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A 000	Initial Comment Complaint Investigation: IL199710/269079- 295.4010 d) IL199646/2690629- 295.3000 a); 295.6000 a) 13) IL199790/2690934 IL199342 Entity Reported Incident Investigation: IL199738- 295.4010 d), 295.6000 a) 13), 295.6010 a)1) IL199735-295.4010 d), 295.6000 a) 13), 295.6010 a)1) IL199148- 295.2000 a), 295.4010 d) IL199054- 295.2000 a), 295.4010 d)	A 000		
A2000	Section 295.2000 Residency Requirements This Regulation is not met as evidenced by: Type 2 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 is not met as evidenced by: Based on interview and record review, the establishment failed to assess and provide	A2000		

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sufficient interventions to prevent multiple falls with or without injuries affecting two (R3, R4) residents requiring higher level of supervision and identified as fall risks.
This failure resulted in falls with injuries.This failure creates a substantial probability to cause harm to all residents.

Findings include:

1) According to R3's face sheet, R3 is 91 years old. R3's diagnoses include but not limited to Dementia with Behavioral Disturbance, Atrial Fibrillation and Flutter, Hypokalemia, Vitamin D Deficiency. R3 moved to the community on 4/23/25. R3's Mini-Mental Score was 17 which indicate R3 cognition as confused. R3's Fall Risk score dated 1/16/26 was 15 points (Total score of 10 or more=Risk of falls).

On 1/21/26 at 3:49PM, R3 was observed in the TV area, R3's walker was parked in front of R3. R3 indicated the cause of falls were "I lost balance. Slipped and fall and unsteady on feet". R3 was asked, "What do you do so as not to fall? R3 replied, "Walk carefully".

According to R3's Progress notes, R3 was had multiple fall history prior to move in and identified as "extremely high risk". 17 Multiple falls were documented since admission:
5/13/25 5:30PM- observed getting up from the dinner table turned around and missed his step...
7/23/25 8:56PM- got up to leave dining area, slipped ...fell onto his buttocks, no injuries
8/15/25 7:58PM- responded to (fall notification), per wife slid down when he was attempting to get lip gloss out of the closet
8/24/25 1:58PM- responded to (fall notification), observed sitting on the floor in another resident's

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room.
8/27/25 6:51PM- responded to (fall notification), observed lying flat on his back in front of dresser, wife stated he was assisting her, and he moved the bed and fell on his butt.
9/12/25 @3:01AM- received a (fall notification) call, fall in room- per video, observed the resident getting out of the bed standing up, and losing balance, falling to the floor and getting himself in bed
10/3/25 7:31AM- responded to (fall notification), observed resident lying flat on his back next to his head, per video- observed getting out of his bed and feet got tangled with bedding which caused him to fall.
10/4/25 5:32AM- per (fall notification) video, getting out of bed, stumbling back, falling on the floor getting up and getting back in bed... resident said he hit his head, sent to hospital for eval. returned no new order.
10/4/25 11:37PM- responded to (fall notification), observed sitting on recliner, writer asked if he fall, no response, assessed, no injury.
10/5/25 6:23AM- observed laying on the floor right side between bed and wall...with skin laceration on right buttock, observed AMS (Altered Mental Status) in resident LOC normally AOx3... sent to hospital. Dx: Dehydration
10/8/25 @3:23AM- (fall notification), someone has fallen in room 223. Observed resident to be laying in co-peer bed sleeping. After viewing video: writer observed resident in the bed and using his walker as a to prevent himself from falling, resident safely placed himself on his knees on the floor, he readjusted himself back onto the bed safely, then adjust the pillow proceeded to go to sleep...
10/17/25 4:43AM- alerted by (fall notification), observed on the floor near recliner... resident stated he urinated on himself.

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A2000	Continued From page 3 11/7/25 9:50PM- notified by (fall notification), - resident observed resident on the floor face down between the bed and nightstand... per resident, fell trying to help wife out of bed. sent to hospital... (returned, no documented injury 11/8/25 4:41am) 11/14/25 12:40AM- (fall notification), found lying on the floor next to bed per resident... fell trying to go to the bathroom. Doesn't think he hit his head... 11/21/25 9:48PM- responded to (fall notification), observed laying on his right side next to bed, skin tear to Left Upper Extremities and to Right Lower Extremities. Per (fall notification), video: resident hit top of head on wall. 911 to transfer to hospital. returned 11/22/25- no documentation if resident had injury. 11/28/25 12:55AM- responded to (fall notification), falling on his butt and hitting his head on the chair. observed visible bruises on his bilateral knees. (sent out to hospital- returned 11/28/25 6:24am- no documented injury) 1/16/26 5:37PM- sitting upright on floor next to toilet ... stated he fell getting off toilet laceration noted to back of the head ...911 called. 1/17/26 1:49am, staples to be removed in 7-10 days. R3's Service Plan for falls indicated the following: Start Date 4/30/25 Problem/Needs. Ambulation Needs/receives verbal cueing/standby for ambulation. Services. Staff to support resident in independent ambulation through cueing and standby assist. Intervention. Adaptive Device: Walker Transfer: Cueing Standby Problem/Need: Fall Risk safety checks require fall risk safety check Start Date 11/17/25 Problem/Needs. High Risk for Falls. Resident receiving PT/OT to improve balance and ambulation.	A2000		

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A2000	Continued From page 4 Goals. Falls (R3) and staff will implement strategies to increase safety and prevent falls. Interventions/Comments 11/28/25 Fall Intervention: Add night light(s) in bathroom and or/room. 11/28/25 Fall Intervention: Conduct visual checks on resident every two hours while asleep. 11/18/25 Fall Intervention: Increase visual checks on resident. Start Date: 4/30/25 Problem/Needs. Fall Risk Safety Checks: requires fall risk safety checks Goals. Fall: (R3) will remain in safe environment. Services: Safety Check: Fall Risk 5/13/25- PT referral 4/29/25 5/13/25 Fatigue allows for rest periods throughout the day 5/13/25 Assist in staying engage in activities. Report to nurse any observed or reported falls/ change in balance, change in toileting ability, changes in cognition, and any observed safety hazards in the resident's unit (cluttered walkways, poor lighting, adaptive equipment in poor repair. Interventions/Comments 12/2/25 Fall Intervention: Caregiver to assist resident with toileting needs. 12/2/25 Fall Intervention: Encourage participation in programming as means of visual supervision. Start Date: 4/30/25 Problem/Need: Safety checks needed/ indicated Goal: Safety Checks: (R3) will remain safe from any harm Services: Face to face check on resident status. Interventions/ Comments Safety checks. On 1/22/26 at 10:09AM, E2 (Clinical Service Director) said, R3's spouse lives with R3 and they like to help each other. R3 has on and off lucidity and has confusion. Hospice is being considered due to decline in cognition and functions, the hospice will provide medication adjustments, extra people in the room to provide more	A2000		

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attention, provide adaptive equipment.
R3 is also receiving anticoagulant therapy (Coumadin) which can make R3 vulnerable to serious injury due to falls. This too was not addressed on service plan.

2) According to R4's face sheet, R4 is 72 years old. R4 moved to the community on 3/31/25. R4's diagnoses include but not limited to Dementia, Major Neurocognitive Disorder. R4's Mini Mental Exam score dated 11/13/25 was 9 points (20-1-Confused). R4's Fall Risk score dated 9/10/25 was 10 points (A score of 10 or more=Risk of falls.

On 1/21/26 at 3:52PM, R4 was observed in the hallway walking independently, socializing with peers. Random rounds on 1/22/26, R4 was observed walking in hallways.

R4's progress notes documented fall with or without injury. These falls are the following:
5/1/25 @5:17AM- living room area, sitting on the floor in front of couch, per resident- slipped off the couch, observed with hematoma to the left side of the head, and a laceration to the left side of the scalp- sent to (local hospital) at 5:25AM- admitted with Syncope
5/25/25 1:26AM- called to living room area, resident lying face down on the floor. Stood up and fall down. Laceration and Hematoma on right side of forehead. Sent to (local hospital).
8/4/25 8:47AM sitting in activity room watching TV, fell asleep was leaning forward and fell hitting her face and head on the floor sustaining laceration with hematoma to right temporal area. Sent to hospital. returned to establishment.
9/10/25 3:23PM- Courtyard, sitting on ground in front of chair- " I sat on edge of chair and slid down on my buttocks."

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A2000	Continued From page 6 9/11/25 1:38AM- unwitnessed fall, found on the floor in hallway, active bleeding to the right side of the forehead. Sent to hospital. returned 9/11/25 5:52AM 12/5/25 9:26AM- unwitnessed fall, RCA hearing loud sound, found resident on the floor, seated upright next to the couch, active bleeding to the right side of the head. Applied pressure. 911 called, sent to hospital. Returned 12/5/25 3:17pm- injury to right side of head was closed with glue ... 12/10/25 2:42 AM- round sat 2AM, observed resident seated on her buttocks on the floor in the hallway with bleeding to the left side of her head, unable to communicate what happened. 911 contacted, sent to the hospital. 12/15/25 11:42PM- Had fallen off the couch in the TV area hit right side of head... observed sitting on the floor while sleeping. Unable to explain what happened. No bruises or bleeding at this time. Sent to the hospital. 12/21/25 10:16AM- observed on the floor on the 100 side near room 123. Unable to explain what happened. Complains of generalized pain, able to ambulate on her own to the common area... sent to the hospital. 12/21/25 9:24PM- admitted- Diagnosis- Multiple Falls, Cellulitis returned 12/22/25 6:00PM 1/12/26 8:55AM- Responded to staff alerting writer that resident had fallen when she attempted to sit down in her recliner chair post fall no injuries. R4' Service plan interventions for fall include the following: Start Date: 12/5/25Problem/Needs- Fall Risk safety checks Services: Report to nurse any observed or reported falls/ change in balance, change in toileting ability, changes in cognition, and any	A2000		

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observed safety hazards in the resident's unit (cluttered walkways, poor lighting, adaptive equipment in poor repair.
Interventions:
12/5/25 Fall intervention: redirect resident to common area when awake at night- Discipline Nurse
9/11/25 Fall intervention: Assist resident with taking rest periods between periods of wandering, walking or exercise. Discipline- Caregiver
9/11/25 Fall intervention: Encourage participation in programming as a means of visual supervision-Discipline Nurse
Start Date: 4/1/25 Problem/Need: Safety checks needed/ indicated- Services: face to face check on resident status. Intervention- Safety checks
Start Date: 1/13/26- Problem: Risk for falls
Intervention: Conduct visual checks on resident during all shifts.

On 1/22/26 at 10:09am, E2 indicated, R4 sleeps in chairs, and considering having a hospital bed.

On R4's notes dated 12/24/25 1:20PM, it indicated; "POA (Power of Attorney) aware regarding frequent falls. POA aware resident refuses to sleep in her bed at night instead sleeps in chair, leaning forward contributing to fall. Recommended providing recliner."
R4 has been falling with injuries in common areas since May 2025, and yet there were no interventions put in place to address this issue resulting to repeated falls with head injury. The intervention of "redirecting to common area" was insufficient without adequate supervision as evidenced by repeated falls in the common area.

R4's Ambulation indicated Physical Assist 1, staff to provide physical assist of 1 for ambulation. R4 was observed walking independently in the

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A2000	Continued From page 8 hallways.	A2000		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: TYPE 1 VIOLATION Section 295.3000 Personnel Requirements, Qualifications and Training a) The establishment shall have staff sufficient in number with qualifications, adequate skills, education and experience to meet the 24 hour scheduled and unscheduled needs of residents and who participate in ongoing training to serve the resident population. (Section 35(a)(3) of the Act) This requirement was not met as evidenced by: Based on interview and record review, the establishment failed to ensure staff have adequate skills to administer medication for one (R2) resident receiving end of life pain medication. This failure involves 1 of 5 residents (R2) Reviewed.This failure resulted in R2 receiving narcotic medication from an unlicensed employee. This failure creates a substantial probability of severe harm to all residents in the Community. Findings include: R2's medical record showed R2 moved into the establishment on 3/11/2024, resided in the memory care unit, and had multiple diagnoses, including but not limited to Dementia	A3000		

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A3000	Continued From page 9 Hypertension, GERD, Depression, COVID-19, Convulsions. On 1/22/2026 at 10:20AM, E15 (Resident Care Assistant/RCA) said that R2 declined rapidly, R2 was walking with a walker right before the decline, then she was in a Broda chair, E15 said that R2 will let them know if she was in pain but a few days before R2 passed, R2was not very expressive but if E15 notice that R2 was in pain, R15 let the nurse know. On 1/22/2026 at 10:25AM, E13 (RCA) said that R2 used to walk around with a walker, E13 said that at the beginning of R2's decline she was still verbal, but later R2 was not very expressive but R2 would grimace if in pain, R2 would cry during care. E13 said that R2 looked very uncomfortable when sitting on the chair. On 1/22/2026 at 10:35AM, E3 (Resident Care Manager) said that R2 was calm, compliant with medication, complain of pain, E3 said R2 had PRN (as needed) Lorazepam for anxiety and agitation, Morphine for pain and SOB. E3 said that before R2 went into hospice she was agitated and anxious, but she was easy to calm done. E3 said that R2 was in pain, E3 said R2 was not very expressive but E3 could observed the grimace, R2 became more agitated when in pain. E3 said that "One day I gave Morphine around 4PM, Z2 (Power of Attorney/POA) came an hour later to let me know R2 was in pain, I told Z2 that I was going to check the MAR (Medication Administration Record) to see if R2 has anything else, Z2 said she was going to call Hospice and Z2 called, the hospice nurse who told Z2 that there was an order for Morphine every hour, I told Z2 and the hospice nurse that I still had to check	A3000		

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the MAR to see the order. When I check the MAR. I saw that there was an order for Morphine every hour, then I went to give it to her."

On 1/22/2026 at 11:15AM, E6 (Resident Care Manager/RCM) said that R2 "was calm, she was not in pain when I worked with her. I made sure she was medicated, gave Morphine every hour as prescribed." E6 said that Z2 would ask E6 to come an assist with R2, Z2 wanted the Morphine to be given every hour to keep R2 comfortable. E6 said that Z2 had some issues with other nurses about medication is not given as prescribed.

On 1/22/2026 at 11:33AM, E4 (RCM) said "I didn't have a lot of interaction with residents, I worked Part-time PRN only. I know that the family wanted R2 to have pain medication every hour on the hour. I gave the medication if R2 needed it."

On 1/22/2026 at 1:33PM, E2 (Clinical Service Director) said that R2's pain medication (Morphine) was schedule three times daily and PRN every hour, E2 said that Z2 "came to me and told me that the overnight nurse was not given the PRN medication as ordered. E2 further said "when I investigated, I noticed that the PRN was not given every hour, the family wanted every hour, nurses were not comfortable given the medication every hour. I reeducate the nurses that it was end of life and it was ok to give medication as prescribed. The nurses were E3 and E4, E3 wanted to get confirmation from hospice to make sure that medication was ordered every hour. I explained nurses that Morphine is not only for pain, also for shortness of breath."

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A3000	Continued From page 11 On 1/22/2026 at 3:27PM, Z6 (Hospice Nurse) "I am not aware that nurses were not given the pain medication as prescribed as I don't have access to the facility's documents, but Z2 was always there and was very vigilant, Z2 notified me that R2 was not getting her medication as prescribed because Z2 can see which nurse is coming to the room and which medication is given." Physician Order Sheet indicated the following: POS 12/23/2025- Lorazepam Con 2mg/mL PRN 12/30/2025- Lorazepam Con 2mg/mL three times daily 1/12/2026- Lorazepam Con 2mg/mL three times daily 12/23/2025- Morphine Sol 20/5mL PRN. Take 0.25mL (5mg) by mouth under the tongue every 1 hour as needed for pain. 1/10/2026- Morphine Sol 100/5mL three times daily 1/12/2026- Morphine Sol 20/5mL three times daily 1/15/2026- Morphine Sol 20/5mL PRN 1/15/2026 Morphine 20mg/mL sol. Give 0.5ml (10mg) every 1 hour scheduled for pain/SOB (shortness of breath). Controlled Drug Record reviewed was not given every hour until medication was changed to regular schedule.	A3000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 1 Violation Section 295.4010 Service Plan	A4010		

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A4010	Continued From page 12 d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act) This requirement is not met as evidenced by: Based on observation, interview and record review, the establishment failed to implement measurable, individualized interventions to prevent multiple falls with or without injuries for two (R3, R4) of two residents reviewed for falls. The establishment also failed to address increasing aggressive behavior of two (R1, R8) resident resulting in aggressive behaviors towards other residents (R8) and staff and residents (R1). This deficient practice has affected three of three residents reviewed for service plans and creates a substantial probability of severe harm to all cognitively impaired residents' safety. Findings include: 1) According to R3's face sheet, R3 is 91 years old. R3's diagnoses include but not limited to Dementia with Behavioral Disturbance, Atrial Fibrillation and Flutter, Hypokalemia, Vitamin D Deficiency. R3 moved in the community on 4/23/25. R3's Mini-Mental Score was 17 which indicate R3 cognition as confused. R3's Fall Risk score dated 1/16/26 was 15 points (Total score of 10 or more=Risk of falls). On 1/21/26 at 3:49PM, R3 was observed in the TV area, R3's walker was parked in front of R3. R3 indicated the cause of falls were "I lose	A4010		

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A4010	Continued From page 13	A4010		

balance. Slipped and fall and unsteady on feet". R3 was asked, "What do you do so as not to fall? R3 replied, "Walk carefully".

According to R3's Progress notes, R3 was had multiple fall history prior to move in and identified as "extremely high risk". Multiple falls were documented since then:
5/13/25 5:30PM- observed getting up from the dinner table turned around and missed his step...
7/23/25 8:56PM- got up to leave dining area, slipped ...fell onto his buttocks, no injuries
8/15/25 7:58PM- responded to (fall notification), per wife slid down when he was attempting to get lip gloss out of the closet
8/24/25 1:58PM- responded to (fall notification), observed sitting on the floor in another resident's room.
8/27/25 6:51PM- responded to (fall notification), observed lying flat on his back in front of dresser, wife stated he was assisting her, and he moved the bed and fell on his butt.
9/12/25 at 3:01AM- received a (fall notification) call, fall in room- per video, observed the resident getting out of the bed standing up, and losing balance, falling to the floor and getting himself in bed
10/3/25 7:31AM- responded to (fall notification), observed resident lying flat on his back next to his head, per video- observed getting out of his bed and feet got tangled with bedding which caused him to fall.
10/4/25 5:32AM- per (fall notification) video, getting out of bed, stumbling back, falling on the floor getting up and getting back in bed... resident said he hit his head, sent to hospital for eval. returned no new order.
10/4/25 11:37PM- responded to (fall notification), observed sitting on recliner, writer asked if he fall, no response, assessed, no injury.

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A4010	Continued From page 14 10/5/25 6:23AM- observed laying on the floor right side between bed and wall...with skin laceration on right buttock, observed AMS (Altered Mental Status) in resident LOC normally AOx3... sent to hospital. Dx: Dehydration 10/8/25 at 3:23AM- (fall notification), someone has fallen in room 223. Observed resident to be laying in co-peer bed sleeping. After viewing video: writer observed resident in the bed and using his walker as a to prevent himself from falling, resident safely placed himself on his knees on the floor, he readjusted himself back onto the bed safely, then adjust the pillow proceeded to go to sleep... 10/17/25 4:43AM- alerted by (fall notification), observed on the floor near recliner... resident stated he urinated on himself. 11/7/25 9:50PM- notified by (fall notification) resident observed resident on the floor face down between the bed and nightstand... per resident, fell trying to help wife out of bed. sent to hospital... (returned, no documented injury 11/8/25 4:41am) 11/14/25 12:40AM- (fall notification)- found lying on the floor next to bed per resident... fell trying to go to the bathroom. Doesn't think he hit his head... 11/21/25 9:48PM- responded to (fall notification)-observed laying on his right side next to bed, skin tear to Left Upper Extremities and to Right Lower Extremities. Per Safely You video: resident hit top of head on wall. 911 to transfer to hospital. returned 11/22/25- no documentation if resident had injury. 11/28/25 12:55AM- responded to (fall notification), falling on his butt and hitting his head on the chair. observed visible bruises on his bilateral knees. (sent out to hospital- returned 11/28/25 6:24am- no documented injury) 1/16/26 5:37PM- sitting upright on floor next to	A4010		

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A4010	Continued From page 15 toilet ... stated he fell getting off toilet laceration noted to back of the head, no loss of consciousness. 911 called. 1/17/26 1:49am-returned CT scan of the head and cervical spine, staples to be removed in 7-10 days. R3's Service Plan for falls indicated the following: Start Date 4/30/25 Problem/Needs. Ambulation Needs/receives verbal cueing/standby for ambulation. Services. Staff to support resident in independent ambulation through cueing and standby assist. Intervention. Adaptive Device: Walker Transfer: Cueing Standby Problem/Need: Fall Risk safety checks require fall risk safety check Start Date 11/17/25 Problem/Needs. High Risk for Falls. Resident receiving PT/OT to improve balance and ambulation. Goals. Falls (R3) and staff will implement strategies to increase safety and prevent falls. Interventions/Comments 11/28/25 Fall Intervention: Add night light(s) in bathroom and or/room. 11/28/25 Fall Intervention: Conduct visual checks on resident every two hours while asleep. 11/18/25 Fall Intervention: Increase visual checks on resident. Start Date: 4/30/25 Problem/Needs. Fall Risk Safety Checks: requires fall risk safety checks Goals. Fall: (R3) will remain in safe environment. Services: Safety Check: Fall Risk 5/13/25- PT referral 4/29/25 5/13/25 Fatigue allows for rest periods throughout the day 5/13/25 Assist in staying engage in activities. Report to nurse any observed or reported falls/ change in balance, change in toileting ability, changes in cognition, and any observed safety	A4010		

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A4010	Continued From page 16	A4010		

hazards in the resident's unit (cluttered walkways, poor lighting, adaptive equipment in poor repair.
Interventions/Comments
12/2/25 Fall Intervention: Caregiver to assist resident with toileting needs. 12/2/25 Fall Intervention: Encourage participation in programming as means of visual supervision.
Start Date: 4/30/25 Problem/Need: Safety checks needed/ indicated
Goal: Safety Checks: (R3) will remain safe from any harm
Services: Face to face check on resident status.
Interventions/ Comments Safety checks.

On 1/22/26 at 10:09AM, E2 (Clinical Service Director) said, R3's spouse lives with R3 and they like to help each other. R3 has on and off lucidity and has confusion. Hospice is being considered due to decline in cognition and functions, the hospice will provide medication adjustments, extra people in the room to provide more attention, provide adaptive equipment.
R3 is also receiving anticoagulant therapy (Coumadin) which can make R3 vulnerable to serious injury due to falls. This too was not addressed on service plan.

2) According to R4's face sheet, R4 is 72 years old. R4 moved to the community on 3/31/25. R4's diagnoses include but not limited to Dementia, Major Neurocognitive Disorder. R4's Mini Mental Exam score dated 11/13/25 was 9 points (20-1-Confused). R4's Fall Risk score dated 9/10/25 was 10 points (A score of 10 or more=Risk of falls.

On 1/21/26 at 3:52PM, R4 was observed in the hallway walking independently, socializing with peers. Random rounds on 1/22/26, R4 was observed walking in hallways.

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A4010	Continued From page 17 R4's progress notes documented fall with or without injury. These falls are the following: 5/1/25 @5:17AM- living room area, sitting on the floor in front of couch, per resident- slipped off the couch, observed with hematoma to the left side of the head, and a laceration to the left side of the scalp- sent to (local hospital) at 5:25AM- admitted with Syncope 5/25/25 1:26AM- called to living room area, resident lying face down on the floor. Stood up and fall down. Laceration and Hematoma on right side of forehead. Sent to (local hospital). 8/4/25 8:47AM sitting in activity room watching TV, fell asleep was leaning forward and fell hitting her face and head on the floor sustaining laceration with hematoma to right temporal area. Sent to hospital. returned to establishment. CT-normal. 9/10/25 3:23PM- Courtyard, sitting on ground in front of chair- " I sat on edge of chair and slid down on my buttocks." 9/11/25 1:38AM- unwitnessed fall, found on the floor in hallway, active bleeding to the right side of the forehead. Sent to hospital. returned 9/11/25 5:52AM 12/5/25 9:26AM- unwitnessed fall, RCA hearing loud sound, found resident on the floor, seated upright next to the couch, active bleeding to the right side of the head. applied pressure. 911 called, sent to hospital. Returned 12/5/25 3:17pm- injury to right side of head was closed with glue ... 12/10/25 2:42 AM- round sat 2AM, observed resident seated on her buttocks on the floor in the hallway with bleeding to the left side of her head, unable to communicate what happened. 911 contacted, sent to the hospital. 12/15/25 11:42PM- Had fallen off the couch in the TV area hit right side of head... observed sitting	A4010		

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A4010	Continued From page 18 on the floor while sleeping. Unable to explain what happened. No bruises or bleeding at this time. Sent to the hospital. 12/21/25 10:16AM- observed on the floor on the 100 side near room 123. Unable to explain what happened. Complains of generalized pain, able to ambulate on her own to the common area... sent to the hospital. 12/21/25 9:24PM- admitted- Diagnosis- Multiple Falls, Cellulitis returned 12/22/25 6:00PM 1/12/26 8:55AM- Responded to staff alerting writer that resident had fallen when she attempted to sit down in her recliner chair post fall no injuries. R4' Service plan interventions for fall include the following: Start Date: 12/5/25Problem/Needs- Fall Risk safety checks Services: Report to nurse any observed or reported falls/ change in balance, change in toileting ability, changes in cognition, and any observed safety hazards in the resident's unit (cluttered walkways, poor lighting, adaptive equipment in poor repair. Interventions: 12/5/25 Fall intervention: redirect resident to common area when awake at night- Discipline Nurse 9/11/25 Fall intervention: Assist resident with taking rest periods between periods of wandering, walking or exercise. Discipline- Caregiver 9/11/25 Fall intervention: Encourage participation in programming as a means of visual supervision-Discipline Nurse Start Date: 4/1/25 Problem/Need: Safety checks needed/ indicated- Services: face to face check on resident status. Intervention- Safety checks Start Date: 1/13/26- Problem: Risk for falls Intervention: Conduct visual checks on resident	A4010		

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A4010	Continued From page 19 during all shifts. On 1/22/26at 10:09am, E2 indicated, R4 sleeps in chairs, and considering having a hospital bed. On R4's notes dated 12/24/25 1:20PM, it indicated; "POA (Power of Attorney) aware regarding frequent falls. POA aware resident refuses to sleep in her bed at night instead sleeps in chair, leaning forward contributing to fall. Recommended providing recliner." R4 has been falling with injuries since May 2025, and yet interventions addressing this was not in place. R4 already incurred several falls with injury in common area while seated. Most of R4's incident occurred in common areas. The intervention of "redirecting to common area" alone was not appropriate since the falls occurred in the common areas. R4 requires a higher level of supervision to prevent falls. R4's Ambulation indicated Physical Assist 1, staff to provide physical assist of 1 for ambulation. R4 was observed walking independently in the hallways. 3) R1's medical record showed R1 moved into the establishment on 11/4/2024. R1 resided in the Memory care unit, and has multiple diagnoses, including but not limited to Diabetes Type II, Depression with anxiety, Hyperlipidemia, Peripheral Vascular Disease, Sleep Apnea, Hypertension, Dementia, and Gout. R1's Nurse's Notes indicated the following: 1/14/2026- R1 in the presence of another struck writer (E3) on the nose with closed fist, when attempting to administer medication... Emergency Medical Service was called and R1 will be sent out to local hospital...	A4010		

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A4010	Continued From page 20 11/28/2025 indicated that R1 scratched an employee on the face and struck the employe on the back with a walker ... Z1 (POA) was notified and informed of the incident ... R1 was sent out to local hospital ... R1's Service Plan, dated 11/14/2025, showed R1- Problem/Needs: Behavior management plan; Resistive to Care: Mild Goals: Behavior management: (R1) behavior will be recorded Behavior management: (R1) will respond to redirection/reapproach.There was no intervention in place to address R1's aggressive behavior. On 1/21/2026 at 3:14PM, E3 (Resident Care Manager) said that R1 is very aggressive physically, that R1 tries to kick others. On 1/22/2026 at approximately 10:25AM, both E13 and E15 (Resident Care Assistant/RCA) said R1 was very aggressive, verbally as well as physically. 4) According to R8's face sheet, R8 is 63 years old. R8's diagnoses include but not limited to Dementia, Hypertension, Anxiety with Depression, Essential Hypertension. R8 moved to the community on 1/25/25. R11's Mini Mental Exam score dated 8/3/25 was 14 points (Confused). Establishment's documents documented R8's aggressive behavior towards peers. R8's progress notes "8/23/25 9:51AM- Writer observed resident standing next to one of his peers on floor. Resident's peer was lying on left side on floor chair side next to resident on floor...	A4010		

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A4010	Continued From page 21	A4010		

Peer responded he pushed me."
According to Incident Report dated 1/21/26 at 8:15AM, R8 pushed peer (R7) on the chest, causing fall. There was no injury observed. According to R7's face sheet, R7 is 92 years old. R7's diagnoses include but not limited to Unspecified Dementia, Type II Diabetes Mellitus and Essential Hypertension.

On 1/26/26 at 1:48PM, E16 (Resident Care Manager) who witnessed the incident said R8 was taking food on R7's plate, when R7 raised hand to tell R8 was to stop, R8 got upset and pushed R7 on the chest causing R7 to fall with the chair R7 was sitting on. E16 said, R8 has aggressive behavior at times.

On 1/26/26 at 2:30PM, E2 said, R8 was more anxious than aggressive and has had altercations with peers including R11. According to R11's notes, on 1/11/26, R11 had an altercation with peer (R8) during breakfast services. Peer struck R11 on left side of jaw. R11's face sheet indicated R11 is 91 years old with diagnoses of Dementia, Difficulty walking, and History of Falling.

R8's Service Plan indicated:
Start Date: 1/11/26Problem/Needs. Behaviors: agitation/anxiety
Goals: (R8) will remain safe
Services: orientation: Mild Confusion. Follow time and place orientation plan to support resident to feel safe in environment and fulfill unmet needs.
Discipline: Caregiver
Behaviors: redirect when behaviors are noted.

On 1/26/26 at 2:55PM, Z4 (Nurse Practitioner) said, R8 has more episodes of agitation and could benefit with higher dose of Seroquel. R8 was previously hospitalized and was stable, when

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A4010	Continued From page 22 R8 went to establishment, R8's daughter requested to decrease the Seroquel dose due to observed drowsiness when R8 spend time at daughter's home. However, when R8 was back in the community, R8 was more stimulated. On 1/26/26 at 2:06PM, E14 (Resident Care Manager) said R8 has been more aggressive for over a month. E14 described R8's behavior as "getting to staff's faces", yelling and hard to redirect.	A4010		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 1 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: 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor. These requirements are not met as evidenced by: Based on interview and record review the facility failed to ensure residents are adequately receiving pain medication for end of life for one (R2) resident and failed provide safe environment for two (R7, R11) resulting in physical abuse. This	A6000		

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A6000	Continued From page 23	A6000		

deficient practice has affected two (R7, R11) of six residents reviewed for abuse and neglect. This failure creates a substantial probability of severe harm to all residents.

Findings include:

R2's medical record showed R2 moved into the establishment on 3/11/2024, resided in the memory care unit, and had multiple diagnoses, including but not limited to Dementia Hypertension, GERD, Depression, COVID-19, Convulsions.

On 1/22/2026 at 10:20AM, E15 (Resident Care Assistant/RCA) said that R2 declined rapidly, R2 was walking with a walker right before the decline, then she was in a Broda chair, E15 said that R2 will let them know if she was in pain but a few days before R2 passed, R2was not very expressive but if E15 notice that R2 was in pain, R15 let the nurse know.

On 1/22/2026 at 10:25AM, E13 (RCA) said that R2 used to walk around with a walker, R13 said that at the beginning of R2's decline she was still verbal, but later R2 was not very expressive but R2 would grimace if in pain, R2 would cry during care. E13 said that R2 looked very uncomfortable when sitting on the chair.

On 1/22/2026 at 10:35AM, E3 (resident Care Manager) said that R2 was calm, compliant with medication, complain of pain, E3 said R2 had PRN (as needed) Lorazepam for anxiety and agitation, Morphine for pain and SOB. E3 said that before R2 went into hospice she was agitated and anxious, but she was easy to calm done. E3 said that R2 was in pain, E3 said R2 was not very expressive but E3 could observed

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the grimace, R2 became more agitated when in pain. E3 said that "One day I gave Morphine around 4PM, Z2 (Power of Attorney/POA) came an hour later to let me know R2 was in pain, I told Z2 that I was going to check the MAR (Medication Administration Record) to see if R2 has anything else, Z2 said she was going to call Hospice and Z2 called, the hospice nurse who told Z2 that there was an order for Morphine every hour, I told Z2 and the hospice nurse that I still had to check the MAR to see the order. When I check the MAR. I saw that there was an order for Morphine every hour, then I went to give it to her."

On 1/22/2026 at 11:15AM, E6 (Resident Care Manager/RCM) said that R2 "was calm, she was not in pain when I worked with her. I made sure she was medicated, gave Morphine every hour as prescribed." E6 said that Z2 would ask E6 to come an assist with R2, Z2 wanted the Morphine to be given every hour to keep R2 comfortable. E6 said that Z2 had some issues with other nurses about medication is not given as prescribed.

On 1/22/2026 at 11:33AM, E4 (RCM) said "I didn't have a lot of interaction with residents, I worked Part-time PRN only. I know that the family wanted R2 to have pain medication every hour on the hour. I gave the medication if R2 needed it."

On 1/22/2026 at 1:33PM, E2 (Clinical Service Director) said that R2's pain medication (Morphine) was schedule three times daily and PRN every hour, E2 said that Z2 "came to me and told me that the overnight nurse was not given the PRN medication as ordered. E2 further said "when I investigated, I noticed that the PRN was not given every hour, the family wanted every hour, nurses were not comfortable given the

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	ASL510274	A. BUILDING: _____ B. WING _____	C 01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTER PLACE	17833 HARLEM AVE TINLEY PARK, IL 60477

(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
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medication every hour. I reeducate the nurses that it was end of life and it was ok to give medication as prescribed. The nurses were E3 and E4, E3 wanted to get confirmation from hospice to make sure that medication was ordered every hour. I explained nurses that Morphine is not only for pain, also for shortness of breath."

On 1/22/2026 at 3:27PM, Z6 (Hospice Nurse) "I am not aware that nurses were not given the pain medication as prescribed as I don't have access to the facility's documents, but Z2 was always there and was very vigilant, Z2 notified me that R2 was not getting her medication as prescribed because Z2 can see which nurse is coming to the room and which medication is given."
Physician Order Sheet indicated the following:
POS
12/23/2025- Lorazepam Con 2mg/mL PRN
12/30/2025- Lorazepam Con 2mg/mL three times daily
1/12/2026- Lorazepam Con 2mg/mL three times daily
12/23/2025- Morphine Sol 20/5mL PRN. Take 0.25mL (5mg) by mouth under the tongue every 1 hour as needed for pain.
1/10/2026- Morphine Sol 100/5mL three times daily
1/12/2026- Morphine Sol 20/5mL three times daily
1/15/2026- Morphine Sol 20/5mL PRN
1/15/2026 Morphine 20mg/mL sol. Give 0.5ml (10mg) every 1 hour scheduled for pain/SOB (shortness of breath).

Controlled Drug Record reviewed was not given every hour until medication was changed to regular schedule.

According to R8's face sheet, R8 is 63 years old.

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R8's diagnoses include but not limited to Dementia, Hypertension, Anxiety with Depression, Essential Hypertension. R8 moved to the community on 1/25/25. R11's Mini Mental Exam score dated 8/3/25 was 14 points (Confused).

Establishment's documents documented R8's aggressive behavior towards peers.
According to Incident Report dated 1/21/26 at 8:15AM, R8 pushed peer (R7) on the chest, causing fall. There was no injury observed.
According to R7's face sheet, R7 is 92 years old. R7's diagnoses include but not limited to Unspecified Dementia, Type II Diabetes Mellitus and Essential Hypertension. On 1/26/26 at 1:27PM, was interviewed but unable to say what happened with R8.

On 1/26/26 at 1:48PM, E16 (Resident Care Manager) who witnessed the incident said R8 was taking food on R7's plate, when R7 raised hand to tell R8 to stop, R8 got upset and pushed R7 on the chest causing R7 to fall with the chair R7 was sitting on. E16 said, R8 has aggressive behavior at times.

On 1/26/26 at 2:30PM, E2 said, R8 was more anxious than aggressive and has had altercations with peers including R11.

According to R11's notes, on 1/11/26, R11 had an altercation with peer (R8) during breakfast services. Peer struck R11 on left side of jaw.
R11's face sheet indicated R11 is 91 years old with diagnoses of Dementia, Difficulty walking, and History of Falling. On 1/26/26 at 2:46PM, R11 was observed in the activity area. R11 was unable to remember what happened with R8.
On 1/26/26 at 2:06PM, E14 (Resident Care

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A6000	Continued From page 27 Manager) said R8 has been more aggressive for over a month. E14 described R8's behavior as "getting to staff's faces", yelling and hard to redirect. R8's Service Plan indicated: Start Date: 1/11/26Problem/Needs. Behaviors: agitation/anxiety Goals: (R8) will remain safe Services: orientation: Mild Confusion. Follow time and place orientation plan to support resident to feel safe in environment and fulfill unmet needs. Discipline: Caregiver Behaviors: Redirect when behaviors are noted.	A6000		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr This Regulation is not met as evidenced by: Type 1 VIOLATION Section 295.6010 Abuse, Neglect, and Financial Exploitation Prevention and Reporting a) When the establishment has a reasonable belief that a resident has been the victim of abuse, neglect, or financial exploitation, the establishment shall: 1) Notify the Department within 24 hours after receiving the allegation, by contacting the Assisted Living Complaint Registry by telephone, fax, or other electronic means. The establishment shall document this report and maintain documentation on the premises for 12 months after the date of the report.	A6010		

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A6010	Continued From page 28 These requirements are not met as evidenced by: Based on interview and record review, the establishment failed to notify State agency of incident with 24 hours of incident as required affecting one (R7) of five residents reviewed for incident reporting. This deficient practice creates a substantial probability of severe harm to all residents. Findings include: According to Incident Report dated 1/21/26 at 8:15AM, R8 pushed peer (R7) on the chest, causing fall. There was no injury observed. On 1/26/26 at 1:48PM, E16 (Resident Care Manager) who witnessed the incident said R8 was taking food on R7's plate, when R7 raised hand to tell R8 to stop, R8 got upset and pushed R7 on the chest causing R7 to fall with the chair R7 was sitting on. E16 said, R8 has aggressive behavior at times. On 1/26/26 at 10:51am, E1 (Executive Director) said, this incident was not reported to State Agency. On 1/22/26 at 3:03PM, E2 (Clinical Services Director) said, initial report is submitted to state agency within 4 hours.	A6010		