STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510505	A. BUILDING: _____ B. WING _____	02/20/2026

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WAVERLY INN MEMORY CARE COMMUNITY	515 W RAND ROAD ARLINGTON HEIGHTS, IL 60004

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A 000	Initial Comment Annual Licensure with FRI/ IL00199549 of 12/16/2025 and FRI/IL00199280 of 12/24/25 . The following were cited: Annual Licensure: 1. Section 295.3040 - Health Care Worker Background Check 2. Section 295.4060 - a) i) 2) B) 3. Section 295.4060 - a) b) c) e) FRI/ IL00199549 of 12/16/2025 Section 295.4010 - a) d) e) g) 1) A) 2) 3) FRI/IL00199280 of 12/24/25 Section 295.4010 - a) d) e) g) 1) A) 2) 3) Section 295.6000 - a) 13 Section 295.6010 - a) 2) b)	A 000		
A3040	Section 295.3040 Health Care Worker Background Check This Regulation is not met as evidenced by: General Violation Section 295.3040 Health Care Worker Background Check An establishment shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code. (Source: Amended at 36 Ill. Reg. 13632, effective August 16, 2012) These requirements were not met, as evidenced by: Based on interview and record review, the facility failed to conduct health care background checks	A3040		

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A3040	Continued From page 1 for multiple staff members over a period of several months. This failure has the probability of affecting the safety of all residents in the community. This is for 5 (E7-E11) of 8 employees reviewed. The findings include: On February 13, 2026, at 2:00 PM, the following personnel files were reviewed together with E1(Regional Director of Operation): - E7 (Culinary Staff) date of hire: July 17, 2025 - E8 (Resident Assistant) date of hire: October 13,2025 - E9 (Housekeeping Staff) date of hire: November 1, 2025 - E10 (Activity Staff) date of hire: January 7, 2026 - E11(Resident Assistant) date of hire: January 22, 2026. During this review, the health care background checks for the staff members listed above were not found. The community was unable to present any documentation or evidence that these requirements were completed. These findings were confirmed by E1 during this survey.	A3040		
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 2 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. 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). e) The service plan shall be reviewed and revised, if necessary, immediately after a significant change in the residents' physical, cognitive, or functional condition (see Section 295.4000). g) Service plans shall address: 1) The level of service the resident is receiving, including: A) assistance with activities of daily living. 2) The amount, type, and frequency of health-related services needed by the resident. 3) Staff responsible for the provisions of the service plan. These requirements were not met, as evidenced by: Based on observation, interview and record review, the facility failed to:	A4010		

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A4010	Continued From page 3 1. Develop and implement individualized interventions to address: (a) R2's risk for elopement, wandering behavior, and risk of fall. (b) R1's socially inappropriate behaviors (e.g., sexual behaviors, grabbing food belonging to others) and risk for fall. 2. Follow R2's service plan to ensure all exit doors are secure. 3. Implement the establishment policy and procedure regarding: (a) Elopement (4-f) for R2's service plan to be adjusted (revised). (b) Wandering (3 a i-vii) to address the amount of supervision required, diet and hydration, and redirection technique. 4. Identify possible complications related to R2's wandering behavior. 5. Identify the frequency of the services provided to the residents and identify the staff responsible for the implementation of care. These failures resulted in R2's elopement incident on December 24, 2025. These failures also resulted in R2's fall on December 11, 2025; R2 sustained an injury to the chin requiring six stitches. This failure has the substantial probability to affect all residents. This failure creates a substantial probability of severe harm to a resident or residents This is for two (R2 and R1) of six residents. The findings include: I. R2 moved into the community on December 10, 2025, with diagnoses to include dementia and dysphagia, with history of mandibular fracture. R2's nurses notes disclosed R2's has difficulty swallowing and follows a liquid diet (i.e., "meals given through a 'sippy cup'"). R2's admitting	A4010		

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A4010	Continued From page 4 nurse's notes identify R2 requiring extensive assistance with all activities of daily living. On December 11, 2025, R2 exhibited "exit seeking behavior, trying to push/open exit doors." From this admission nurse's note (December 10, 2025) and through current progress notes, R2 was repeatedly documented as a "wanderer [who] ambulates throughout the community most of the day." On February 13, 2026, at 11:52 AM, E3 (LPN) described R2 as requiring a one staff assist with all of activities of daily living. R2 was described to, "Wander all over the community, pulling call lights from the walls, taking stuff, anything that R2 can grab on, and will lay it down after a while ... Yes, R2 will also go into other resident's rooms if the doors are open." On February 13, 2026, at 12:56 PM, R2 was in their room ambulating independently. R2 is non-verbal [due to dysphagia]. During toileting, R2 required both a two caregiver assist and assistance from a nurse (E3). E3 explained, "R2 needed at least two staff because R2 wouldn't stay still. So, someone needed to hold R2 down." R2's undated service plan identifies R2 with exit seeking behavior during the day and at night, wanders throughout the building and wanders into other residents' rooms. There were no specific interventions listed to address these concerns. R2's service plan only identifies the following objective/plan: - Provide redirection so that I can safely move within the building. - Provide redirection to reduce wandering into other residents' rooms. - Encourage me to find a routine that helps me maintain my independence and safety while navigating the building.	A4010		

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A4010	Continued From page 5 On December 24, 2025, at 8:45 AM, a facility reported incident was submitted to the Department regarding R2's incident of elopement. Resident (R2) was found outside the building [for 21 minutes] without a coat on [the Accu-weather was recorded at 28 degrees Fahrenheit- low of 28 / high of 48-degree Fahrenheit]. On February 19, 2026, at 11:00 AM, E6 (Director of Residents Services), presented the community policy and procedure on wandering as follows: If the resident wanders frequently or has a history of wandering, interventions will be addressed in the resident service plan, which may include: i. The amount of supervision required, based on availability of alarm exits, wander guards, or delayed egress. ii. Access to safe space/areas of wandering, including outdoor areas. iii. Redirection techniques. iv. Encouraging routine physical activities. v. Encouraging residents preferred activities. vi. Use of ambulatory devices. vii. Diet and hydration. These procedures were not addressed and incorporated in R2's service plan. R2's was not revised to include more individualized care plans. R2's service plan concerns were initially discussed with E1 (Regional Director of Operation) on February 13, 2026, at 2:30 PM. II. R1 moved into the community on May 24, 2024, with diagnoses to include vascular dementia, hypertension and history of right humerus fracture (June 12, 2025). On February 13, 2026, at 12:49 PM, R1 was in the TV lounge sitting on a wheelchair. R1 was noted with cognitive deficit [self-awareness only].	A4010		

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A4010	Continued From page 6 E3 (LPN) described R1 requiring one staff assistance with all of activities of daily living including transfer and mobility. E3 stated, "R1 needs someone to push R1's wheelchair, requires supervision and is high risk for fall." The facility reported incident submitted to the Department, on December 16, 2025, at 3:30 PM, R1 was "witnesses" getting up from the wheelchair and walking unassisted, loss balance and falling sideways. R1 was taken to the Emergency Room and was diagnosed with hematoma to the right elbow. R1's nurses note also show R1 with inappropriate behavior, the following were documented: - On November 6, 2025, during activity, R1 stated, "come with me, I will take care of your ding- dong." It was also documented that R1's attempting to grab staff members. - January15, 2026- non-compliant with medication, refusing and spitting meds. - January15, 2026- Other residents complaining, R1 trying to take their food and drinks. Need constant re-direction and education. - The service plan under mobility section shows the following: a. Need: One-person partial assistance, hand hold. Objective/plan: Remove safety and trip hazards. Observed gait and mobility .... b. Behavioral expression. In this section, R1 was identified as cooperative, social, talkative, with appropriate affect and mood. R2's identified behaviors, inappropriate social behaviors (e.g., sexual behaviors and grabbing food belonging to other residents) and R2's fall	A4010		

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A4010	Continued From page 7 risk were not addressed in R2's service plan. There were no revisions conducted to show changes in interventions. These findings were discussed and confirmed by E1(Regional Director of Operation) during this survey.	A4010		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Type 1 Violation Section 295.4060 Alzheimer's and Dementia Programs a) In addition to this Section, Alzheimer and dementia programs shall comply with all of the other provisions of the Act. (Section 150(a) of the Act) b) No person shall be admitted or retained in an assisted living or shared housing establishment if the establishment cannot provide or secure appropriate care, if the resident 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 150(b) of the Act) 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	A4060		

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A4060	Continued From page 8 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) e) No person shall be accepted for residency or remain in residence if the person is dangerous to self or others and the establishment would be unable to eliminate the danger through the use of appropriate treatment modalities. (Section 150(d) of the Act) 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 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,	A4060		

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A4060	Continued From page 9 caregiver stress; and v) techniques for successful communication These requirements were not met, as evidenced by: Based on interview and record review, the facility failed to: 1. Provide a safe environment for residents living with dementia. 2. Provide supervision and monitoring to R3, a resident identified to display verbal and physical aggression. 3. Identify and address R3's aggressive behaviors. 4. Develop and implement specific and individualized interventions to protect other residents from potential harm. 5. Based on interview and record review, the facility failed to provide the required 16 hours of on-the-job supervision and training for new staff. These failures resulted in R3 physically abusing multiple residents: 1. On December 6, 2025, R3 "punched" R6 in the face. R6 sustained "abrasions and swelling in the face". 2. On January 2, 2026, R3 "hit" R4 on the left side of the face and on the back. This applies to two (R4 and R6) residents physically abused by R3. This failure creates a substantial probability of severe harm to a resident or residents. This failure has the probability to affect the care and treatment of all residents in the establishment. This is for 3 (E12, E8 and E11) of 3 care givers selected.	A4060		

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A4060	Continued From page 10 The findings include: R3 moved into the community on November 10, 2025, with diagnoses to include Alzheimer/dementia, aphasia and congestive heart failure. On February 13, 2026, at 1:20 PM, E3/LPN described R3 as confused, with physical and verbal aggression, non-compliant with care and unpredictable. R3 ambulates independently though requires assistance with all of activities of daily living. R3 was described to be a wanderer with exit seeking behavior. The following incidents were found in R3's nurses notes: - On January 2, 2026, at 6:35 PM in the dining room, the activity assistant witnessed resident (R3) hitting a female resident (R4) that was sitting in the dining room. The resident hit female resident on the left side of her face and also hit the resident (R4) in the back. The incident was described to appear to be unprovoked. R3 was transported to the behavioral unit. - On December 6, 2025, at 1:45 PM, a care giver heard someone calling for help in the hallway. R3 was observed to be "throwing punches at a female resident's (R6) face". The Resident Assistant quickly ran to the scene to prevent R3 from inflicting further harm. R3 was still swinging their arms to try to hit the female resident (R6). 911 was called. R3 remained "very combative," almost hitting one of the EMTs. R3 also spat at the EMTs. R3 was restrained to remain on the stretcher and was transported to the behavioral unit. On February 20, 2026,at 2:46 PM, E6 (Director of Nursing/LPN) stated, "Yes, R6 sustained abrasion and swelling on the face." The behavioral expression service plan shows:	A4060		

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A4060	Continued From page 11 Needs: Occasional intervention to de-escalate. R3 has been noted as becoming verbally abusive towards staff. Stating, "I'm going to kill you, I'm going to shoot you." Use kind, gentle verbal support and provide distraction and the appreciation PRN to improve presence mood ... Objective and Plan: Helps me in expressing my feelings and disposition and positive voice. Help me practice conflict resolution... The physical aggression of R3 towards other residents was not identified in R3's service plan. R3's service plan was not revised and there were no specific interventions developed to minimize or prevent these incidents from recurring, and to keep other residents from the unit safe from R3. These findings were discussed and confirmed by E1 (Regional Director of Operation) during this survey. The findings include: On February 13, 2026, at 2:20 PM, review of the employee files was conducted with E1 (Regional Director of Operation). The community was unable to present evidence or documentation of the required 16 hours supervised dementia training. These are for the following staff: - E12/LPN - date of hire -May 1, 2025 - E8/Resident Assistant- date of hire- October 13, 2025 - E11/Resident Assistant - date of hire- January 22, 2026. These findings were discussed and confirmed by E1 during this survey.	A4060		
A6000	Section 295.6000 Resident Rights	A6000		

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A6000	Continued From page 12 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 were not met, as evidenced by: Based on observation, interview, and record review, the facility failed to: a. Implement a comprehensive safety approach to R2 identified to be an "elopement risk" and a resident that wanders. b. Provide adequate supervision and monitoring to residents in the unit. c. Provide a secure environment by maintaining functioning exit doors. d. Appropriately respond to a resident's alarm system [motion detector] in the resident room. These failures resulted in an incident of neglect. R2 eloped from the community on December 24, 2025. The community staff were not aware R2 was missing for 21 minutes (from 8:19 AM through 8:40 PM) until a family member found R2 outside the building without a coat. This failure has the substantial probability to affect all residents.	A6000		

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A6000	Continued From page 13 This is for one (R2) of one resident reviewed for elopement. The findings include: R2 moved into the community on December 10, 2025, with diagnoses to include dementia and dysphagia related to a history of mandibular fracture. R2's nurses notes disclose R2's difficulty with swallowing. R2 follows a liquid diet (e.g., "meals given through a 'sippy cup'"). R2's admitting nurses notes identify R2 as requiring extensive assistance with all activities of daily living. R2's admission nurses note (December 10, 2025) through current progress notes, document R2 as a "wanderer [who] ambulates throughout the community most of the day." The nursing notes dated December 11, 2025 show that R2 was exhibiting "exit seeking behavior, trying to push/open exit doors." The community reportable incident submitted to the Department read: "On December 24, 2025, at 8:45 PM, resident (R2) was found outside. Resident (R2) followed someone out the door. Resident (R2) was out with no coat." On February 18, 2026, at 9:30 AM, E2 (2nd shift LPN) explained, "It was a crazy night! I think it was the residents' Christmas party, then a lot of residents with behaviors, residents wandering around. We [staff] all know that R2 is a wanderer and at risk for elopement. I asked the Resident Assistant (E4) where R2 was. E4 stated, 'In the room, in bed.' I'm not sure what time I asked E4. There was a [behavioral] incident with one of the residents (R3), so I assisted that resident to bed myself. There was a lot of things going on that night, really. All staff were busy assisting residents. No, we didn't know R2 was missing!	A6000		

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	ASL510505	A. BUILDING: _____ B. WING _____	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAVERLY INN MEMORY CARE COMMUNITY	515 W RAND ROAD ARLINGTON HEIGHTS, IL 60004

(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
A6000	Continued From page 14	A6000		

No one was in front [near the nursing station/reception area]. We found out R2 was outside when a family member came to drop off another resident. No, we didn't know how long the residents (R2) was outside."

On February 18, 2026, at 10:56 AM, E4 (2nd shift Resident Assistant) said, "I had ten residents to put to bed. I started putting residents to bed at 8:00 PM. I put R2 first." E4 claimed that while working with other residents, R2's sensor alarm [in R2's room] went off. E4 explained, "That means the resident got out of bed. I was busy so I went and turned off the alarm. No, I didn't check on the resident (R2). I continued putting other residents to bed. No, I did not know the resident (R2) was missing."

On February 18, 2026, at 10:11 AM, E5 (Physical Plant Director) explained that during daytime, the front door is monitored by a receptionist until 7:00 PM. E5 stated, "On that day, the door by the receptionist area [to go in and out of the unit] was not secured. There was no one monitoring the door at that time. The receptionist left at 7:00 PM. We found out the next day (December 25, 2025) that the door was not completely shut. The magnet on the door was not latching. Yes, the residents can just push it, and it will open. Yes, anyone can just walk out of the unit. The door seems locked but its not completely shut."

E5 also explained that upon review of the camera (outside the building, showing a full view of the community front door), at 8:19 PM, the residents (R2) left from the front door alone, by herself. E5 said, "No, the resident (R2) didn't follow anyone. R2 was wearing pajama pants, and no coat. E5 claimed, "She (R2) never sat down on the bench [outside]. The resident (R2) was just circling

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A6000	Continued From page 15 around the front door until a car pulled in front of the building to drop off their resident (R3) and they saw her (R2) so they brought her in. That was around 8:40 PM (twenty-one minutes). The accu-weather was recorded to be below freezing (28 degrees Fahrenheit).	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: 2) Investigate and develop a written report within 14 days after the initial report. The establishment shall send the written report to the Department 24 hours after it is completed and shall maintain a copy of the written report on the premises for 12 months after the date of the report. b) A written report of the investigation conducted pursuant to subsection (a)(2) shall contain at least the following: 1) Dates, times, and description of the alleged abuse, neglect or financial exploitation. 2) Description of any injury to the	A6010		

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A6010	Continued From page 16 resident. 3) Description of any change in the resident's physical, cognitive, functional, or emotional condition. 4) Any actions taken by the licensee. 5) A list of individuals and agencies interviewed or notified by the establishment. 6) Names of witnesses to the alleged abuse, neglect, or financial exploitation; and 7) If the abuse, neglect, or financial exploitation is substantial, a description of the action to be taken by the establishment to prevent the abuse, neglect or financial exploitation from occurring in the future. These requirements were not met, as evidenced by: Based on interview and record review of the facility failed to: 1. Conduct a thorough investigation related to the elopement incident of R2. 2. Submit the final report to the Department (14 days after the incident date) to identify the possible root cause and implementation of new and specific interventions for prevention. 3. Implement the elopement policy and procedures to reevaluate the resident(s), particularly after an incident, to determine the appropriateness of residing in the community. These failures resulted in non-compliance with the required regulation in reporting and investigation of a neglect/R2's elopement incident on December 24, 2025.	A6010		

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A6010	Continued From page 17 These failures have substantial probability to place all residents' safety at risk. This failure creates a substantial probability of severe harm to a resident or residents The findings include: On December 24, 2025, at 8:45 AM, a facility reported incident was submitted to the Department regarding R2's elopement incident. On February 13, 2026, at 10:00 AM, this report was presented and read: Resident (R2) was found outside. Residents followed someone out the door. Resident was out with no coat. The community was unable to present evidence of an investigation related to R2's elopement and unable to present proof that the final report was sent to the Department. These findings were discussed and confirmed by E1 (Regional Director of Operation). On February 19, 2026, at 11:00 AM, the elopement policy and procedure reads as follows: 1. If an elopement occurs the following steps will be immediately initiated. (f) The resident will be reevaluated to determine if the resident is still appropriate for retention in the community. i. If the resident's physician deems the residents can remain in the community, the residents service plan will be adjusted, and all changes immediately implemented to prevent further development. This procedure was not implemented. On February 29, 2026, at 11:00 AM, E6 (Director of Resident Services/LPN) acknowledged that R2 was assessed for elopement only upon	A6010		

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A6010	Continued From page 18 admission/initial, dated December 1, 2025, and no further assessments were conducted after the elopement on December 24, 2025.	A6010		