STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510039	A. BUILDING: _____ B. WING _____	C 10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GURNEE PLACE MEMORY CARE	505 N HUNT CLUB ROAD GURNEE, IL 60031

(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 Facility Reported Incident 10/3/25 - IL197998 - 295.6000a)5)13) Facility Reported Incident 10/7/25 - IL 198003 - 295.6000a)5)13)	A 000		
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; This REQUIREMENT was not met as evidenced by: Based on interview and record review the facility failed to ensure staff did not neglect residents by not providing incontinence care required by their service plan. This applies to 3 of 3 residents (R1,	A6000		

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A6000	Continued From page 1	A6000		

R2, R3) reviewed for neglect in the sample of 3.

The findings include:

1. The facility's self reported incident report shows, "On 10/3/25, the community received a complaint from a family member alleging that a resident (R1) was observed in bed soiled when the hospice caregiver arrived for scheduled visit at 7 am. An investigation was immediately initiated, including reviewing footage and conducting interviews. E3 caregiver was the caregiver assigned the care of this resident (R1) from 10/2/25 10pm to 630am on 10/3/25. In review of the video footage, it was observed that E3 did not enter the resident (R1) apartment until 530 am on 10/3/25 to provide care. No other caregivers were observed to enter the resident (R1) apartment from 10/2/25 10pm to 530 am on 10/3/25. In an interview with E3, she acknowledged that she was responsible for but did not provide resident (R1) care 10/2/25 10pm to 10/3/25 530 am through resident required and was care planned for care. Resident (R1) was stable with no adverse effects. E3 caregiver was terminated on 10/3/25 based on footage reviewed supporting her interview of her acknowledging that care was not provided as care planned."

On 10/15/25 at 9:54 AM, E1 Executive Director stated, once R1's incident was brought to her attention she reviewed video footage from the night. She found on the video footage that E3 caregiver did not do her checks every 2 hours like she was supposed too. When E1 Executive Director called to terminate E3 caregiver, E3 caregiver did admit that she did not provide care to the residents on 10/3/25. When E3 caregiver was asked why she charted she did provide cares, she did not have a reason. E1 executive

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Director stated, that is "neglect." One of the core values of the facility is integrity and E3 caregiver did not have any. The residents went all night not being checked or changed. She also stated, E3 caregiver was assigned the units where R1, R2 and R3 all reside.

2. The facility's self reported incident report shows, "On 10/7/25 at approximately 8:45 am, a caregiver (E6 caregiver) escalated to E1 Executive Director that residents were observed wet with urine, with linens soiled, when she started her morning shift. An investigation was immediately initiated, including reviewing footage and conducting interviews with the team member responsible for this resident's care, residents, and team members working on the night shift. Residents were assessed and no adverse effects or changes to skin integrity were observed. In review of camera footage, it was observed that caregiver (E4) entered the community spa room by herself at 12:06 am and remained in the spa until 4:47 am on 10/7/25. The community spa room has two exit doors, both of which are observed in the footage. In an interview with E4 caregiver, she acknowledged that she was assigned the care of residents from 10/6/25 10pm to 10/7/25 630am, and indicated that she did not complete the required and care planned care while she was in the spa room doing personal homework. No other caregivers were observed to enter the resident apartments from 12:06 am to 4:47 am on 10/7/25. All residents in the community were assessed by a nurse with no adverse effects noted. E4 caregiver was terminated 10/7/25 based on footage reviewed and her interview acknowledging that she did not provide care per care plan...."

On 10/15/25 at 9:54 AM, E1 Executive Director

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stated, E6 caregiver informed her that residents were not changed all night. E1 Executive Director reviewed the footage. The video footage showed, E4 caregiver was assigned to R1 that night. She entered R1's room at 11:05 PM and exited his room at 11:17 PM. No other safety checks were completed after that time. The video footage shows she entered the spa at 12:06 AM and exited at 4:47 AM with a pink blanket over her shoulders. When E4 caregiver was asked about the incident she stated she was doing class work during that time. E4 was terminated. She verified E4 caregiver was working the assignment with R1, R2 and R3 reside.

On 10/15/25 at 10:16 AM, E6 caregiver stated, she worked on 10/7/25 day shift. When she came in and started her safety checks she noticed all of the residents were wet like they hadn't been changed all night. This wasn't the first time E4 caregiver did that so she reported it to E1 Executive Director.

On 10/15/25 at 10:55 AM, E4 caregiver stated, she did work on 10/7/25 on R1, R2 and R3's hallway. She received a phone call that her dad passed away and was grieving. She didn't know how to deal with it. She stated, she did her safety checks around 11 PM/12 AM and again at 4 AM. She did state, she was doing class work between those times.

R1's service plan dated 10/2/25 shows, "Toileting: Will provide toileting needs with assistance. Care staff to report any changes in toileting ability."

R2's service plan dated 2/3/25 shows, "Toileting: Will maintain current level of function. Requires Assistance for: peri-care; negotiate clothing after

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A6000	Continued From page 4 toileting." R3's service plan dated 10/15/25 shows, "Toileting: Will be able to safely use of toileting and use of incontinence products with assistance. Requires assistance for: scheduled toileting activity, to and from toilet; peri-care; adaptive device in place." The facility's initial resident centered care plan (service plan) policy dated January 2023 shows, "Policy: All residents will have an initial care plan that includes the instructions needed to provide effective and person centered cre of the resident that meet professional standards of quality...." The facility's abuse, neglect, and exploitation, suspected crime policy dated May 2025 shows, "Policy: It is the policy of this community to take appropriate steps to prevent the occurrence : Abuse, Neglect, Misappropriation of resident property.... Definitions: Abuse is defined at 483.5 as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes that deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being.... Neglect: Is the failure of the community, its employees, or service providers to provide goods and services to a resident necessary to avoid physical harm, pain, mental anguish, or emotional distress...."	A6000		