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	ASL510266	A. BUILDING: _____ B. WING _____	01/08/2026

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A 000	Initial Comment Annual Licensure Survey- Violations cited: 295.2000 a)c)1) 295.2040 a)c)e)h 295.2050 a)b 295.3030 a)b)c)d 295.4000 a)b)c 295.4010 a)b)1)c)d)e)g)1)c 295.6000 a)1)2 Complaint Investigation #25412776/IL199331 Violations cited: 295.2000 a)c)1) 295.2050 a)b 295.4000 a)b)c 295.4010 a)b)1)c)d)e)g)1)c 295.6000 a)1)2	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) c) A person shall not be accepted for residency if: 1) The person poses a serious threat to himself	A2000		

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A2000	Continued From page 1 or herself or to others; Based on interview and record review, the Establishment failed to ensure that a resident continued to meet residency requirements once a significant change of condition presented with increased physical aggression, increased wandering and inappropriate behaviors. (R2) These failures resulted in harm to another resident (R1) as well as harm to the staff and creates a substantial probability of severe harm to a resident or residents. Findings Include: The Establishment is Licensed for Assisted Living. R2's Semi Annual Evaluation, dated 7/8/2025 documents a cognitive impairment and has a diagnosis of Dementia with behaviors identified as becoming aggressive with the staff, over anxious and some times non compliant. R2's Summary of assessment documents, "Resident is alert and oriented to self and staff but disoriented to place and thing. Resident has episodes of behaviors where he will become aggressive with staff and non compliant with care." R2's Nurses note, dated 10/15/25 at 9:10 AM documents that R2 was sent out to local hospital for an increase in behavior and aggressive actions towards staff on 10/12/2025. R2's Nurses note, dated 10/18/2025 at 8:11 AM documents that R2 was aggressive, going into other residents room, throwing walker at staff. R2's POA notified and came to de escalate the behavior.	A2000		

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A2000	Continued From page 2	A2000		

R2's Nurses note, dated 10/19/25 at at 10:57 PM documents that R2 was having behaviors of taking off his clothes, shoes, socks, removed tablecloth and was pouring pepper all over the table, refusing to stay in his room, clapping and barking like a dog. R2's note documents R2's POA was notified and came to de escalate the behavior.

R2's Behavior Note, dated 10/23/25 at 9:00 AM documents that the resident was aggressive non compliant, incontinent of bowel. 08:11 AM, staff returned call saying that resident used fist and pushed left side of head on other staff. The note further documents that R2 grabbed staff neck and pushed her down toward the floor and grabbed her right forearm and twisted it behind her back.

R1's Incident Report, dated 11/20/2025 at 6:21 AM documents, "Resident was observed in living area, sitting on rollator, stating she had fallen. Reported severe back pain. Resident stated she had a fall. E4/Personal Care Assistant, assisted resident from floor when another resident was attempting to assist her from floor. Reports that a male resident had entered her doorway, was "trying to tell me something" but the resident was unable to understand him. She then attempted to "get him out of my room, "shooing him," to which he "shooed back" and I, "fell backward." Denies having rollator near her during incident. Denies H/S (head strike) V/S (vital signs) obtained. POA and PCP notified. Sent for eval related to pain. Res (Resident) was slurring her words, and not speaking cohesively following incident, which is abnormal for resident." Resident Description: "says (R2) was coming down the hall she was trying to get him to go the other way and fell

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A2000	Continued From page 3	A2000		

backwards."

R1's Incident note, dated 11/20/2025 at 6:36 AM, documents, "Staff texted me informing me that resident in D3 was on the floor in the room. In route to the community his nurse reported to POA concerning incident. Upon arriving to community to assess resident and transported to my office on the rollator. (Local Emergency Medical Service) was called at 7:34 AM to transport to (Local Hospital) for eval and treat."

R1's Nurse's Note, dated 11/20/25 at 3:11 PM, documents, "Called ER (emergency room) for update.-see previous note. Resident is being admitted for lumbar fracture and pain management, also has a mild UTI-treated with (ATB) in ER. Neurosurgery to consult tomorrow with possible vertebroplasty. Daughter aware of plan. Will continue to follow and update as necessary."

R1's Imaging x-ray and CT scan dated 11/20/2025 documents, Impression: Burst Fracture of L5.

R2's Medical Record note, titled "other" on 11/20/2025 at 12:10 PM documents, "Meeting held with Admin (Administration), DON, and POA. Resident had episode of wandering in another resident's room, and increased episodes of wandering noted following incident occurring 10/23/25. Discussed care plan and progression of Dementia. Admin. and DON discussed changes in behavior with PCP and received orders for Memory Care Admission."

Documentation supports that R2 was discharged to a Memory Care Setting on 11/30/2025.

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A2000	Continued From page 4 On 1/6/2025 at 9:00 AM, E2/Wellness Director confirmed that R2 had a change in condition in October when he began with increased aggression towards staff, wandering and inappropriate behaviors.	A2000		
A2040	Section 295.2040 Disaster Preparedness This Regulation is not met as evidenced by: Type 1 Violation Section 295.2040 Disaster Preparedness a) For the purpose of this Section, "disaster" means an occurrence, as a result of a natural force or mechanical failure such as water, wind or fire, or a lack of essential resources such as electrical power, that poses a threat to the safety and welfare of residents, personnel, and others present in the establishment. c) At least six drills shall be conducted per year on a bimonthly basis. At least two of the drills shall be conducted during the night when residents are sleeping. All drills shall be held under varied conditions to: e) Drills shall include residents, establishment personnel, and other persons in the establishment. h) A written evaluation of each drill shall be submitted to the establishment manager and shall be maintained for one year from the date of the drill. The evaluation shall include the date and time of the drill, names of employees participating in the drill, and identification of any residents who received assistance for evacuation. Based on interview and record review, the Establishment failed to ensure:	A2040		

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A2040	Continued From page 5 1) Disaster drills were completed during varying times, 2) The drills included names of the residents participating in the drills to include what assistance residents received during the drill, and 3) Ensure the drills were conducted on the night shift and performed with one staff only as identified on the staffing schedule. These failures crest a substantial probability of severe harm or death to the residents residing in the Establishment. Findings include: The Establishment's resident roster, dated 1/6/2026 documents 12 residents residing in the facility. (R3-R14) The Establishment's staffing schedule documents 1-2/PCA (Personal Care Assistants) and administration and Nurse on day shift Monday - Friday, 1-2 PCA's on evening shifts and 1 PCA for Night Shift. Weekend Schedule with 2 PCA's on days/evenings and 1 PCA on night shift. Upon review of the Establishment's Fire Drills, it is noted that the Establishment is conducting disaster drills monthly on all three shifts, however further review of the drills it is noted that all the drills on the night shifts 3/20/25,6/1/25,7/1/25 and 10/27/25 are all completed at 11:00 PM and included two staff members participation in the drills and does not document that the drills were completed with one staff member as per the schedule documents only one staff on duty on the night shift. Further review of the monthly drills, it is also noted that the names of the personnel participating are identified as participating however there are no specific residents listed as	A2040		

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A2040	Continued From page 6 participating in the drills that identify what assistance the residents received during the drill. On 1/7/2026 at 1:40 PM, E 1/Administrator confirmed that the disaster drills were not completed during varying times on the night shift, all done at 11:00 PM with two staff participation when only staff is scheduled nightly. E1 also confirmed that there were no residents identified on any the drills to identify what assistance the residents required during the drills. E 1 stated that there are 12 residents residing at the facility with 11 of the 12 requiring verbal cueing and 1 resident that requires physical assist for transfer and mobility.	A2040		
A2050	Section 295.2050 Incident and Accident Reporting This Regulation is not met as evidenced by: Type 2 Violation Section 295.2050 Incident and Accident Reporting a) An establishment shall report to the Department any serious incident or accident. For the purposes of this Section, "serious" means any incident or accident that causes physical or emotional harm or injury to a resident. A change in an individual's (resident's) condition that is due to health or medical decline is not a reportable incident or accident. b)The report shall be made by contacting the Department of Public Health Division of Assisted Living via email at DPH.LTCAL@illinois.gov or as requested by the Department within 24 hours after the occurrence of the incident or accident.	A2050		

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A2050	Continued From page 7 Based on interview and record review, the Establishment failed to ensure that a resident's fall, requiring hospital treatment for a lumbar fracture was reported to IDPH per regulations. (R1) This failure has the substantial probability of harm to the residents residing at the Establishment by limiting IDPH notifications of incidents that may require additional investigation. Finding include: The Establishment's resident roster, dated 1/6/2026 identifies 12 residents that reside in the facility. (R3-R14) R1's Incident note, dated 11/20/2025 at 6:36 AM, documents, "Staff texed me informing me that resident in D3 was on the floor in the room. In route to the community his nurse reported to POA concerning incident. Upon arriving to community to assess resident and transported to my office on the rollator. (Local Emergency Medical Service) was called at 7:34 AM to transport to (Local Hospital) for eval and treat." R1's Nurse's Note, dated 11/20/25 at 3:11 PM, documents, "Called ER (emergency room) for update.-see previous note. Resident is being admitted for lumbar fracture and pain management, also has a mild UTI-treated with (ATB) in ER. Neurosurgery to consult tomorrow with possible vertebroplasty. Daughter aware of plan. Will continue to follow and update as necessary." R1's Imaging x-ray and CT scan dated 11/20/2025 documents, Impression: Burst Fracture of L5.	A2050		

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A2050	Continued From page 8 On 1/7/2026 at 1:35 PM, E1/Administrator and E2/Wellness Director confirmed that R1's fall resulting in hospitalization for a lumbar fracture was not reported to IDPH as required.	A2050		
A3030	Section 295.3030 Initial Health Eval for Dir Care and FS empl This Regulation is not met as evidenced by: Violation Type 3 Section 295.3030 Initial Health Evaluation for Direct Care and Food Service Employees a) Each direct care and food service employee shall have an initial health evaluation, which shall be used to ensure that employees are not placed in positions that would pose undue risk of infection to themselves, other employees, residents, or visitors. b) The initial health evaluation shall be conducted not more than 30 days prior to and no later than 30 days after the employee's initial employment in the establishment. c) The initial health evaluation shall include the employee's immunization status. d) The initial health evaluation shall include a physical examination. The examination shall include a determination that the employee appears to be physically able to perform the job functions that the establishment intends to assign to the employee. Based on interview and record review, the Establishment failed to ensure direct care staff received an initial health evaluation no later that 30 days after initial employment. (E4)	A3030		

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A3030	Continued From page 9 Review of the Establishment's staffing roster, it is noted that E4/PCA(Personal Care Assistant) was hired on 4/3/2025. Review of E4's Personnel file, there is no evidence within the record of an initial health evaluation being completed. On 1/7/2026 at 1:30 PM, E1/Administrator and E2/Wellness Nurse confirmed that there was not an initial health evaluation within E4's personnel file.	A3030		
A4000	Section 295.4000 Physician/s Assessment This Regulation is not met as evidenced by: Type 2 Violation Section 295.4000 Physician's Assessment a) No more than 120 days prior to admission of a resident to any establishment, a comprehensive assessment that includes an evaluation of the prospective resident's physical, cognitive, and psychosocial condition shall be completed by a physician. The physician's assessment shall include documentation of the presence or the absence of tuberculosis infection in accordance with the Control of Tuberculosis Code. At the time of admission, the physician's assessment must reflect the resident's current condition. b) At least annually, once a resident has moved into the establishment, a comprehensive assessment shall be completed by a physician. c) A physician's assessment shall be completed by a physician upon identification of a significant change in the resident's condition.	A4000		

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A4000	Continued From page 10 Based on interview and record review, the Establishment failed to ensure that Physician Certifications were completed prior to admission (R3), completed with a significant change in condition (R2) and annually (R1). The facility also failed to ensure that the Physician Assessments were completed and signed by a Physician (R4). These failures have the substantial probability of harm to the residents residing in the facility related to ensuring that residents are appropriate for Assisted Living. Findings include: The Establishment's resident roster, dated 1/6/2026 documents 12 residents residing in the facility. (R3-R14) R3's Medical Record documents an admission date of 12/16/2024. Further review of R3's record, there is no evidence of a Physician Certification being completed upon admission or annually. R2's Medical Record documents a significant change in condition beginning in October 2025 as follows: R2's Nurses note, dated 10/15/25 at 9:10 AM documents that R2 was sent out to local hospital for an increase in behavior and aggressive actions towards staff on 10/12/2025. R2's Nurses note, dated 10/18/2025 at 8:11 AM documents that R2 was aggressive, going into other residents room, throwing walker at staff. R2's POA notified and came to de escalate the behavior. R2's Nurses note, dated 10/19/25 at at 10:57 PM	A4000		

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documents that R2 was having behaviors of taking off his clothes, shoes, socks, removed tablecloth and was pouring pepper all over the table, refusing to stay in his room, clapping and barking like a dog. R2's note documents R2's POA was notified and came to de escalate the behavior.

R2's Behavior Note, dated 10/23/25 at 9:00 AM documents that the resident was aggressive non compliant, incontinent of bowel. 08:11 AM, staff returned call saying that resident used fist and pushed left side of head on other staff. The note further documents that R2 grabbed staff neck and pushed her down toward the floor and grabbed her right forearm and twisted it behind her back.

R2's most current Physician Certification is dated 6/15/2025 and identified as annual. There is no evidence that a significant change of condition Physician Certification was completed.

R1's Medical Record documents an admission date of 12/14/23. R1's most current Physician Certification is dated 3/18/24.

R4's Physician Certification is identified as a significant charge of condition and is dated 8/19/2025 and is completed and signed by Nurse Practitioner, not the Physician.

On 1/7/2025 at 1:35 PM, E1/Administrator and E2/Director of Wellness confined that there was no reproducible evidence of R3 having a Physician Certification completed before admission. E1 and E2 confirmed that there was no significant change of condition Physician Certification completed on R2 once his behaviors changed. E1 and E2 confirmed that R1's

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A4000	Continued From page 12 Physician Certification was not done annually and that R4's Physician Certification was signed by the Nurse Practitioner, not the Physician.	A4000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 1 Violation Section 295.4010 Service Plan 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. b) The service plan shall be developed by: 1) The resident, resident's representative or any individual requested by the resident; c) The service plan shall be signed and dated by all individuals involved in its development. 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 resident's physical, cognitive, or functional condition (see Section 295.4000). g) Service plans shall address:	A4010		

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A4010	Continued From page 13 1) The level of service the resident is receiving, including: C) special accommodations for the resident; Based on interview and record review, the Establishment failed to ensure that the service plan was revised to include the resident's change of cognition, increased aggressive behaviors, increased wandering behaviors with interventions to decrease these behaviors (R2) and failed to ensure that the service plans were signed by the resident/resident's representative (R1-R4) These failures create a substantial probability of severe harm to a resident or residents that reside in the facility. Findings include: The Establishment's resident roster, dated 1/6/2026 documents 12 residents residing in the facility. (R3-R14) R2's Nurses note, dated 10/15/25 at 9:10 AM documents that R2 was sent out to local hospital for an increase in behavior and aggressive actions towards staff on 10/12/2025. R2's Nurses note, dated 10/18/2025 at 8:11 AM documents that R2 was aggressive, going into other residents room, throwing walker at staff. R2's POA notified and came to de escalate the behavior. R2's Nurses note, dated 10/19/25 at at 10:57 PM documents that R2 was having behaviors of taking off his clothes, shoes, socks, removed tablecloth and was pouring pepper all over the table, refusing to stay in his room, clapping and barking like a dog. R2's note documents R2's POA was notified and came to de escalate the	A4010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510266	A. BUILDING: _____ B. WING _____	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY GARDENS	370 FOUNTAINS PARKWAY FAIRVIEW HEIGHTS, IL 62208

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A4010	Continued From page 14 behavior. R2's Behavior Note, dated 10/23/25 at 9:00 AM documents that the resident was aggressive non compliant, incontinent of bowel. 08:11 AM, staff returned call saying that resident used fist and pushed left side of head on other staff. The note further documents that R2 grabbed staff neck and pushed her down toward the floor and grabbed her right forearm and twisted it behind her back. Review of R2's Service Plan, dated 8/14/2025 does not identify any behaviors of wandering or physical aggression to include any interventions for such behaviors. R2's Service Plan was only signed by the Nurse. R1's Service Plan, dated 1/24/25 is only signed by the Nurse. R2's Service Plan, dated 12/20/2025 is not signed by R2 or R2's representative. R4's Service Plan, dated 5/10/25 is not signed by R4 or R4's representative. On 1/7/2026 at 1:35 PM, E1/Administrator and E2/Wellness Director confirmed that R2's Service Plan was not updated/revised to include his inappropriate behaviors, aggressive behaviors and wandering behaviors. E1 and E2 also confirmed that R1-R4's service plans were not signed by the residents or resident representatives.	A4010		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by:	A6000		

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A6000	Continued From page 15 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: 1) The right to live in an environment that promotes and supports each resident's dignity, individuality, independence, self-determination, privacy, and choice and to be treated with consideration and respect; 2) The right to respect for bodily privacy and dignity at all times, especially during care and treatment; Based on interview and record review, the Establishment failed to ensure that appropriate safeguards were in place to prevent residents identified with having increased aggressive and wandering behaviors from wandering into another residents room resulting in a resident falling and sustaining a lumbar fracture. (R1 and R2) These failures resulted in harm to R1 and creates the substantil probability of severe harm to a resident or residents residing in the Establishment. Findings include: The Establishments resident roster documents 12 residents residing in the Establishment. (R3-R14) R2's Semi Annual Evaluation, dated 7/8/2025 documents a cognitive impairment and has a diagnosis of Dementia with behaviors identified as becoming aggressive with the staff, over anxious and some times non compliant. R2's	A6000		

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A6000	Continued From page 16	A6000		

Summary of assessment documents, "Resident is alert and oriented to self and staff but disoriented to place and thing. Resident has episodes of behaviors where he will become aggressive with staff and non compliant with care."

R2's Nurses note, dated 10/15/25 at 9:10 AM documents that R2 was sent out to local hospital for an increase in behavior and aggressive actions towards staff on 10/12/2025.

R2's Nurses note, dated 10/18/2025 at 8:11 AM documents that R2 was aggressive, going into other residents room, throwing walker at staff. R2's POA notified and came to de escalate the behavior.

R2's Nurses note, dated 10/19/25 at at 10:57 PM documents that R2 was having behaviors of taking off his clothes, shoes, socks, removed tablecloth and was pouring pepper all over the table, refusing to stay in his room, clapping and barking like a dog. R2's note documents R2's POA was notified and came to de escalate the behavior.

R2's Behavior Note, dated 10/23/25 at 9:00 AM documents that the resident was aggressive non compliant, incontinent of bowel. 08:11 AM, staff returned call saying that resident used fist and pushed left side of head on other staff. The note further documents that R2 grabbed staff neck and pushed her down toward the floor and grabbed her right forearm and twisted it behind her back.

Review of R2's Service Plan, dated 8/14/2025 does not identify any behaviors of wandering or physical aggression to include any interventions

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A6000	Continued From page 17	A6000		

for such behaviors.

R1's Incident Report, dated 11/20/2025 at 6:21 AM documents, "Resident was observed in living area, sitting on rollator, stating she had fallen. Reported severe back pain. Resident stated she had a fall. E4/Personal Care Assistant, assisted resident from floor when another resident was attempting to assist her from floor. Reports that a male resident had entered her doorway, was "trying to tell me something" but the resident was unable to understand him. She then attempted to "get him out of my room, "shooing him," to which he "shooed back" and I, "fell backward." Denies having rollator near her during incident. Denies H/S (head strike) V/S (vital signs) obtained. POA and PCP notified. Sent for eval related to pain. Res (Resident) was slurring her words, and not speaking cohesively following incident, which is abnormal for resident." Resident Description: "says (R2) was coming down the hall she was trying to get him to go the other way and fell backwards."

R1's Incident note, dated 11/20/2025 at 6:36 AM, documents, "Staff texted me informing me that resident in D3 was on the floor in the room. In route to the community his nurse reported to POA concerning incident. Upon arriving to community to assess resident and transported to my office on the rollator. (Local Emergency Medical Service) was called at 7:34 AM to transport to (Local Hospital) for eval and treat."

R1's Nurse's Note, dated 11/20/25 at 3:11 PM, documents, "Called ER (emergency room) for update.-see previous note. Resident is being admitted for lumbar fracture and pain management, also has a mild UTI-treated with (ATB) in ER. Neurosurgery to consult tomorrow

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A6000	Continued From page 18 with possible vertebroplasty. Daughter aware of plan. Will continue to follow and update as necessary." R1's Imaging x-ray and CT scan dated 11/20/2025 documents, Impression: Burst Fracture of L5. On 1/6/2025 at 9:00 AM, E2/Wellness Director confirmed that R2 had a change in condition in October when he began with increased aggression towards staff, wandering and inappropriate behaviors. On 1/7/2026 at 1:35 PM, E1/Administrator and E2/Wellness Director confirmed that R2's Service Plan was not updated/revised to include his inappropriate behaviors, aggressive behaviors and wandering behaviors or interventions to deescalate the behaviors.	A6000		