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	ASL510084	A. BUILDING: _____ B. WING _____	04/17/2026

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LISLE CREEK ESTATES	1700 ROBIN LN LISLE, IL 60532

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A 000	Initial Comment This is a Change of Ownership survey in conjunction with two complaints CO#2672547/IL00200455 and CO#2672339/IL00200376 CHOW (Change of Ownership) Violations: Section 295.2040) Disaster Preparedness g) Section 295.3020) Employee Orientation and Ongoing Training a) 1-6) b) 1-6) d) 1-5) Section 295.4010) Service Plan d) g) 1) A) C) 2) 3) h) Section 295.4050) Tuberculin Skin Test Procedures Complaint Investigation Survey Violations: CO#2672339/IL00200376 - Substantiated. Section 295.2050) Incident and Accident Reporting a) b) Section 295.4010) Service Plan d) Section: 295.6000) Resident Righs a) CO#2672547/IL00200455 - Unsubstantiated. No deficiencies cited.	A 000		
A2040	Section 295.2040 Disaster Preparedness This Regulation is not met as evidenced by: Type 1 Violation Section 295.2040) Disaster Preparedness g) Drills shall involve the actual evacuation of residents to an assembly point as specified in the emergency plan and shall provide residents with experience using various means of escape. If an establishment has an evacuation capability classification of impractical, those residents who	A2040		

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A2040	Continued From page 1 cannot meaningfully assist in their own evacuation or who have special health problems shall not be required to participate in the drill; however, other requirements of the Life Safety Code will apply. This requirement is not met as evidenced by: Based on record review, and interview, the establishment failed to ensure staff and residents evacuated the establishment during fire drills. This failure has creates a substantial probability of severe harm to all the residents. Findings include: Fire drills were reviewed with E5 (Director of Plant Operations II) on 4/10/26 at 1:07 PM. The fire drills indicated below contained, "Number of residents Evacuated: 0/ shelter in place". 1/4/26 - 1st shift (7:00 AM). 2/23/26 - 2nd shift (3:00 PM). 3/4/26 - 3rd shift (11:00 PM). 4/9/26 - 1st shift (9:00 AM). During an interview with E5 (Director of Plant Operations II) on 4/10/26 at 1:07 PM, E5 stated staff and assisted living residents "relocate, shelter in place to the central area, atrium on the 5th floor, I show them where the stairways are ..." During the same interview, E5 confirmed that staff and residents do not evacuate the establishment during fire drills.	A2040		
A2050	Section 295.2050 Incident and Accident Reporting	A2050		

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A2050	Continued From page 2 This Regulation is not met as evidenced by: Violation Section 295.2050) Incident and Accident Reporting a) b) 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. This requirement is not met as evidenced by: Based on record review, and interview, the establishment failed to submit an incident report to the Illinois Department of Public Health (IDPH) within the required time frame for one of five (R1) resident records reviewed. This failure has the probability to affect all residents. Findings include: An entrance interview was conducted with E1 (Executive Director), E2 (Director of Health and Wellness), and E3 (Nurse Manager AL I) on 4/10/26 at 9:44 AM. A request was made to review the establishment's reportables and incident reports from January 2026 to the present. On 4/10/26 approximately 11:30 AM, a report of	A2050		

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A2050	Continued From page 3 the establishment's incidents and reportables were presented and reviewed. A report of the establishment's incidents contained the name of R1, "Incident Date 2/21/2026. Incident Close Date 3/24/2026. Type/Nature of Incident Witnessed Fall". However, the reportables lacked documentation of R1's incident. R1's record was reviewed on 4/14/26 at 9:50 AM and included, R2 moved into the establishment on 10/4/19. R1 had multiple diagnoses including, but not limited to Typical Atrial Flutter, Essential Primary Hypertension, Anemia in Chronic Kidney Disease, and Type 2 Diabetes Mellitus. The Service Plan dated 9/16/2025 contained, "Resident unable to dress bottom half 2/9/26"... Resident requires X2 assistance for transfers. Resident has trouble standing + bearing weight 2/18/26 ..." The establishment failed to notify IDPH within 24 hours of the incident identified above. The above findings were reviewed with R2 (Director of Health and Wellness) on 4/10/26 approximately at 1:20 PM, and 4/14/26 at 12:23 PM.	A2050		
A3020	Section 295.3020 Employee Orientation and Ongoing Training This Regulation is not met as evidenced by: Type 3 Violation Section 295.3020 Employee Orientation and Ongoing Training a1-6, b 1-6, d 1-5	A3020		

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A3020	Continued From page 4 a) Each new employee shall complete orientation within 10 days after the starting date of employment that includes: 1) The establishment's philosophy and goals. 2) Promotion of resident dignity, independence, self-determination, privacy, choice, and resident rights. 3) Confidentiality of resident records and resident information. 4) Hygiene and infection control. 5) Abuse and neglect prevention and reporting requirements; and 6) Disaster procedures. b) Each employee shall also complete orientation within 30 days after the starting date of employment that includes: 1) Orientation to the characteristics and needs of the establishment's residents. 2) The significance and location of resident service plans. 3) Internal establishment requirements and the establishment's policies and procedures. 4) The employee's job responsibilities and limitations. 5) CPR and emergency procedures for medical events, if applicable; and 6) Training in assistance with activities of daily living appropriate to the job. d) All training shall be documented with: 1) Date. 2) Starting and ending time. 3) Instructors and their qualifications. 4) Short description of content; and 5) Staff member's written signature. These requirements were not met, as evidenced by: Based on interview and record review, the facility failed to provide orientation and training to all	A3020		

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A3020	Continued From page 5 employees upon the change of ownership on January 1, 2026. This failure has the substantial probability of affecting all residents in the establishment. This applies to all of the employees in the establishment. The findings include: On April 10, 2026, at 3:19 PM, an initial review of employee orientations was conducted with E14 (Human Resource Director). Orientation documentations were not found in any individual files reviewed (E2,3, 13, 10, 12, 11 and E9). E14 expressed "It could be on the electronic file." On April 14, 2026, at 2:00 PM, E14 sated, "I cannot find any orientation documentation for any of the staff."	A3020		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 1 Violation Section 295.4010 Service Plan - REPEAT VIOLATION a, d, e, g (1)A, C 2- 3, h 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	A4010		

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A4010	Continued From page 6 establishment shall respect and accept the residents' 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 residents receive, including: A) assistance with activities of daily living. C) accommodation for the residents. 2) The amount, type, and frequency of health-related services needed by the residents. 3) Staff responsible for the provisions of the service plan. h) The service plan shall include all support services provided or arranged for by the establishment. This requirement is not met as evidenced by: Based on interview and record review, the facility failed to: 1. Ensure staff followed the Service Plan regarding safe transfer for R1. 2. Implement a preventative plan of care to address the possible development of skin alteration(s) for residents identified as high risk for and with history of healed pressure injuries. 3. Conduct a revision and/or update the service plan to include instructions for providing personal care, and to address the development of a Stage 2 pressure injury localized to R3's buttocks.	A4010		

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A4010	Continued From page 7 4. Implement interventions based on the identified needs of the residents to promote healing and minimize discomfort. 5. Monitor and document the progression of R3's wound. 6. Provide complete and thorough incontinence care to R3. This unsafe transfer resulted in R1 sustaining a major injury on 2/21/2026, R1 was diagnosed with ankle fracture. R3 acquiring an avoidable Stage 2 pressure injury localized to the buttocks. This failure creates a substantial probability of harm to a resident or residents. This failure has the substantial probability of affecting all residents in the establishment. This applies to one resident that sustained a major injury/anke fracture (R1), and one resident reviewed with a facility-acquired pressure injury (R3). Findings include: 1. On 4/10/26 approximately 11:30 AM, the establishment's incident report was reviewed and contained R1's name with an incident date of 2/21/2026 and identified as a "Witnessed Fall". Interview with E2 (Director of Health and Wellness) on 4/10/26, approximately at 1:20 PM. E2 stated, E4 was present during the fall on 2/21/26, 911 was called and R1 was transported to the emergency room. R1 had sustained an ankle fracture and no longer resides in this assisted living establishment, now reside in shelter care. Shelter Care provides additional assistance with transfers and/or general activities of daily living. R1's record was reviewed on 4/14/26 at 9:50 AM.	A4010		

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A4010	Continued From page 8 The record contained R1's Service Plan dated 9/16/2025, signed by a registered nurse and included, " ... Resident unable to dress bottom half 2/9/26"... Resident requires X2 assistance for transfers. Resident has trouble standing + bearing weight 2/18/26 ... W/C (wheelchair) is primary mode of locomotion on and off the unit ... Resident requires assistance of two staff member transfer". Interview with E4 (Care Associate [Assisted Living] AL) on 4/10/26 at 2:05 PM. E4 (Care Associate AL) stated she was present during R1's fall on 2/21/26 at 9:50 AM. E4 stated, during the morning of 2/21/26, R1 called for assistance to be bathed and dressed. R1 had stated she wanted to "sleep the whole day" and complained of being "weak". E4 stated she provided a sponge bath in bed, put R1's legs through the pant legs, E4 was standing on R1's left side, and had R1 stand up holding onto the front of a wheelchair, as E4 pulled up R1's pants. As E4 was pulling up R1's pants, R1's left leg gave out , "She slid and I catched her. She cannot stand up." This writer asked, how does R1 ambulate? E4 responded, "She does not walk ..." E4 stated, the nurse provided instructions for the RAs (Resident Care Associates) to use the pole in R1's apartment to dress R1 because her legs are weak and R1 is unable to stand, but on 2/21/26, R1 wanted everything done in bed. E4 failed to comply with instructions in R1's Service Plan that required X2 (2 people) assistance for transferring, and/or call for additional assistance to dress R1 because R1 had stated she was "weak" the morning of 2/21/26. As of 4/14/26, R1's Service Plan lacked documentation that staff should use the pole in R1's apartment to dress R1.	A4010		

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A4010	Continued From page 9 The above findings were reviewed with E2 (Director of Health and Wellness) on 4/10/26 approximately at 1:20 PM, 4/14/26 at 12:23 PM. 2. R3 moved into the establishment on October 3, 2025, with diagnoses to include malnutrition, hypertension, orthostatic hypotension, and atrial fibrillation. On April 14, 2026, at 11:57 AM, E2 (Health and Wellness Director/LPN) described R3 as cognitively intact and able to ambulate with a walker, but requiring hands-on assistance from staff members and assistance with bathing. E2 also identified R3 with a Stage 2 pressure injury in the inner buttocks, acquired in the establishment. On January 20, 2026, R3's nurse's notes initially identified a Stage 2 wound on R3's right buttocks. The second and final nurse's notes regarding this wound was documented on March 2, 2026, described as, an "open area on the inner butt." There was no further documentation on the progress or status of the wound. The establishment was unable to provide any evidence of a comprehensive initial assessment or any ongoing clinical wound assessment. On April 14, 2026, at 2:20 PM, E2 presented the following home health wound assessments: 1. March 19, 2026: Pressure injury to the right inner buttocks, measuring 1.2 cm length X 2.0 cm width X 0.1 cm depth. a. E2 stated, "This is a new pressure injury [identified on March 19, 2026]." E2 was unuse if this was the same pressure injury noted on January 20, 2026, or a healed wound that	A4010		

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A4010	Continued From page 10 reopened. 2. April 13, 2026: The wound was cleansed, patted dry, and cream and a sacral dressing was applied. a. No wound was assessment documented. On April 14, 2026, at 1:00 PM, E2 stated, "It's hard to answer how R3 developed the wound because R3 ambulates but requires assistance using the bathroom. Maybe R3 needed help with incontinence care." On April 14, 2026, at 2:18PM, a skin assessment was conducted with E2. R3 was in the room sitting in a recliner. R3 was alert and oriented, ambulates with a walker. R3 stated, "Yes, I am aware I have a bedsore on my behind. Yes, it's uncomfortable and at times it hurts! Maybe it's a combination of me sitting too much and that they do not clean my behind well." On skin assessment, a Stage 2 pressure injury localized to the right buttocks, approximately 1.0 x 1.0 cm in size, and two Stage 1 pressure injuries localized to the right and left buttocks, both approximately 3.0 x 3.0 cm. The establishment did not have a measuring tool to obtain exact measurements of the wounds. R3's Stage 2 pressure injury localized to the right inner buttock was not addressed in R3's service plan dated March 15, 2026. This finding was discussed and confirmed by E2 on April 14, 2026.	A4010		
A4050	Seciton 295.4050 Tuberculin Skin Test Procedures	A4050		

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A4050	Continued From page 11 This Regulation is not met as evidenced by: Type 2 Violation Section 295.4050 Tuberculin Skin Test Procedures Tuberculin skin tests for employees and residents shall be conducted in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696). These requirements were not met, as evidenced by: Based on interview and record review, the facility failed to perform tuberculosis screening on new staff and conducted a routine TB screening. This has the potential to affect the health and wellness of the immunocompromised residents in the establishment. This failure has the substantial probability of harm affecting all residents in the establishment. This applies to five of seven employees (E9, 11, 12, 10 and E3). The findings include: On April 10, 2026, at 2:50 PM, employee tuberculosis testing was reviewed with E14 (Human Resources Coordinator). The following employees have missing/incomplete testing: 1. E9 (Care Associate)- hired on November 4, 2025- no skin testing done. 2nd step Mantoux missing on the following staff: 2. E11(Cook)- hired on February 6, 2026. 3. E12 (Housekeeping)- date of hire- April 6, 2026. 4. E10 (CNA)- hire date March 9, 2026. No routine TB screening on: 1. E3 (LPN)- hired date May 12, 2023.	A4050		

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A6000	Continued From page 12	A6000		
A6000	Section 295.6000 Resident Rights	A6000		

This Regulation is not met as evidenced by:
Type 2 violation

Section 295.6000 Resident Rights a) 1)
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;

These requirements are not met as evidenced by:

Based on interview, record review, and observation, the establishment failed to ensure a resident was treated with respect, ensuring that care was provided in a safe manner. This was found in one of five (R1) resident records reviewed. This failure creates a substantial probability of harm to residents.

Findings include:

Interview with E4 (Care Associate AL) on 4/10/26 at 2:05 PM. E4 stated she was present during R1's fall on 2/21/26 at 9:50 AM. E4 stated that during the morning of 2/21/26, R1 had verbalized

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A6000	Continued From page 13	A6000		

she was weak and wanted to sleep the whole day but requested to be bathed and dressed. E4 stated she bathed R1 in bed, applied her upper clothing, slid her pants onto R1's lower legs, "She stood up so I could pull up her pants and she was holding to the front of the wheelchair (locked) ...R1 was holding the front of wheelchair." As E4 was pulling up the resident's pants, R1's legs gave out. E4 stated, R1 does not walk. E4 stated, she had received previous instructions from the nurse to use the "pole" in R1's her apartment. R1 would hold onto the pole when getting dressed. E4 stated, on 2/21/26 the pole was not used, instead she had R1 stand holding onto the wheelchair. E4 stated, " ...As she was sliding down, I moved her leg it was bending ..."

R1's record was reviewed on 4/14/26 at 9:50 AM. The record contained the Service Plan dated 9/16/2025 that included, " ... Resident unable to dress bottom half 2/9/26"... Resident has trouble standing + bearing weight ... Resident requires assistance of two staff member transfer".

Interview with E2 (Director of Health and Wellness) on 4/10/26, approximately at 1:20 PM. E2 stated after R1's fall on 2/21/26, 911 was called and R1 was transported to the emergency room. R1 had sustained an ankle fracture, and no longer resides in this assisted living establishment, currently in shelter care. This writer asked, why did the E4 attempt to dress R1 without the assistance of another care associate? E2 responded, "we considered that to be an improper transfer, she should've had a 2nd person.

The establishment failed to ensure R1 lived in an environment that promote safe resident care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510084	A. BUILDING: _____ B. WING _____	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LISLE CREEK ESTATES	1700 ROBIN LN LISLE, IL 60532

(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 The above findings were reviewed with R2 (Director of Health and Wellness) on 4/10/26 approximately at 1:20 PM, and 4/14/26 at 12:23 PM.	A6000		