. We had to constantly keep an eye on her and we were paranoid that she was going to fall. We have 3 staff for 15-19 residents. She had a caregiver when she first came here- she came with her from home - for about a month and then she didn't come anymore. She was not on hospice. She would walk with us but with a gait belt and very wobbly. She ate ok, with help. She liked to sleep in the morning but did ok at lunch. She didn't really speak- just when she got mad. She would not stay still. She would sit for like 2 seconds and then she was up again. We were

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A2000	Continued From page 3	A2000		

always telling her (R1) open your eyes, look up."

On 10/16/25 at 11:15AM E7(R1's Physician) stated, "I was asked to see (R1) and I spoke to the family about additional care as they thought she may need a higher level of care. I spoke with the daughter personally about getting a caregiver. The daughter thought she was overmedicated and I asked for a log- just a simple time- she is up and time she sat, time she took this med- just have the staff jot it down so I can see what her whole day looks like. I know psychiatry was looking at her too. I think cost was an issue but I think she needed a higher level of care than they could provide here and my Nurse Practitioner talked to the daughter about that in August. She was a difficult case and I don't know that there was anything else the facility could have done."

R1's Progress Note Written by E8 (R1's Nurse Practitioner) dated 8/11/25 states, "The resident, currently residing in an assisted living facility, now requires increased skilled nursing care to ensure safety and adequate medical support. Progressive decline in mobility, increased dependence with activities of daily living, and heightened fall risk necessitate 24 hour skilled supervision and ongoing assessment. Skilled placement and or 24 hour caregiving services is recommended to provide comprehensive monitoring, therapeutic interventions, and a safer environment for the resident's overall well -being."

R1's Progress Note written by E8 (R1's Nurse Practitioner) dated 8/25/25 states, "Staff reports that she requires near constant supervision and at times requires more than two person assist for safety." "Requires higher level of care or 24 hour caregiving services to ensure safety." "Plan Summary: Resident requires higher level of

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A2000	Continued From page 4	A2000		

skilled or 24 hour care for safety due to cognitive and physical decline. Continue interdisciplinary monitoring and supportive interventions."

On 10/16/25 at 12:40 PM E2 (Resident Care Director) stated, "At that time we had a memory care director- we were discussing (R1) in the morning meeting. Staff was taking turns walking around with (R1)- psych was seeing her- he was in contact with the family. This conversation was continuous with the family. Because of the finances of hiring a caregiver, they refused. This is not a one to one facility- she was very restless, very agitated. She needed one to one for sure. It happened very quickly. The staff saw her walking but they could not get to her in time."

On 10/16/25 at 1:00 PM E1 (Executive Director) stated, " We got Geripsych involved- we engaged a new MD- neuropsychologist- (our previous memory care director) was having conversations with family about discharge. We thought if she could get a caregiver- The Geripsych doctor started seeing her- discharge was on the line and we had agreed to pause it- because he was confident that he could medically intervene to get things under control. We reviewed the process of that fall. I think a caregiver was in the works. (E4) had sat (R1) in the chair- he took the next resident to the bathroom- the nurse (E3) was actively doing meds in the medication room- there was no evidence that (R1) hit the table- probably a direct hit on the floor. The nurse was probably about 12 feet away. The family was most upset about the lack of communication. The nurse called to report the incident. (The memory care director) called the next day but didn't give a lot of detail about the fall. I had a Zoom meeting with 4 of the siblings on 9/30/25 at 3 PM- It was me and (E2). We reviewed in detail everything that

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A2000	Continued From page 5	A2000		

occurred. After the fall we would have issued a discharge notice without a doubt."

R1's Service Plan dated 7/29/25 shows that R1 has diagnoses including Dementia and Macular Degeneration and states, "At risk for falls due to one or more of the following risks: Needs additional supervision/monitoring related to neurological diagnosis, physical limitation or issues with feet causing an unsteady gait; Resident has a history of frequent falls with or without injury; Has poor safety awareness around use of the wheelchair such as not locking brake prior to transfer, impulsive behaviors such as standing or walking without asking for assistance; Resident takes one or more of the following medications:vasodilators, cardiac, analgesic, psychotropic, diuretic, vestibular, anticonvulsant, antidepressant or narcotics; Experiencing one or more of the following:depression combative or resistive to care, anxiety, confusion, disorientation, delirium."

R1's Death Certificate date 9/24/25 shows her cause of death as Subdural Hematoma consequence to a fall on 9/15/25.

The facility's Alzheimer's Disease Special Care Disclosure states, "Establishment's Pre-Admission, Admission and Residency Termination Procedures: Residency Requirements: No Individual shall be accepted for residency or remain in residence if the establishment cannot provide or secure appropriate services, if the individual requires a level of service or type of service for which the establishment is not licensed or which the establishment does not provide, or if the establishment does not have the staff appropriate in numbers and with appropriate skill to provide

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A2000	Continued From page 6 such services."	A2000		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Type 1 Violation 295.4060 Section 295.4060 Alzheimer's and Dementia Programs c) No persons shall be accepted for residency or remain in residence if the person's mental or physical condition has so deteriorated to render residency in such a program to be detrimental to the health, welfare or safety of the person or of other residents of the establishment. The assessment must be approved by the resident's physician and shall occur prior to acceptance for residency, annually, and at such time that a change in the resident's condition is identified by a family member, staff of the establishment, or the resident's physician. (Section 150(c) of the Act) This requirement was not met as evidenced by: Based on interview and record review the facilty failed to ensure a resident with dementia was safe by providing supervision to prevent falls. This applies to 1 of 3 residents (R1) reviewed for safety / dementia care in the sample of 3. This failure creates a substantial probability of severe harm to a resident or residents.	A4060		

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A4060	Continued From page 7 The findings include: R1's Nurse's Notes dated 9/15/25 state, "Writer nearby in MC (Memory Care) living area, heard a loud noise from dining room area. Writer arrived to dining area and observed resident lying on the floor on her right side. Upon assessment resident awake, alert and oriented to residents baseline, resident unable to voice how the fall happened, resident noted with bleeding from right side head area, writer applied pressure to control bleeding until paramedics arrived. Vitals: T-98.6, BP 129/67, P 70, RR 18, O2stat 96%. 911 called, paramedics arrived at 7:26pm, transported resident to (Local hospital) via ambulance for further evaluation. POA daughter notified. MD notified. MCD (memory care director) notified. Location: Dining Room Day & Time: 09/15/2025 7:20 PM " R1's Nurse's Notes dated 9/13/25 state, "Caregiver saw resident wandering in the dining room by herself and went to redirect her back to the TV room" and 9/6/25 state, "Resident was given scheduled sleeping med but noted woke up and was walking in the dining room and TV room." On 10/16/25 at 11:45 AM E3 (LPN) stated, "It was in the evening. Dinner was over and I was in the middle of medication pass. I had seen (R1) about 10 minutes before that with (E4-CNA) he had walked with her and sat her in a chair between the living and the dining area. I heard a loud noise from the dining room and I went to the dining room and found (R1) on the floor bleeding from the right side of her head. I applied pressure and told the staff to call 911. There were other residents around but no staff in the dining room. There was one staff in the living area and 2 staff	A4060		

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A4060	Continued From page 8	A4060		

in the hallway providing care to other residents. (R1) was constantly walking around and she was a high fall risk. We tried to always have her where staff could see her. We tried to supervise her as much as possible. I called (R1's) daughter and told her that (R1) fell and hit her head and I was sending her to the hospital. Her daughter asked where (R1) was when she fell and I told her (R1) was in the dining room and her daughter sounded like she was busy and she said she was going to see if she could find someone to go to the hospital and meet her there."

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A4060	Continued From page 9 R1's Service Plan dated 7/29/25 shows that R1 has diagnoses including Dementia and Macular Degeneration and states, "At risk for falls due to one or more of the following risks: Needs additional supervision/monitoring related to neurological diagnosis, physical limitation or issues with feet causing an unsteady gait; Resident has a history of frequent falls with or without injury; Has poor safety awareness around use of the wheelchair such as not locking brake prior to transfer, impulsive behaviors such as standing or walking without asking for assistance; Resident takes one or more of the following medications:vasodilators, cardiac, analgesic, psychotropic, diuretic, vestibular, anticonvulsant, antidepressant or narcotics; Experiencing one or more of the following:depression combative or resistive to care, anxiety, confusion, disorientation, delirium." R1's Death Certificate date 9/24/25 shows her cause of death as Subdural Hematoma consequence to a fall on 9/15/25.	A4060		