STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510114	A. BUILDING: _____ B. WING _____	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENDALE OF ALGONQUIN	2001 WEST ALGONQUIN RD ALGONQUIN, IL 60102

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comment Annual Survey and IL00199982 conducted 3/2/2026-3/3/2026. IL00199982: No Violations Annual: REPEAT VIOLATION 295.2040a)b)2)5)e)g)h) 295.3020a)1-6)b)1-6)d)1-5) 295.4000a)b) 295.4010c)d)e)f)g)1)B)2)h) REPEAT VIOLATION 295.4060i)1)B)2)A)i-v)B)i-v)C)i-x) 295.8000a)1)	A 000		
A2040	Section 295.2040 Disaster Preparedness This Regulation is not met as evidenced by: GENERAL REPEAT 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. b) Each establishment shall: 2) Instruct all personnel employed on the premises in the use of fire extinguishers.	A2040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510114	A. BUILDING: _____ B. WING _____	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENDALE OF ALGONQUIN	2001 WEST ALGONQUIN RD ALGONQUIN, IL 60102

(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
A2040	Continued From page 1 5) Orient each resident to the emergency and evacuation plans within 10 days after the resident's arrival. Orientation shall include assisting residents in identifying and using emergency exits. Documentation of the orientation shall be signed and dated by the resident or the resident's representative. e) Drills shall include residents, establishment personnel, and other persons in the establishment. 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 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. 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. These requirements were not, met as evidenced by: Based on record review and interview, the establishment failed to (1) document resident or visitor involvement in fire drills (2) instruct all personnel employed on the premises in the use of fire extinguishers (3) orient each resident to the	A2040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510114	A. BUILDING: _____ B. WING _____	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENDALE OF ALGONQUIN	2001 WEST ALGONQUIN RD ALGONQUIN, IL 60102

(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
A2040	Continued From page 2 emergency and evacuation plans within 10 days after the resident's arrival (R9). This failure has the probability to affect all residents. Findings include: During record review on 3/02/2026 at 9:30 AM it was found that the establishment's last annual survey was conducted on 5/7/2025-5/8/2025. During this survey they were cited for violation of 295.2040 Emergency Preparedness and 295.4060 Alzheimer's and Dementia Programs. During record review on 3/02/2026 at 3:04 PM the employee file of E6 (Caregiver) was reviewed. E6 was hired on 1/28/2026. E6's employee file had no documentation of fire extinguisher training. During record review on 3/02/2026 at 3:10 PM the employee file of E5 (LPN) was reviewed. E5 was hired on 11/11/2025. E5's employee file had no documentation of fire extinguisher training. During record review on 3/02/2026 at 3:35 PM the establishment's fire drills were reviewed. These fire drills did not identify any resident or visitors. During record review on 3/02/2026 at 3:50 PM the establishment's life safety inspection statement of findings for 8/21/2025 was reviewed. The statement of findings noted: The evacuation drill documentation failed to include the following: B. Evacuation drill record demonstrating all residents attended and those residents that did not attend due to illness. Evacuation Drills Records demonstrating all residents attended unless the residents were unable based on allowable exceptions of the Licensure code listed	A2040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510114	A. BUILDING: _____ B. WING _____	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENDALE OF ALGONQUIN	2001 WEST ALGONQUIN RD ALGONQUIN, IL 60102

(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
A2040	Continued From page 3	A2040		

below. A list of room numbers indicating the resident attended, or the room is vacant, or resident is out of the building, a hospice patient meeting the requirements of Section 2905.2000(f), or the resident is quadriplegic or paraplegic, or individuals with neuro-muscular diseases, such as muscular dystrophy and multiple sclerosis, or other chronic diseases and conditions meeting the requirements of Section 2905.2000(9). or a temporary illness that would prevent the resident from self-evacuation.

During record review on 3/3/2026 at 12:15 PM it was found that R9, with an admission date of 7/25/2025, did not have documentation of orientation to the emergency evacuation plan.

During an interview with E4 (Director of Plant Operations) on 3/02/2026 at 3:43 PM the following was stated:

Surveyor: "Are residents involved in your fire drills?"
E4: "Yes."
Surveyor: "Where is that documented?"
E4: "I don't see it here. Nope. We don't have them sign a paper or anything. I know we did for one of the tornado drills but not for the fire drills."

During an interview with E1 (Executive Director) on 3/02/2026 at 4:00 PM they stated, "I know that [E5] started the training but didn't finish it. In our system, you can't go back and finish things that were supposed to be done the previous year. We have started a new process. We just hired a business office assistant, an HR manager to better keep track of things. I'm going to be honest. I'm not sure how much training I'll be able to produce for you. We were tagged just back in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510114	A. BUILDING: _____ B. WING _____	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENDALE OF ALGONQUIN	2001 WEST ALGONQUIN RD ALGONQUIN, IL 60102

(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
A2040	Continued From page 4 January for training and we are currently working to fix things." During an interview with E4 on 3/3/2026 at 1:59 PM they stated, "The only emergency orientation I couldn't find was [R9]'s. I had heart surgery a little while back so I missed a few things."	A2040		
A3020	Section 295.3020 Employee Orientation and Ongoing Training This Regulation is not met as evidenced by: GENERAL VIOLATION Section 295.3020 Employee Orientation and Ongoing Training 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	A3020		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510114	A. BUILDING: _____ B. WING _____	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENDALE OF ALGONQUIN	2001 WEST ALGONQUIN RD ALGONQUIN, IL 60102

(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
A3020	Continued From page 5 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:	A3020		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510114	A. BUILDING: _____ B. WING _____	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENDALE OF ALGONQUIN	2001 WEST ALGONQUIN RD ALGONQUIN, IL 60102

(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
A3020	Continued From page 6 Based on record review and interview, the establishment failed to ensure employees had orientation. This failure involves 5 of 5 employees reviewed for this requirement (E5, E6, E10, E11, & E13). This failure has the probability to affect all residents. Findings include: During record review on 3/2/2026 at 3:04 PM E6's (Caregiver) employee file was reviewed. E6 has a hire date of 1/28/2026. E6's file did not include documentation of orientation. During record review on 3/2/2026 at 3:07 PM E13's (Server) employee file was reviewed. E13 has a hire date of 9/24/2025. E13's file did not include documentation of orientation. During record review on 3/2/2026 at 3:10 PM E5's (LPN) employee file was reviewed. E5 has a hire date of 11/11/2025. E5's file did not include documentation of orientation. During record review on 3/2/2026 at 3:13 PM E10's (LPN) employee file was reviewed. E10 has a hire date of 11/10/2025. E10's file did not include documentation of orientation. During record review on 3/2/2026 at 3:16 PM E11's (Caregiver) employee file was reviewed. E11 has a hire date of 1/29/2026. E11's file did not include documentation of orientation. During an interview with E1 (Executive Director) on 3/02/2026 at 4:00 PM they stated, "I know that [E5] started the training but didn't finish it. In our system, you can't go back and finish things that were supposed to be done the previous year. We	A3020		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510114	A. BUILDING: _____ B. WING _____	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENDALE OF ALGONQUIN	2001 WEST ALGONQUIN RD ALGONQUIN, IL 60102

(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
A3020	Continued From page 7 have started a new process. We just hired a business office assistant, an HR manager to better keep track of things. I'm going to be honest. I'm not sure how much training I'll be able to produce for you. We were tagged just back in January for training and we are currently working to fix things."	A3020		
A4000	Section 295.4000 Physician/s Assessment This Regulation is not met as evidenced by: TYPE 3 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. This requirement was not met, as evidenced by: Based on record review and interview, the establishment failed to have physician assessments completed by a physician. This failure involves 2 of 10 residents reviewed for this	A4000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510114	A. BUILDING: _____ B. WING _____	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENDALE OF ALGONQUIN	2001 WEST ALGONQUIN RD ALGONQUIN, IL 60102

(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
A4000	Continued From page 8 requirement (R2 & R6). Findings include: During record review on 3/3/2026 at 11:06 AM it was found that R2, with an admission date of 1/28/2026, had a physician assessment completed on 1/9/2026 by Z1 (APRN). During record review on 3/3/2026 at 12:00 PM it was found that R6, with an admission date of 5/30/2025, had a physician assessment completed on 5/21/2025 by Z2 (FNP). During an interview with E2 (Director of Health Services) on 3/3/2026 at 1:08 PM they stated that they were not aware that physician assessments could not be completed by advanced practice nurses.	A4000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: GENERAL VIOLATION Section 295.4010 Service Plan 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,	A4010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510114	A. BUILDING: _____ B. WING _____	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENDALE OF ALGONQUIN	2001 WEST ALGONQUIN RD ALGONQUIN, IL 60102

(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
A4010	Continued From page 9 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). f) Based on the physician's assessment, the service plan may provide for the disconnection or removal of any kitchen appliance. (Section 15 of the Act) g) Service plans shall address: 1) The level of service the resident is receiving, including: B) dietary needs, if the establishment provides therapeutic diets; and 2) The amount, type, and frequency of health-related services needed by the resident; h) The service plan shall include all support services provided or arranged for by the establishment. These requirements were not met, as evidenced by: Based on record review and interview, the establishment failed to (1) revise service plans as needed to address changes in the health-related services needed by the resident (2) include the frequency of health-related services in service	A4010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510114	A. BUILDING: _____ B. WING _____	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENDALE OF ALGONQUIN	2001 WEST ALGONQUIN RD ALGONQUIN, IL 60102

(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
A4010	Continued From page 10 plans (3) revise service plans as residents dietary needs change. These failures involve 5 of 10 residents reviewed for this requirement (R1, R2, R3, R5, & R9). This failure has the probability to affect all residents. Findings include: During record review on 3/2/2026 at 2:20 PM establishment resident lists were reviewed. The list of residents with wounds included R5. The list of residents with home care for wound care included R5. The list of residents with PHYSICAL THERAPY/ OCCUPATIONAL THERAPY SERVICES included R2, R3, & R5. During record review on 3/3/2026 at 10:22 AM R1's 12/3/2025 service plan did not address hospice services. During record review on 3/3/2026 at 10:30 AM R1's progress notes reveal that R1 was receiving hospice services from 2/5/2026 until they passed away on 2/18/2026. R1's progress notes also reveal that R1 returned on 2/5/2026 with orders for honey thick liquids and pureed textured food. During record review on 3/3/2026 at 11:13 AM R2's 2/17/2026 service plan does not address the PHYSICAL THERAPY/ OCCUPATIONAL THERAPY SERVICES that they are currently receiving. During record review on 3/3/2026 at 11:17 AM it is found that R2's progress notes stated PHYSICAL THERAPY/ OCCUPATIONAL THERAPY SERVICES was ordered on 1/29/2026.	A4010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510114	A. BUILDING: _____ B. WING _____	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENDALE OF ALGONQUIN	2001 WEST ALGONQUIN RD ALGONQUIN, IL 60102

(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
A4010	Continued From page 11 During record review on 3/3/2026 at 11:24 AM it is found that R3's 2/17/2026 service plan does not list the frequency of the PHYSICAL THERAPY/ OCCUPATIONAL THERAPY SERVICES services that they are receiving. During record review on 3/3/2026 at 11:27 AM R3's progress notes show that PHYSICAL THERAPY/ OCCUPATIONAL THERAPY SERVICES was ordered on 1/17/2026. During record review on 3/3/2026 at 11:48 AM R5 is reviewed. R5 has an admission date of 6/30/2025. R5's service plan, dated 8/20/2025 had not been updated to address R5's left heel wound of the home health wound care nursing he is receiving. The service plan also does not list the frequency of his PHYSICAL THERAPY/ OCCUPATIONAL THERAPY SERVICES. During record review on 3/3/2026 at 11:55 AM R5's progress notes show that he is currently being seen for wound care. During record review on 3/3/2026 at 12:30 PM R9's record is reviewed. R9 has an admission date of 7/23/2025. R9's service plan, dated 7/28/2025, states that they are on PHYSICAL THERAPY/ OCCUPATIONAL THERAPY SERVICES though they are not. During an interview with E1 (Executive Director) on 3/3/2026 at 10:30 AM they stated, "[R1] started on hospice as soon as she came back from the hospital I believe." An interview with E2 (Director of Health Services) on 3/3/2026 at 1:08 PM went as follows: Surveyor: "Are you aware that physician	A4010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510114	A. BUILDING: _____ B. WING _____	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENDALE OF ALGONQUIN	2001 WEST ALGONQUIN RD ALGONQUIN, IL 60102

(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
A4010	Continued From page 12 assessments must be done by a physician and not an NP?" E2: "No. That is new information." Surveyor: "Does [R2] see PHYSICAL THERAPY/ OCCUPATIONAL THERAPY SERVICES? How often?" E2: "Yes. They come twice a week." Surveyor: "How often does PHYSICAL THERAPY/ OCCUPATIONAL THERAPY SERVICES come for [R3]?" E2: "I think it is twice a week." Surveyor: "How often does PT come for [R5]?" E2: "Twice a week." Surveyor: "How often does wound care come to see [R5]?" E2: "Also, Twice a week." Cont... Surveyor: "Is [R9] receiving PT services?" E2: "No. He is not. He walks by himself."	A4010		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: GENERAL REPEAT VIOLATION Section 295.4060 Alzheimer's and Dementia Programs i) Training requirements for individuals working in a special program: 1) Manager qualifications and training: B) The manager or supervisor must complete, in addition to the training required in subsection (i)(2) of this Section and in Section 295.3020, six hours of annual continuing education regarding dementia care.	A4060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510114	A. BUILDING: _____ B. WING _____	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENDALE OF ALGONQUIN	2001 WEST ALGONQUIN RD ALGONQUIN, IL 60102

(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
A4060	Continued From page 13 2) Staff training: A) All staff members must receive, in addition to the training required in Section 295.3020, four hours of dementia-specific orientation prior to assuming job responsibilities without direct supervision within the Alzheimer's/dementia program. Training must cover, at a minimum, the following topics: i) basic information about the causes, progression, and management of Alzheimer's disease and other related dementia disorders; ii) techniques for creating an environment that minimizes challenging behavior; iii) identifying and alleviating safety risks to residents with Alzheimer's disease; iv) techniques for successful communication with individuals with dementia; and v) residents' rights. 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 in 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;	A4060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510114	A. BUILDING: _____ B. WING _____	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENDALE OF ALGONQUIN	2001 WEST ALGONQUIN RD ALGONQUIN, IL 60102

(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
A4060	Continued From page 14 iv) resident rights and choice for persons with dementia, working with families, caregiver stress; and v) techniques for successful communication. C) Direct care staff must annually complete 12 hours of in-service education regarding Alzheimer's disease and other related dementia disorders. Topics may include: i) assessing resident capabilities and developing and implementing service plans; ii) promoting resident dignity, independence, individuality, privacy and choice; iii) planning and facilitating activities appropriate for the dementia resident; iv) communicating with families and other persons interested in the resident; v) resident rights and principles of self-determination; vi) care of elderly persons with physical, cognitive, behavioral and social disabilities; vii) medical and social needs of the resident; viii) common psychotropics and side effects; ix) local community resources; and x) other related issues. These requirements have not been met, as evidenced by:	A4060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510114	A. BUILDING: _____ B. WING _____	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENDALE OF ALGONQUIN	2001 WEST ALGONQUIN RD ALGONQUIN, IL 60102

(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
A4060	Continued From page 15 Based on record review and interview, the establishment failed to 1) Ensure the Memory Care Manager received at least 18 hours of continuing training regarding dementia care annually 2) Ensure employees receive at least 12 hours of continuing training regarding dementia care annually 3) Ensure all staff members must receive, in addition to the training required in Section 295.3020, four hours of dementia-specific orientation prior to assuming job responsibilities without direct supervision 4) Ensure direct care staff receive 16 hours of on-the-job supervision and training within the first 16 hours of employment following orientation. These failures involve 7 of 7 employees reviewed for these requirements (E5, E6, E7, E8, E9, E10 & E11). This failure has the probability to affect all residents. Findings include: During record review on 3/02/2026 at 9:30 AM it was found that the establishment's last annual survey was conducted on 5/7/2025-5/8/2025. During this survey they were cited for violation of 295.2040 Emergency Preparedness and 295.4060 Alzheimer's and Dementia Programs. During record review on 3/02/2026 at 3:04 PM E6's (Caregiver) employee file, with a hire date of 1/28/2026 was reviewed. E6's employee file did not include the required 16 hour shadowing. E6's employee file documented only 3.5 hours of dementia specific training prior to assuming direct caregiver responsibilities instead of the required 4 hours. During record review at 3:10 PM on 3/02/2026 E5's (LPN) employee file, with the hire date of 11/11/2025 was reviewed. E5's file did not include	A4060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510114	A. BUILDING: _____ B. WING _____	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENDALE OF ALGONQUIN	2001 WEST ALGONQUIN RD ALGONQUIN, IL 60102

(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
A4060	Continued From page 16 the required 16 hour shadowing. During record review at 3:13 PM on 3/02/2026 E10's (LPN) employee file, with the hire date of 11/10/2025 was reviewed. E10's file did not include the required 16 hour shadowing. During record review at 3:16 PM on 3/02/2026 E11's (Caregiver) employee file, with the hire date of 1/29/2026 was reviewed. E11's file did not include the required 16 hour shadowing. During record review on 3/02/2026 at 3:17 PM it was found that E8 (Caregiver), with a hire date of 1/20/2025, only had 9.25 of the required 12 hours of annual dementia training. During record review on 3/02/2026 at 3:19 PM it was found that E9 (Caregiver), with a hire date of 2/12/2025, only had 6.75 of the required 12 hours of annual dementia training. During record review on 3/02/2026 at 3:20 PM it was found that E7 (Memory Care Manager), with a hire date of 9/9/2016, only had 6.25 of the required 18 hours of annual dementia training for the memory care manager. During an interview with E1 (Executive Director) on 3/02/2026 at 4:00 PM they stated, "I know that [E5] started the training but didn't finish it. In our system, you can't go back and finish things that were supposed to be done the previous year. We have started a new process. We just hired a business office assistant, an HR manager to better keep track of things. I'm going to be honest. I'm not sure how much training I'll be able to produce for you. We were tagged just back in January for training and we are currently working to fix things."	A4060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510114	A. BUILDING: _____ B. WING _____	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENDALE OF ALGONQUIN	2001 WEST ALGONQUIN RD ALGONQUIN, IL 60102

(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
A8000	Section 295.8000 Food Service	A8000		

This Regulation is not met as evidenced by:
GENERAL VIOLATION

Section 295.8000 Food Service

a) If food service is provided by the establishment or by contract with a food service provider, the following requirements shall be met:

1) Food services shall meet the Food Service Sanitation Code (77 Ill. Adm. Code 750) and any applicable local requirements.

This requirement was not met, as evidenced by:

Based on record review and observation, the establishment did not meet Food Service Sanitation Code (77 Ill. Adm. Code 750) and any applicable local requirements.
This failure has the probability to affect all residents.

Findings include:

During record review on 3/2/2026 at 11:11 AM the establishment's most recent local health department kitchen inspection was reviewed. This inspection, conducted on 12/08/2025 cited several violations, including but not limited to:
"Item #23- Section 23(pf) Proper date marking and disposition. Reference 3-501.17 (A)."
"Item #39- Section 39 (C) Food stored in an unapproved location. Food shall be protected from contamination by storing it in a clean, dry location; where it is not exposed to splash, dust

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510114	A. BUILDING: _____ B. WING _____	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENDALE OF ALGONQUIN	2001 WEST ALGONQUIN RD ALGONQUIN, IL 60102

(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
A8000	Continued From page 18 or other contamination; and at least 6 inches above the floor. Reference 3-305.11. Observed food items on the ground in the walk-in cooler and walk-in freezer." "Item #55- Section 55 (C) Physical facilities are soiled. Physical facilities shall be cleaned as often as necessary to keep them clean. Reference 6-501.12 (A &B). Observed debris underneath the shelving in the walk-in freezer." During observation of the establishment kitchen on 3/2/2026 several violations were noted. At 11:18 AM containers of steak seasoning were on the floor in the dry storage room. At 11:20 AM the walk-in cooler was noted to have some sort of meat in a metal container covered with plastic wrap. The meat was not labeled and did not have date markings. The cooler floor was soiled. During observation of the walk-in freezer at 11:22 AM green beans in a cardboard box were stored directly on the floor. Some sort of meat in a metal pan with saran wrap loosely covering it was stored directly on the floor. A cardboard box of croissants stuffed with spinach and ricotta was stored directly on the floor. A cardboard box of frozen eggrolls was stored directly on the floor. A cardboard box of some sort of buttermilk was stored directly on the floor. A cardboard box of hot dog rolls was stored directly on the floor. An unidentifiable food in an open cardboard box was stored directly on the floor. The freezer floor was heavily soiled with food scraps and crumbs.	A8000		