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A 000	Initial Comment Complaint Investigation IL200155 Violations: 295.2050a)b)c) 295.4010b)d)e) 295.4060h)3)A) 295.6000a)13) 295.7000b)9)	A 000		
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 an incident or accident that has a significant negative effect on a resident's health, safety or welfare. A significant negative effect shall be assumed whenever an unplanned or unscheduled visit to a hospital is necessary as a result of that incident or accident, treatment is provided, and follow-up care is required. b) The report shall be made by contacting the Department of Public Health Central Complaint Registry or by fax or by other electronic means within 24 hours after the occurrence of the incident or accident. c) A copy of the report shall be maintained by the establishment for one year after the date of the incident or accident. (Source: Amended at 28 Ill. Reg. 14593, effective October 21, 2004) Based on observation, interview, and record	A2050		

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A2050	Continued From page 1	A2050		

review the establishment failed to report a fall resulting in injury for one (R2) of three residents reviewed for falls in the sample of three. This failure creates a substantial probability of harm to a resident or residents.

Findings include:

The establishments Incident Reporting policy and procedure dated 3/26/19 documents "The Community (establishment) shall report to the Department an incident or accident that has a significant negative effect on a resident's health, safety or welfare. A significant negative effect shall be assumed whenever an unplanned or unscheduled visit to a hospital is necessary as a result of that incident or accident, treatment is provided, and follow-up care is required." The report shall be made by contacting the State Agency within 24 hours after the incident for one year or one survey period. "A copy of any incident report containing state and reportable information will be sent to the state licensing agency within the required time frame." This policy also documents that "Reportable event: Resident injury that results in being sent to hospital or death due to injury" are to be reported to the Executive Director and Regional Director of Operations.

The Incident Report for R2 dated 1/13/26 documents R2 with unwitnessed fall at 9:10 pm. R2 was found sitting on the floor in dining room "with pool of blood all over," resident crying and laceration over right eyebrow. R2 was sent out to the local hospital.

The After Visit Summary for R2 dated 1/13/26 documents reason for visit as laceration on face, "Avulsion of skin of face" and CT of the head was

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A2050	Continued From page 2 done. R2 returned to the establishment with a physician order to apply triple antibiotic to laceration twice daily. The Observation note for R2 dated 1/14/26 at 8:00 am documents "Noted had a phone call from (nurse) from (local hospital) states that result from CT (computed tomography) scan bleeding from RT (right) frontal of head and states she would be faxing it also." The Observation note for R2 dated 1/14/26 at 12:30 pm documents "Resident in room resting with eyes closed at this time. Resident is on 15-minute checks by caregiver staff d/t (due to) fall c (with) traumatic brain injury to right temporal lobe. "Resident was tearful at that time, holding head c palm of hand." The establishment was unable to provide initial or final report documentation of the State Agency being notified. On 2/19/26 at 2:15 pm E1 ED (Executive Director) stated she does not have a reportable for R2's 1/13/26 fall. On 2/19/26 at 2:30 pm E20 Regional Nurse Consultant stated the information for R2 was not sent to her and she was unaware of R2 having received any type of brain bleed or traumatic brain injury or would have reported it to the State Agency.	A2050		
A4010	Section 295.4010 Service Plan	A4010		

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A4010	Continued From page 3 This Regulation is not met as evidenced by: General Violation Section 295.4010 Service Plan b) The service plan shall be developed by: 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). Based on interview and record review the establishment failed to ensure resident falls were addressed for three (R1, R2, and R3) of three residents reviewed for service plans. Findings include: The establishments Service Plan policy and procedure dated 11/2/23 documents "The service plan shall include all support services provided or arranged for by the establishment. The service plan shall be reviewed annually, or as the residents' condition, preferences, or service needs change. The service plan shall be reviewed and revised, if necessary, after a significant change in the resident's physical, cognitive, or functional condition." 1. The Incident Report for R1 dated 12/24/25 at 7:12 am documents R1 had an unwitnessed fall. The current service plan for R1 does not address	A4010		

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A4010	Continued From page 4 or include interventions related to R1's 12/24/25 fall. The Service Plan Task for R1 documents R1 is at risk for falls and was last updated on 10/15/25. 2. The Incident Reports for R2 dated 12/27/25 at 7:30 am, 1/13/26 at 9:10 pm, and 1/16/26 at 5:30 pm document R2 had unwitnessed falls. The current service plan for R2 does not address or include interventions related to R2's 12/27/25, 1/13/26, and 1/16/26 unwitnessed falls. The Service Plan Task for R2 documents R2 is at risk for falls and was last updated on 11/11/25. 3. The Incident Report for R3 dated 2/1/26 at 4:30 am documents R3 had an unwitnessed fall. The current service plan for R3 does not address or include interventions related to R3's 2/1/26 fall. The Service Plan Task for R3 documents R3 is a high risk for falls and was last updated on 11/4/25. On 2/18/26 at 1:00 pm, E2 HWD (Health and Wellness Director) stated the dates on the Service Plan Task gives the dates the specific service plan areas were updated and confirmed R1, R2, and R3's service plans do not address or include interventions related to R1 through R3's most current falls.	A4010		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs	A4060		

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A4060	Continued From page 5 This Regulation is not met as evidenced by: Type 1 Violation Section 295.4060 Alzheimer's and Dementia Programs h) An establishment that offers to provide a special program for persons with Alzheimer's disease and related disorders shall: 3) Develop and implement policies and procedures that ensure the continued safety of all residents in the establishment including, but not limited to, those who: A) May wander; Based on observation, interview, and record review the establishment failed to follow fall policy and procedures for three (R1, R2, and R3) of three residents reviewed for falls in the sample of three. This failure creates a substantial probability of severe harm to a resident or residents. Findings include: The establishments Incident Reporting policy and procedures dated 3/26/2019 documents "All incidents or unusual occurrences at the Community will be documented in a timely manner and appropriate action taken according to established procedures and state regulations." "The Executive Director will ensure all necessary reports are completed and all specified timeliness are followed according to state regulations. Staff will take immediate and proper steps to see that residents or parties involved receive necessary intervention, including emergency medical treatment as needed. The Wellness Director or trained designee will complete an incident report after taking proper steps to see that the resident or parties involved receive necessary	A4060		

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A4060	Continued From page 6	A4060		

intervention." The establishment will report to the State Agency "an incident or accident that has a significant negative effect on a resident's health, safety or welfare." "Any follow-up documentation will be recorded on the original incident report."

On 2/19/26 at 8:47 am, E16 CNA (Certified Nursing Assistant) stated she worked third shift on 2/2/26 and R1, R2, and R3 had falls. E16 CNA stated she helped when R2 fell and E3 LPN did not do anything, no vital signs, didn't check R2 thoroughly, and there is no paperwork. E3 LPN told (E16 CNA) to get R2 up off the floor. E16 CNA stated she told E3 LPN she didn't feel comfortable getting R2 up without R2 being assessed. E16 CNA stated R3 LPN does this all the time. E16 CNA stated she reported this to prior Executive Director and does not know if anything was done because it is still happening. R1 and R3 also had falls that E21 RA helped with.

On 2/19/26 at 11:55 am E21 RA stated she worked on 2/2/26 and recalls R1 falling and E3 LPN told E21 RA to just get R1 up. E3 LPN doesn't do anything when a resident falls, just has us get them up. "I have only seen a Nurse do a fall assessment one time since I have been here, since December." E21 RA stated she can't remember anything about R3's fall.

On 2/19/26 at 11:19 am, E15 RA stated there have been times when the Nurse doesn't assess the resident and just has us get them up. E4 LPN has done that on day shift a few times. We always report the falls to the Nurse.

The establishment was unable to provide documentation of investigation having been completed, no root cause analysis, and not fall interventions for any of R1, R2, and R3's falls

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A4060	Continued From page 7 from December through February. On 2/18/26 at 1:00 pm, E2 HWD stated when a resident falls it is to be reported to the Nurse, vitals are obtained, and the Nurse is to assess the resident and send the resident to the hospital if needed. The Nurse is to do an incident report and make all the notifications. E2 HWD provided all the incident reports dated December 2025 through February 2026. E2 HWD confirmed there are no incident reports for R1, R2, and R3 for 2/2/26 and the Service Plans for R1, R2, and R3 have not been revised to include their falls.	A4060		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 1 Violation Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; Based on interview and record review the establishment failed to assess, document, and report falls for three (R1, R2, and R3) of three residents reviewed for falls in the sample of three. These failures create a substantial probability of harm to a resident or residents.	A6000		

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A6000	Continued From page 8 Findings include: The establishments Resident Rights Policy dated 8/25/2016 documents the Resident has "The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor." The establishments Incident Reporting policy and procedures dated 3/26/2019 documents "All incidents or unusual occurrences at the Community will be documented in a timely manner and appropriate action taken according to established procedures and state regulations." "The Executive Director will ensure all necessary reports are completed and all specified timeliness are followed according to state regulations. Staff will take immediate and proper steps to see that residents or parties involved receive necessary intervention, including emergency medical treatment as needed. The Wellness Director or trained designee will complete an incident report after taking proper steps to see that the resident or parties involved receive necessary intervention." The establishment will report to the State Agency "an incident or accident that has a significant negative effect on a resident's health, safety or welfare." "Any follow up documentation will be recorded on the original incident report." On 2/18/26 at 3:31 pm, E18 Former RA (Resident Aide) stated she did not work on 2/2/26 but on 2/3/26 coworkers told (E18) that R1, R2, and R3 had fallen. E3 LPN (Licensed Practical Nurse) told them not to do the paperwork because they didn't get hurt and it was too much paperwork for E3 LPN. E18 Former RA stated E5 RN (Registered Nurse) has said it before too, but E3 LPN did it all time. On 2/19/26 at 8:47 am, E16 CNA (Certified	A6000		

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A6000	Continued From page 9	A6000		

Nursing Assistant) stated she worked third shift on 2/2/26 and R1, R2, and R3 had falls. E16 CNA stated she helped when R2 fell and E3 LPN did not do anything, no vital signs, didn't check R2 thoroughly, and there is no paperwork. E3 LPN told (E16 CNA) to get R2 up off the floor. E16 CNA stated she told E3 LPN she didn't feel comfortable getting R2 up without R2 being assessed. R3 LPN does this all the time. E16 CNA stated she reported this to prior Executive Director and does not know if anything was done because it is still happening. R1 and R3 also had falls that E21 RA helped with.

On 2/19/26 at 11:55 am E21 RA stated she worked on 2/2/26 and recalls R1 falling and E3 LPN told E21 RA to just get R1 up. E3 LPN doesn't do anything when a resident falls, just has us get them up. "I have only seen a Nurse do a fall assessment one time since I have been here, since December." E21 RA stated she can't remember anything about R3's fall.

On 2/19/26 at 11:19 am, E15 RA stated there have been times when the Nurse doesn't assess the resident and just has us get them up. E4 LPN has done that on day shift a few times. We always report the falls to the Nurse.

On 2/19/26 at 10:43 am, E3 LPN confirmed she worked on 2/2/26 and does not recall any residents falling on 2/2/26. R2 is always putting herself on the floor and she asked them to put on her service plan. E3 LPN stated she was talked to about not documenting a fall back in early 2024 but has documented ever since.

On 2/19/26 at 1:10 pm, E20 Regional Nurse Consultant stated E3 LPN was talked to and received a write up in December 2025 regarding

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A6000	Continued From page 10 not documenting a fall. The employee file for E3 LPN documents E3 LPN did receive a write up for not documenting a resident fall in December 2025. The establishment was unable to provide Incident Reports for R1, R2, and R3 for falls on 2/2/26. R1, R2, and R3's electronic records do not include documentation of R1, R2, and R3 falls on 2/2/26.	A6000		
A7000	Secton 295.7000 Resident Records This Regulation is not met as evidenced by: General Violation Section 295.7000 Resident Records b) An establishment shall maintain a resident's record that contains at least the following: 9) Notation of known accidents, incidents or injuries; Based on interview and record review the establishment failed to ensure resident falls were documented for three (R1, R2, and R3) of three residents reviewed for falls in the sample of three. Findings include: The establishments Incident Reporting policy and procedures dated 3/26/2019 documents "All incidents or unusual occurrences at the Community will be documented in a timely manner and appropriate action taken according to established procedures and state regulations." "The Executive Director will ensure all necessary	A7000		

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A7000	Continued From page 11	A7000		

reports are completed and all specified timeliness are followed according to state regulations." "The Wellness Director or trained designee will complete an incident report after taking proper steps to see that the resident or parties involved receive necessary intervention." The establishment will report to the State Agency "an incident or accident that has a significant negative effect on a resident's health, safety or welfare." "Any follow up documentation will be recorded on the original incident report." "The incident report will be placed in a designated location at the Community for review by the Executive Director or designee."

1. On 2/19/26 at 8:47 am, E16 CNA (Certified Nursing Assistant) stated she worked third shift on 2/2/26 and R1, R2, and R3 had falls and E3 LPN did not do paperwork for their falls. E16 CNA stated E3 LPN does this all the time.

On 2/19/26 at 11:55 am E21 RA stated she worked on 2/2/26, recalls R1 falling and E3 LPN told E21 RA to just get R1 up. E3 LPN doesn't do anything when a resident falls, just has us get them up. E21 RA stated she can't remember anything about R3's fall.

The electronic record for R1, R2, and R3 do not include fall documentation or incident reports.

The establishment was unable to provide incident reports dated 2/2/26 for R1, R2, or R3.

2. The Incident Report for R2 dated 1/23/26 and electronic record do not include R2's CT (computed tomography) results or follow up documentation regarding R2's fall.

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A7000	Continued From page 12 The establishment was unable to provide documentation of investigation having been completed, no root cause analysis, and no fall interventions for any of R1, R2, and R3's falls from December through February. Establishment also does not have an initial or final result of the incident notifying the State Agency of R2's fall requiring hospital visit and head injury. On 2/19/26 at 2:30 pm, E20 Regional Nurse Consultant stated she was unaware of R2 having had a CT or having a brain injury. E20 confirmed R2's record does not include the CT results from 1/13/26 and lack of follow-up documentation. On 2/19/26 at 7:50 am E1 ED (Executive Director) stated she is unaware of R1, R2, and R3 having falls on 2/2/26 and does not have any state reportable falls.	A7000		