STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510333	A. BUILDING: _____ B. WING _____	C 02/25/2026

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STORYPOINT NAPERVILLE	504 N RIVER RD NAPERVILLE, IL 60563

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A 000	Initial Comment Complaint Investigation IL00199978/ 2671410- No deficiency cited IL00200353/ 2672245- No deficiency cited Entity Reported Incident Investigation IL00200331 Incident date 2/18/26 295.4000 h) 295.4010 d) h) 295.7000 b) 10)	A 000		
A4000	Section 295.4000 Physician/s Assessment This Regulation is not met as evidenced by: Type 2 Violation Section 295.4000 Physician's Assessment h) The establishment shall monitor and have a reporting procedure in place for notifying a relative or other individual in an emergency situation, significant change in resident's condition, or termination of residency. This requirement is not met as evidenced by: Based on interview and record review, the establishment failed to notify resident's (R2) physician of aggressive behavior, resulting in lack of assessment and interventions to address behaviors, that led to physical aggression towards staff. This affected one (R2) of three residents reviewed. This failure resulted in ongoing aggression towards staff. This failure creates the substantial probability of harm to R2, staff and all residents.	A4000		

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A4000	Continued From page 1 Findings include: An onsite visit was conducted on 2/24/26, and 2/25/26. According to R2's face sheet R2 is 85 years old. R2 moved to the Assisted Living unit of the establishment on 6/1/23. R2 lives in the same apartment as R3. R2's diagnoses include but are not limited to Unspecified Dementia, Unspecified Severity without Behavioral Disturbance, Mood Disturbance, and Anxiety, Major Depressive Disorder, Chronic Gout, Hypertensive heart Disease with Heart Failure, Muscle Weakness, and Unsteadiness on Feet. R2's SLUMS (St. Louis University Mental Status) exam score dated 10/24/25 was 3, which indicate (a score of 1-19) Dementia. On 2/24/25 at 3:39PM, R2 was observed in apartment, seated on a recliner with feet raised. Alert, and oriented. Stated no issues regarding Activities for Daily Living assistance provided by staff. R2's Notes beginning September 2025 to 2/25/26 were reviewed. Notes dated 2/28/26 (1705), documented R2 exhibiting aggressive behavior and hit a Caregiver on the right hand and on the right side of stomach. Another note dated 1/27/26 also documented aggressive behavior by cursing, threatening and grabbing. These incidents had no record of notifying R2's physician. Multiple staff interviews verified R2 has had behavior issue which started few months back: On 2/24/26 at 1:42PM, E5 (Care Associate), said R2 is confused a lot of the time, verbally abusive to a lot of the staff, threatens people almost every day. A lot of the times when R2 needs to be	A4000		

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A4000	Continued From page 2	A4000		

changed or go to the bathroom, R2 would become aggressive. This behavior has been ongoing for the past six months. E5 said the behaviors include making threats, making a fist and raising hands.

On 2/24/26 at 1:51PM, E6 (Care Associate), said R2's aggressive behavior has been observed since October, and becoming more aggressive since January. Aggressive behavior would include making threats, "I am going to hit you", makes gestures such as making a fist or when putting on R2 shirt, R2 goes like R2 is going to strike with elbow.

On 2/24/26 at 2:08PM, E7 (Licensed Practical Nurse), confirmed receiving reports from care associates about R2's aggressive behavior.

On 2/24/26 at 2:20PM, E4 (Care Associate) confirmed that on 2/18/26 when R2 was being assisted R2 hit E4 on the right hand and again on the right side of stomach. E4 said, R2 threatened to hit E4 on the face. E4 said there were times when R2 would call E4 names such as "animal", "dog" ... E4 confirmed R2 had behaviors issues since October 2025.

On 2/24/26 at 3:34PM, E8 (Care Associate) confirmed R2's behavior issues. E8 said, some days (R2) is yelling, would make threats, "I am going to push you, I am going to hit you, punch you". E8 said there was one incident wherein R2 tried to grab E8 but missed.

On 2/25/26 at 9:37AM, E9 (Care Associate) confirmed sometimes R2 was aggressive, more verbal than physical, screaming, cursing, making verbal threats, yelling, cursing, making a fist but did not make contact.

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A4000	Continued From page 3 On 2/25/26 at 11:44AM, E14 (Wellness Team Supervisor), confirmed getting the report from E4 on 2/18/26. E4 reported that R2 hit E4. E14 overheard (over the phone) E4 telling R2 not to hit (E4) again. When E14 went to the floor, E14 found R2, R3 and E4 by the elevator. E14 said R2 denied hitting E4 but was aggravated and started to stand up from wheelchair and tried to get to E4 with fist balled. E14 confirmed that R2 has had behaviors for months. On 2/25/26 at 1:32PM, E3 (Licensed Practical Nurse) confirmed presence on 2/18/26 incident, E3 confirmed hearing R2 stating "I am going to pop you again". E3 said, R2 gets aggressive sometimes especially when spouse is present. These residents live together. During this incident, R2 was supposed to be sent to the hospital for evaluation, but Z5 (Family Member) refused to send R2. R2's Service plan dated 10/24/25 as well as current service plan with updates dated 2/19/26, did not have interventions for behaviors. Apart from the 2/19/26 and 1/27/26 notes, there were no other entries on R2 health records documenting aggressive behavior despite multiple observations by staff. On 2/24/26 at 12:48PM, E2 (Wellness Director) said, "Anytime they have a behavior they have to notify the physician and POA (Power of Attroney). At 1:28PM, E2 confirmed that there were no interventions in place for R2's behaviors. E2 also confirmed these behaviors have not been reported to R2's physician, which could have addressed the behavior and prevented the physical aggression, by obtaining order for psychiatric evaluation or medication review.	A4000		

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A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 2 Violation Section 295.4010 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) h) The service plan shall include all support services provided or arranged for by the establishment. These requirements are not met as evidenced by: Based on interview and record review, the establishment failed to incorporate resident service plan physical therapy interventions for one (R2) resident. The establishment also failed to implement interventions that addressed resident's (R2) behaviors resulting in physical aggression towards staff. This failure resulted in physical aggression towards staff. This failure creates a substantial probability of harm to R2, staff and all residents. Findings include: An onsite visit was conducted on 2/24/26, and 2/25/26.	A4010		

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A4010	Continued From page 5 According to R2's face sheet R2 is 85 years old. R2 moved to the Assisted Living unit of the establishment on 6/1/23. R2 lives in the same apartment as R3. R2's diagnoses include but are not limited to Unspecified Dementia, Unspecified Severity without Behavioral Disturbance, Mood Disturbance, and Anxiety, Major Depressive Disorder, Chronic Gout, Hypertensive heart Disease with Heart Failure, Muscle Weakness, and Unsteadiness on Feet. R2's SLUMS (St. Louis University Mental Status) exam score dated 10/24/25 was 3, which indicate (a score of 1-19) Dementia. On 2/24/25 at 3:39PM, R2 was observed in apartment, seated on a recliner with feet raised. Alert, and oriented. Stated no issues regarding Activities for Daily Living assistance provided by staff. On 2/24/26 at 3:50PM, Z6 (Director of Rehabilitation) said, R2 can get up when R2 chooses to, on contact guard assist for safety but able to do it alone. For transfer, R2 requires contact guard assist. For toileting R2 required two persons to assist. The issue was R2's preference to stay on the recliner the whole day by own choice/preference. This causes deconditioning (decline in physical function of the body because of physical inactivity and/or bedrest or an extremely sedentary lifestyle). Z6 said, the best time for R2 is in the morning, able to maximize participation, but at 5pm session conducted by Z6, R2 was a different person. Z6 said R2 was improving but losing ground due to laying down all day long, this was R2's spouse's preference. Z6 said interventions include, up and engage in activities, on chair, not recliner- as the recliner does not help with deconditioning.	A4010		

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A4010	Continued From page 6 R2's Service plan with revision date of 2/19/26, as well as previous service plan dated 10/24/25 did not discuss or incorporate Physical Therapy interventions. R2's Notes beginning September 2025 to 2/25/26 were reviewed. R2's Notes dated 2/28/26 (1705), documented R2 exhibiting aggressive behavior and hit a Caregiver on the right hand and on the right side of stomach. Another of R2's note dated 1/27/26 also documented- aggressive behavior by cursing, threatening and grabbing. Multiple staff interviews verified R2 have had behavior issues which started few months back: On 2/24/26 at 1:42PM, E5 (Care Associate), said R2 is confused a lot of the time, verbally abusive to a lot of the staff, threatens people almost every day. A lot of the times when R2 needs to be changed or go to the bathroom, R2 would become aggressive. This behavior has been ongoing for the past six months. E5 said the behaviors include making threats, making a fist and raising hand. On 2/24/26 at 1:51PM, E6 (Care Associate), said R2's aggressive behavior has been observed since October, and becoming more aggressive since January. Aggressive behavior would include making threats, "I am going to hit you", makes gestures such as making a fist or when putting on R2 shirt, R2 make striking gesture using elbow. On 2/24/26 at 2:08PM, E7 (Licensed Practical Nurse), confirmed receiving reports from Care Associates about R2's aggressive behavior. Especially during care. On 2/24/26 at 2:20PM, E4 (Care Associate)	A4010		

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A4010	Continued From page 7	A4010		

confirmed that on 2/18/26 when R2 was being assisted R2 hit E4 on the right hand and again on the right side of stomach. E4 said, R2 threatened to hit E4 on the face. E4 said there were times when R2 would call E4 names such as "animal", "dog" ... E4 confirmed R2 had behaviors issues since October 2025.

On 2/24/26 at 3:34PM, E8 (Care Associate) confirmed R2's behavior issues. E8 said, some days (R2) is yelling, would make threats, "I am going to push you, I am going to hit you, punch you". E8 said there was one incident wherein R2 tried to grab E8 but missed.

On 2/25/26 at 9:37AM, E9 (Care Associate) confirmed sometimes R2 was aggressive, more verbal than physical, screaming, cursing, making verbal threats, yelling, cursing, making a fist but did not make contact.

On 2/25/26 at 11:44AM, E14 (Wellness Team Supervisor), confirmed getting the report from E4 on 2/18/26. E4 reported that R2 hit E4. E14 overheard (over the phone) E4 telling R2 not to hit (E4) again. When E14 went to the floor, E14 found R2, R3 and E4 by the elevator. E14 said R2 denied hitting E4 but was aggravated and started to stand up from wheelchair and tried to get to E4 with fist balled. E14 confirmed that R2 has had behaviors for months.

On 2/25/26 at 1:32PM, E3 (Licensed Practical Nurse) confirmed presence on 2/18/26 incident, E3 confirmed hearing R2 stating "I am going to pop you again". E3 said, R2 gets aggressive sometimes especially when spouse is present. These residents live together. During this incident, R2 was supposed to be sent to the hospital for evaluation, but Z5 (Family Member)

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A4010	Continued From page 8 refused to send R2. These same staff indicated R2 requires 2 persons to assist with ADLs. R2's Service plan dated 10/24/25 as well as current did not have interventions for behaviors. Apart from the 2/19/26 and 1/27/26 notes, there were no other entries on R2 health records documenting aggressive behavior. On 2/24/26 at 1:28PM, E2 (Wellness Director) confirmed that there were no interventions in place for R2's behaviors. E2 also confirmed these behaviors have not been reported to R2's physician, which could have addressed the behavior and prevented the physical aggression. E2 said that the staff reported increasing needs in January, staff reported changes in R2. R2 required more assistance in terms of transfers, toileting and showers, requiring 2 people to assist. Physical Therapy was initiated on 1/23/26.	A4010		
A7000	Secton 295.7000 Resident Records This Regulation is not met as evidenced by: TYPE 2 VIOLATION Section 295.7000 Resident Records b) An establishment shall maintain a resident's record that contains at least the following: 10) Documentation of any significant change in a resident's behavior or physical, cognitive, or functional condition that would trigger an assessment or evaluation, and action taken by	A7000		

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A7000	Continued From page 9 employees to address the resident's changing needs; This requirement is not met as evidenced by: Based on interview and record review, the establishment failed to document multiple reported observations by staff of aggressive behaviors affecting one (R2) of three residents reviewed, which resulted in lack of assessment by physician and interventions to address behavior, which led to eventual physical aggression towards staff. This failure resulted in physical aggression towards staff. This failure creates substantial probability of harm to R2, staff and all residents. Findings include: An onsite visit was conducted on 2/24/26, and 2/25/26. According to R2's face sheet R2 is 85 years old. R2 moved to the Assisted Living unit of the establishment on 6/1/23. R2 lives in the same apartment as R3. R2's diagnoses include but are not limited to Unspecified Dementia, Unspecified Severity without Behavioral Disturbance, Mood Disturbance, and Anxiety, Major Depressive Disorder, Chronic Gout, Hypertensive heart Disease with Heart Failure, Muscle Weakness, and Unsteadiness on Feet. R2's SLUMS (St. Louis University Mental Status) exam score dated 10/24/25 was 3, which indicate (a score of 1-19) Dementia. On 2/24/25 at 3:39PM, R2 was observed in apartment, seated on a recliner with feet raised.	A7000		

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A7000	Continued From page 10	A7000		

Alert, and oriented. Stated no issues regarding Activities for Daily Living assistance provided by staff.

Multiple staff interviews verified R2 has had behavior issue which started few months back:

On 2/24/26 at 1:42PM, E5 (Care Associate), said R2 is confused a lot of the time, verbally abusive to a lot of the staff, threatens people almost every day. A lot of the times when R2 needs to be changed or go to the bathroom, R2 would become aggressive. This behavior has been ongoing for the past six months. E5 said the behaviors include making threats, making a fist and raising hands.

On 2/24/26 at 1:51PM, E6 (Care Associate), said R2 aggressive behavior has been observed since October, and becoming more aggressive since January. Aggressive behavior would include making threats, "I am going to hit you", makes gestures such as making a fist or when putting on R2 shirt, R2 goes like R2 is going to strike with elbow.

On 2/24/26 at 2:20PM, E4 (Care Associate) confirmed that on 2/18/26 when R2 was being assisted R2 hit E4 on the right hand and again on the right side of stomach. E4 said, R2 threatened to hit E4 on the face. E4 said there were times when R2 would call E4 names such as "animal", "dog" ... E4 confirmed R2 had behaviors issues since October 2025.

On 2/24/26 at 3:34PM, E8 (Care Associate) confirmed R2's behavior issues. E8 said, some days (R2) is yelling, would make threats, "I am going to push you, I am going to hit you, punch you". E8 said there was one incident wherein R2

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A7000	Continued From page 11	A7000		

tried to grab E8 but missed.

On 2/25/26 at 9:37AM, E9 (Care Associate) confirmed sometimes R2 was aggressive, more verbal than physical, screaming, cursing, making verbal threats, yelling, cursing, making a fist but did not make contact.

On 2/25/26 at 11:44AM, E14 (Wellness Team Supervisor) confirmed getting the report from E4 on 2/18/26. E4 reported that R2 hit E4. E14 overheard (over the phone) E4 telling R2 not to hit (E4) again. When E14 went to the floor, E14 found R2, R3 and E4 by the elevator. E14 said R2 denied hitting E4 but was aggravated and started to stand up from wheelchair and tried to get to E4 with fist balled. E14 confirmed that R2 has had behaviors for months.

On 2/25/26 at 1:32PM, E3 (Licensed Practical Nurse) confirmed presence on 2/18/26 incident, E3 confirmed hearing R2 stating "I am going to pop you again". E3 said, R2 gets aggressive sometimes especially when spouse is present. These residents live together. During this incident, R2 was supposed to be sent to the hospital for evaluation, but Z5 (Family Member) refused to send R2.

R2's Service plan dated 10/24/25 did not have interventions for behaviors. Apart from the 2/19/26 and 1/27/26 notes, there were no other entries on R2 health records documenting aggressive behavior.

Despite months of observing these behaviors, R2's Notes beginning September 2025 to 2/25/26 were reviewed and per note, there were only two entries documenting these behaviors- dated 2/28/26, it documented R2 exhibiting aggressive

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A7000	Continued From page 12 behavior and hit a Caregiver on the right hand and on the right side of stomach. Another note dated 1/27/26 also documented aggressive behavior by cursing, threatening and grabbing. There were no notes documenting R2's physician was notified of these behaviors. R2's Service plan dated 10/24/25 did not have interventions for behaviors. Apart from the 2/19/26 and 1/27/26 notes, there were no other entries on R2 health records documenting aggressive behavior. On 2/24/26 at 1:28PM, E2 (Wellness Director) confirmed that there were no interventions in place for R2 behaviors. E2 also confirmed these behaviors have not been reported to R2's physician, which could have addressed the behavior and prevented the physical aggression. E2 also confirmed, there was lack of documentation of the reported observations by multiple staff of R2's aggressive behavior.	A7000		