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A 000	Initial Comment FACILITY REPORTED INCIDENT SURVEY IL00200334 295.2040 a) b) 5) 295.3000 a) 295.4010 a) b) 1) 2) 3) c) e) g) 1) A) C) 2) 295.7000 b) 5) IL00200681 295.4000 a) 295.4060 a)b)c)e) f) 295.6000 a) 13)	A 000		
A2040	Section 295.2040 Disaster Preparedness This Regulation is not met as evidenced by: Type 2 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: 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.	A2040		

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A2040	Continued From page 1 This requirement was not met as evidenced by: Based on record review and interview, the establishment failed to provide documentation of resident emergency and evacuation plan orientation for five (R1, R2, R3, R4, and R5) of five residents reviewed. This failure has the substanti probability to cause harm to all residents in the establishment. Findings include: R1 is an 81-year-old resident admitted to the establishment on 1/22/2025 with diagnoses including but not limited to hypothyroidism and seizures. R2 is a 98-year-old resident admitted to the establishment on 4/30/2025 with diagnoses including but not limited to hypertensive heart disease without heart failure and adjustment disorder. R3 is a 79-year-old resident admitted to the establishment on 1/30/2026 with diagnoses including but not limited to dementia with behavioral disturbances and psychosis and no longer resides in the establishment. R4 is an 86-year-old resident admitted to the establishment on 5/28/25 with diagnoses including but not limited to migraine and anxiety disorder. R5 is a 96-year-old resident admitted to the establishment on 10/21/25 with diagnoses including but not limited to severe protein-calorie malnutrition and chronic kidney disease.	A2040		

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A2040	Continued From page 2 Surveyor was not provided with emergency evacuation orientation for R1, R2, R3, R4, and R5. On 3/19/2026, at 2:37 pm, E1 Interim Administrator stated E2 stated we do not have any signed resident orientations for any of the residents requested. On 3/20/2026, at 9:16 am, (with E1 Interim Administrator present) E2 stated we do not have a new resident orientation signature page for the resident orientation that we do upon admission. We do not have them sign anything when we do orientation with them. We do evacuation drills. We also have an intro to new residents monthly.	A2040		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: Violation Section 295.3000 Personnel Requirements, Qualifications and Training a) The establishment shall have staff sufficient in number with qualifications, adequate skills, education and experience to meet the 24 hour scheduled and unscheduled needs of residents and who participate in ongoing training to serve the resident population. (Section 35(a)(3) of the Act) This requirement was not met as evidenced by:	A3000		

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A3000	Continued From page 3 Based on record review and interview, the establishment failed to ensure to have staff with adequate skills to meet the needs of the residents in their care and provide supervision to prevent a fall for one (R1) of five residents reviewed. Findings include: R1 is an 81-year-old resident admitted to the establishment on 1/22/2025 with diagnoses including but not limited to hypothyroidism and seizures. R2 is a 98-year-old resident admitted to the establishment on 4/30/2025 with diagnoses including but not limited to hypertensive heart disease without heart failure and adjustment disorder. R3 is a 79-year-old resident admitted to the establishment on 1/30/2026 with diagnoses including but not limited to dementia with behavioral disturbances and psychosis and no longer resides in the establishment. R4 is an 86-year-old resident admitted to the establishment on 5/28/25 with diagnoses including but not limited to migraine and anxiety disorder. R5 is a 96-year-old resident admitted to the establishment on 10/21/25 with diagnoses including but not limited to severe protein-calorie malnutrition and chronic kidney disease. R1's service plan dated 1/23/26 is signed by E4 Registered Nurse/RN and the E2 Assisted Living and Memory Care Director but later discovered that these signatures were obtained on 3/19/2026 during survey when provided to surveyor. R1's	A3000		

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service plan does not address tonic-clonic seizures or any interventions for preventing harm to resident when seizures happen. R1's incontinence care plan documents Care staff to provide verbal reminders to use bathroom prior to meals and activities. Limited assistance needed such as reminders/cueing/and/or assistance to and from bathroom and set up of supplies. Fall service plan documents approaches/tasks: therapy assessed resident's apartment for safety, encourage resident to utilize call pendant for assistance, resident to receive outside physical therapy services, resident to ask for assistance when toileting at night, at risk for falls related to significant fall history, high risk for falls related to seizure disorder.

R1's progress note dated 2/5/2026 documents in part: Resident Aide on duty to assisted living paged this writer to resident apartment and reported that resident was on the floor. Writer responded immediately. Upon entering room, resident was observed laying down on the floor to her right side (fetal position) between bedside table and toilet wall. Call pendant active and within her reach. Resident is alert, oriented and responsive. Resident stated upon interview, I just went to the bathroom, then came out to go back to my bed, but then lost my balance and fell on the floor. Resident complains of pain or her right hip, right shoulder and right temporal. 10/10 on pain scale. Called 911 for emergency services.

R1's progress note dated 2/5/2026 documents in part Director spoke with residents power of attorney. Resident is discharging for skilled rehabilitation.

R2's service plan dated 3/10/26 is signed by E4 RN and E2 Assisted Living and Memory Care

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Director but later discovered that these signatures were obtained on 3/19/2026 during survey when provided to surveyor.

R3's service plan dated 2/5/2026 is signed by E4 RN and E2 Assisted Living Memory Care Director but later discovered that these signatures were obtained on 3/19/2026 during survey when provided to surveyor. Service plan documents power of attorney verbally agreed.

R4's service plan dated 3/13/2026 is signed by the R4 and E2 Assisted Living Memory Care Director but later discovered that these signatures were obtained on 3/19/2026 during survey when provided to surveyor.

R5's service plan dated 1/1/2026 is signed by the R5 and E2 Assisted Living Memory Care Director but later discovered that these signatures were obtained on 3/19/2026 during survey when provided to surveyor.

R1's fall risk evaluation dated 11/21/25 documents resident is high risk for falls.

R1's hospital records dated 2/5/26 documents in part: patient had an unwitnessed fall at establishment. Patient complains of right shoulder pain. X-ray impression for right shoulder documents Acute comminuted impacted and mildly displaced fractures of right humeral head and neck.

Surveyor was presented an undated physician assessment for R2 that was signed by E10 physician with attached medication review report dated 7/7/2023.

Surveyor was later presented with previously

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undated physician assessment for R2 now dated with date of 4/30/2025.

On 3/19/2026, at 11:56 am, E2 Assisted Living Memory Care Director stated: I do not have signed service plans for R1 and R2. I just got verbal agreement. I do not have emails supporting that. I just have an email confirming we had a call scheduled. For R3 his service plan is not signed. His power of attorney/POA refused to sign it. She did not agree with care that was happening here. R3 was pretty behavioral and we were requesting he get some additional support. Then he had the resident-to-resident issue and he has not been back since.

On 3/19/2026, at 1:59 AM, E2 Assisted Living Memory Care Director stated: R2 admitted to memory care on 3/13/2025 from assisted living. I do not know when the second physician certification was done as there is no date. I do not know who the physician is that signed it. It looks like E10's signature who is a physician. I will look it up and let you know the date. Typically, the floor nurses are in charge of supporting making sure physician certifications are signed and dated.

On 3/19/2026, at 3:30 PM, E2 Assisted Living Memory Care Director stated: I put the pieces together on the undated physician certification and it should have been dated 4/30/2025. I added the date to the physician certification of 4/30/2025. I am fairly positive that it should have went with Discharge notice from when she went Skilled to memory care. I will reach out to E10 Medical Doctor. I added the date to the document prior to reaching out to the physician. When surveyor asked E2 if she altered a document prior to speaking with the doctor, she stated I am calling E10 Medical Doctor now, and E2 started

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dialing on her cell phone. Surveyor asked E2 if service plan for R5 was signed today. E2 Assisted Living Memory Care Director stated, No. When presented with the evidence that the evacuation care plan had an initiation date of 3/19/26, and the last page of service plan was dated with 1/1/26 but it was a manual signature and the impression of signature could be felt on backside of page, surveyor asked E2 Assisted Living Memory Care Director again if E2 and R5 signed the service plan today and back dated it. E2 stated the service plan for R5 was signed by me and R5 today and backdated to 1/1/2026. When asked why E2 back dated to that date, E2 stated because that is when R5 returned from the hospital post fall. We are not in the habit of altering documents and backdating documents. When asked by surveyor why she altered the document, E2 Assisted Living Memory Care Director stated the reason that was done today was that I wanted to give you an updated signed signature page with R5's service plan. I did go over service plan with R5 when R5 returned from the hospital, but I did not have R5 sign the service plan at that time. When asked by surveyor, the only reason I found out it was backdated is because you updated the evacuation service plan today because evacuation service plan was missing from another resident service plan and pointed out to you, and I noticed the wet signed signature on the updated form? E2 stated yes.

On 3/19/2026, at 3:49 pm, E1 Interim Administrator was notified of document alteration for both documents by E2 Assisted Living Memory Care Director. E2 stated: I am not aware of any altering of documents, and I am not party to this, and I would not allow this. Who E2's supervisor is not clear to me being the interim. I am not exactly sure. I have helped her out if there

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is a resident issue or something, but I am not sure. I approve her timecard as I do with the director of nursing. Being an interim, I am not involved with any of that. I am not sure who is involved in the assisted living care plans and who is involved. I will find out for you who her supervisor is. E1 stated he would have E3 Assistant Director of Nursing of Health Care Center come to scan documents to surveyor.

On 3/20/2026, at 8:47 am, E1 Interim Administrator was asked by surveyor if he found out who E2 Assisted Living Memory Care Director supervisor is. E1 stated yes, I am. I do not review her work or reports or anything but yes, I found out I am her supervisor. I sign her timecard.

On 3/20/2026, at 9:29 am, E1 Interim Administrator stated: I have been in this position since December 29, 2025. I have been an administrator since 1983. I have never encountered an incident in the past with altering documents. We don't do that. It would be stupid. It is what it is. Since I am her supervisor, and next week is my last week, I am working with corporate on this issue. I mentioned there was some concern to her yesterday afternoon. We will see where this goes. My corporate contact did not give me any guidance at this time. We have to investigate.

On 3/20/2026, at 10:04 am, E10 Medical Doctor and Medical Director for Skilled area stated: I am aware of an issue with a physician assessment that did not have a date for R2. I am unsure when that was completed. I would assume that it would have been completed around the date of the medication review report that was submitted with the physician assessment. I was not made aware of this and did not authorize E2 Assisted Living

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Memory Care Director to add a date to my physician assessment for R2 that did not have a date on it. Usually if the medication list is for July 7, 2023, I would go by that date. It has happened in the past where staff let me know and I verify it is ok to add a date to a document if they verify it with me. They are to notify me. It can happen where it was an urgency that they add a date on a document, and they notify me later and I am ok with it if they have documentation to verify when it happened. In this case, where E2 Assisted Living Memory Care Director dated it 2 years after it was done so I am not sure how that happened. It has happened that it may be off by a few months. This is the first time this has happened where it is 2 years difference. I guess I signed it on time, but I do not know how the date went missing off that document for two years. Best practice would be for them to contact me before changing or adding any dates to any of my documents that I signed. I always try to make sure I sign and date my documents. This would put me at liability having a document dated two years after it was actually done. I will have to touch base with my malpractice attorney to find out. It is such a unique situation that has not happened before. When asked how you would know if this has happened before if they are not calling you prior to changing your documentation, E10 stated I would not know. When asked if you are aware of this happening in the past with such an egregious amount of time lapse from when document was created to when the date was added, she stated No.

On 3/20/2026, at 10:16 am, E2 Assisted Living Memory Care Director was shown the medication review report that was submitted with the undated physician assessment and asked her to look at the date. E2 stated: I guess that the physician

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assessment should have been done around the same date of the medication review record. I assumed the physician assessment went with when R2 was transferred to memory care from skilled. I should have looked more into it and also called the doctor prior to changing her documentation. After looking at service plans surveyor asked if the two incidents we spoke about were the only documents altered yesterday. E2 Assisted Living Memory Care Director stated I got a signature from R5 yesterday. I did sign R4's yesterday and I had R4 sign yesterday and backdated it for 3/13/2026 as I did not have a signature page for our last care conference. I did the care conference on 3/13/26 but did not get signatures. I did not alter any other documents yesterday. Everything is correct. After surveyor pointed out inconsistencies on other service plans E2 Assisted Living Memory Care Director stated R2 and R1's service plan was signed yesterday as well, and I asked E4 Registered Nurse to sign yesterday as well, and I backdated it to when the care conference happened. I also added the son's name to R1's and added the date of 2/18/26 because that is when he agreed to the care conference. I will have to look in PCC to see where I got that date. There is a lot of dynamics, and he had to clarify things with his sisters. For R3 I did sign the service plan, and I had E4 RN sign the service plan yesterday backdating it to 2/5/2026. I believe 2/5/26 was the care conference, I would have to look at the chart. I also added on the service plan that R3's power of attorney verbally agreed on 2/5/2026 and that was added yesterday on 3/19/2026. It is not ok to alter and backdate service plans. I know it is not ok to do that because documentation should be done in real time. I learned that in nursing school and throughout my career. When asked why E2 altered documents for all 5 residents picked, E2

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stated I was trying to bring things up into compliance. It has been a struggle to keep up on service plans in this community. This is not normal practice for me. Going forward I am going to get support and make sure that things are getting documented and signed in real time instead of backdating. For R1 she did not have any seizure precautions in place, R1 just got medication and labs and family followed up with neurology. R1 did have seizures here in the past. R1 had absent seizures, just staring off, but then it progressed to tonic clonic seizures for about less than a year. R1 had no auras with them or did not know when they were coming. R1 did not wear a helmet or have padded bed rails or anything like that in place. R3 did have behaviors. R3 was constant locomotion, packing, he would go into other rooms frequently, he would refuse care. The things we put in place to prevent these behaviors were to verbally redirection, engagement and activities. R3 did have a one-on-one caregiver briefly to acclimate to the community. We were working on a plan to discharge R3 safely, including R3 being required to have one-to-one supervision and the family did not agree to that. It was their decision not to have him return back here. They refused to sign the latest care plan dated 2/5/26. I wrote on there that the wife verbally agreed to care plan, but she did not agree to this care plan she agreed to previous care plan. I signed that care plan yesterday and it was backdated to 2/5/2026.

On 3/20/2026, at 11:17 am, E4 RN when asked if she signed service plans for R1, R2, and R3 yesterday and backdated them E4 stated: yes, E2 Assisted Living Memory Care Director told me I have not done that in the past. When asked what made you do that yesterday, E4 stated because my manager told me to. I should not be

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A3000	Continued From page 12 backdating and altering documents. I am not sure why she even asked me to sign it. I know I should not be backdating documents because it is not true. Documents should be dated the day that it is done. I just know from experience that we date documents when we sign them. Back dating documents would be considered falsifying documents. E4 asked if this would affect her license. Surveyor replied that she was not sure what happened after this. E4 stated I have never been asked to do anything else that I know is wrong by my manager at this facility. I am not sure how legitimate or legal a service plan is. I do not know how important it is. I just know it shows the services provided to the residents I suppose. I did not know the service plan required my signature. I was never asked to sign one before. When E2 Assisted Living Memory Care Director asked me to sign the service plans I did not know that I was doing something wrong. I had never been taught about service plans before. When asked if she was taught in nursing school to document in real time she stated, I do not remember if I was taught in school to document in real time.	A3000		
A4000	Section 295.4000 Physician/s Assessment This Regulation is not met as evidenced by: Type 2 Violation Section 295.4000 Physician's Assessment a) No more than 120 days prior to admission of a resident to any establishment, a comprehensive assessment that includes an	A4000		

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GREENFIELDS OF GENEVA	ON801 FRIENDSHIP WAY GENEVA, IL 60134

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A4000	Continued From page 13 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. This requirement was not met as evidenced by: Based on record review and interview the establishment failed to ensure physician assessments were completed by a physician for two (R2 and R3) of five residents reviewed. This creates a substantial probability of harm to a resident or residents. Findings include: R2 is a 98-year-old resident admitted to the establishment on 4/30/2025 with diagnoses including but not limited to hypertensive heart disease without heart failure and adjustment disorder. R2 Physician assessment dated 5/7/2025 is signed by a nurse practitioner and not a physician. R2 Physician assessment dated 7/3/2024 is signed by a nurse practitioner and not a physician. R3 is a 79-year-old resident admitted to the establishment on 1/30/2026 with diagnoses including but not limited to dementia with behavioral disturbances and psychosis and no longer resides in the establishment.	A4000		

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A4000	Continued From page 14 R3 Physician assessment dated 1/27/2026 is signed by a physician assistant and not a physician. Evaluation of the prospective resident's physical, cognitive, and psychosocial condition shall be completed by a physician. R3 did not meet the residency requirements to be accepted to the establishment. This action resulted in a resident physically assaulting another resident and staff. On 3/19/2026, at 11:56 am, E2 Assisted Living/Memory Care Director stated the physician should sign the physician assessment. Previously they had allowed nurse practitioners to sign but we have moved forward with physician only to sign assessments. Going forward only physicians will sign physician assessments. Physician Assessment Policy with last reviewed date of 4/19/24 documents in part: 1. No more than 120 days prior to the 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 abscense 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.	A4000		
A4010	Section 295.4010 Service Plan	A4010		

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A4010	Continued From page 15 This Regulation is not met as evidenced by: Type 2 REPEAT VIOLATION Section 295.4010 Service Plan a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the Act) The establishment shall respect and accept the resident's choices regarding the service plan. b) The service plan shall be developed by: 1) The resident, resident's representative or any individual requested by the resident; 2) The manager or manager's designee; and 3) A registered nurse, if the resident is receiving nursing services or medication administration, or is unable to direct self-care. c) The service plan shall be signed and dated by all individuals involved in its development. e) The service plan shall be reviewed and revised if necessary immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000). g) Service plans shall address: 1) The level of service the resident is	A4010		

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A4010	Continued From page 16 receiving, including: A) assistance with activities of daily living; C) special accommodations for the resident; 2) The amount, type, and frequency of health-related services needed by the resident; This requirement was not met as evidenced by: Based on observation, record review and interview the establishment failed to ensure service plans were developed by resident/resident's representative, manager/manager's designee and a registered nurse and failed to obtain signatures from said individuals on service plans for five (R1, R2, R3, R4, and R5) of five residents reviewed, failed to ensure all areas of activities of daily living were addressed in service plans for two (R1 and R3) of five residents reviewed, and failed to update service plan for change of condition for one (R4) of five residents reviewed. This failure creates a substantial probability of harm to a resident or residents. Findings include: R1 is an 81-year-old resident admitted to the establishment on 1/22/2025 with diagnoses including but not limited to hypothyroidism and seizures. R2 is a 98-year-old resident admitted to the establishment on 4/30/2025 with diagnoses including but not limited to hypertensive heart disease without heart failure and adjustment disorder.	A4010		

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A4010	Continued From page 17 R3 is a 79-year-old resident admitted to the establishment on 1/30/2026 with diagnoses including but not limited to dementia with behavioral disturbances and psychosis and no longer resides in the establishment. R4 is an 86-year-old resident admitted to the establishment on 5/28/25 with diagnoses including but not limited to migraine and anxiety disorder. R5 is a 96-year-old resident admitted to the establishment on 10/21/25 with diagnoses including but not limited to severe protein-calorie malnutrition and chronic kidney disease. R1's service plan dated 1/23/26 has not been signed by resident or resident representative. Service plan is signed by E4 Registered Nurse/RN and the E2 Assisted Living and Memory Care Director but later discovered that these signatures were obtained on 3/19/2026 during survey when provided to surveyor. R1's service plan does not address emergency evacuation. R1's service plan does not address tonic-clonic seizures or any interventions for preventing harm to resident when seizures happen. R2's service plan dated 3/10/26 has not been signed by resident or resident's representative. Service plan is signed by E4 RN and E2 Assisted Living and Memory Care Director but later discovered that these signatures were obtained on 3/19/2026 during survey when provided to surveyor. R3's service plan dated 2/5/2026 has not been signed by resident or resident's representative.	A4010		

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A4010	Continued From page 18 Service plan is signed by E4 RN and E2 Assisted Living Memory Care Director but later discovered that these signatures were obtained on 3/19/2026 during survey when provided to surveyor. R3's service plan does not address emergency evacuation. R4's service plan dated 3/13/2026 is not signed by a registered nurse. Service plan is signed by the R4 and E2 Assisted Living Memory Care Director but later discovered that these signatures were obtained on 3/19/2026 during survey when provided to surveyor. Service plan not updated with fall and new fall interventions for falls dated 12/26/25 and 1/23/26. R5's service plan dated 1/1/2026 is not signed by a registered nurse. Service plan is signed by the R5 and E2 Assisted Living Memory Care Director but later discovered that these signatures were obtained on 3/19/2026 during survey when provided to surveyor. On 3/19/2026, at 1:59 AM, E2 Assisted Living Memory Care Director stated for R1 I do not see where the service plan addresses evacuation. For R3 on his service plan I do not see where it addresses evacuation. On 3/19/2026, at 3:30 PM, Surveyor asked E2 Assisted Living Memory Care Director if service plan for R5 was signed today. E2 stated, No. When presented with the evidence that the evacuation care plan had an initiation date of 3/19/26, and the last page of service plan was dated with 1/1/26 but it was a manual signature and the impression of signature could be felt on backside of page, surveyor asked E2 again if she and R5 signed the service plan today and back dated it. E2 Assisted Living Memory Care	A4010		

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A4010	Continued From page 19 Director stated the service plan for R5 was signed by me and R5 today and backdated to 1/1/2026. When asked why E2 back dated to that date, E2 stated because that is when R5 returned from the hospital post fall. We are not in the habit of altering documents and backdating documents. When asked by surveyor why she altered the document, E2 stated the reason that was done today was that I wanted to give you an updated signed signature page with R5's service plan. I did go over service plan with R5 when she returned from the hospital, but I did not have R5 sign the service plan at that time. When asked by surveyor, the only reason I found out it was backdated is because you updated the evacuation service plan today because evacuation service plan was missing from another resident service plan and pointed out to you, and I noticed the wet signed signature on the updated form? E2 Assisted Living Memory Care Director stated yes. On 3/19/2026, at 3:41 pm, E2 Assisted Living Memory Care Director stated I am an Licensed Practical Nurse/LPN. A Registered Nurse/RN, resident/resident representative and manager are required to sign all service plans. On most of the service plans I do not have an RN signature. The service plans are an area of opportunity for us to improve. We have a plan in place that we are working on getting the service plans signed by all required personnel. The majority of our nurses are RNs. To be quite honest it just has not been part of the Registered Nurses scope. It is new to us to have the Registered Nurses be a part of the service plan. On 3/20/2026, at 11:17 am, E4 RN when asked if she signed service plans for R1, R2 and R3 yesterday and backdated them E4 stated yes. E2 Assisted Living Memory Care Director told me to.	A4010		

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A4010	Continued From page 20	A4010		

I have not done that in the past. When asked what made you do that yesterday, E4 stated because my manager told me to. I should not be backdating and altering documents. I am not sure why she even asked me to sign it. I know I should not be backdating documents because it is not true.

On 3/20/2026, at 10:16 am, After looking at service plans surveyor asked E2 Assisted Living Memory Care Director if the two incidents we spoke about were the only documents altered yesterday. E2 stated I got a signature from R5 yesterday. I did sign R4's (service plan) yesterday and I had R4 sign yesterday and backdated it for 3/13/2026 as I did not have a signature page for our last care conference. I did the care conference on 3/13/26 but did not get signatures. I did not alter any other documents yesterday. Everything is correct. After surveyor pointed out inconsistencies on other service plans, E2 Assisted Living Memory Care Director stated R2 and R1's service plan was signed yesterday as well, and I asked E4 Registered Nurse to sign yesterday as well, and I backdated it to when the care conference happened. I also added the son's name to R1's service plan and added the date of 2/18/26 because that is when he agreed to the care conference. For R3 I did sign the service plan, and I had E4 RN sign the service plan yesterday backdating it to 2/5/2026. I believe 2/5/26 was the care conference, I would have to look at the chart. I also added on the service plan that family member verbally agreed on 2/5/2026 and that was added yesterday on 3/19/2026. It is not ok to alter and backdate service plans. I know it is not ok to do that because documentation should be done in real time. I learned that in nursing school and throughout my career. When asked why she altered documents for all 5

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A4010	Continued From page 21 residents picked, E2 Assisted Living Memory Care Director she stated I was trying to bring things up into compliance. It has been a struggle to keep up on service plans in this community. This is not normal practice for me. Going forward I am going to get support and make sure that things are getting documented and signed in real time instead of backdating. I brought you the census in and outs for R4. R4 went out to hospital after fall on 12/26/25 and returned on 12/30/2025. At that point her service plan should have been updated with her fall and a new intervention, and it wasn't. There is only one intervention listed after falls on 1/10/26 and 1/22/2026. For 1/23/26 fall it is not listed and does not have a new fall intervention. She went back out to the hospital on 3/8/2026. For R1 she did not have any seizure precautions in place, R1 just got medication and labs and family followed up with neurology. R1 did have seizures here in the past. R1 had absent seizures, just staring off, but then it progressed to tonic clonic seizures for about less than a year. R1 had no auras with them or did not know when they were coming. R1 did not wear a helmet or have padded bed rails or anything like that in place.	A4010		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Type 1 Violation Section 295.4060 Alzhimer's and Dementia Programs a) In addition to this Section, Alzheimer and	A4060		

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A4060	Continued From page 22 dementia programs shall comply with all of the other provisions of the Act. (Section 150(a) of the Act) b) No person shall be admitted or retained in an assisted living or shared housing establishment if the establishment cannot provide or secure appropriate care, if the resident requires a level of service or type of service for which the establishment is not licensed or which the establishment does not provide, or if the establishment does not have the staff appropriate in numbers and with appropriate skill to provide such services. (Section 150(b) of the Act) c) No persons shall be accepted for residency or remain in residence if the person's mental or physical condition has so deteriorated to render residency in such a program to be detrimental to the health, welfare or safety of the person or of other residents of the establishment. The assessment must be approved by the resident's physician and shall occur prior to acceptance for residency, annually, and at such time that a change in the resident's condition is identified by a family member, staff of the establishment, or the resident's physician. (Section 150(c) of the Act) e) No person shall be accepted for residency or remain in residence if the person is dangerous to self or others and the establishment would be unable to eliminate the danger through the use of appropriate treatment modalities. (Section 150(d) of the Act f) No person shall be accepted for residency or remain in residence if the person meets the criteria provided in subsections (b) through (g) of Section 75 of the Act. (Section 150(e) of the Act)	A4060		

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A4060	Continued From page 23 This requirement was not met as evidenced by: Based on record review and interview the establishment failed to ensure one (R3) of five residents reviewed met residency requirements prior to admission to the establishment. This failure creates a substantial probabilit of severe harm to a resident or residents. Findings include: R3 is a 79-year-old resident admitted to the establishment on 1/30/2026 with diagnoses including but not limited to dementia with behavioral disturbances and psychosis and no longer resides in the establishment. R3's admission physician assessment dated 1/27/2026 documents summary of applicant's condition: sever major neurocognitive disorder due to Alzheimer's with behavioral disturbances. Physician assessment also documents resident needing assistance with the following areas: dressing, toileting, evacuating in case of emergency, medication management, bathing, grooming and incontinence care. R3's service plan dated 2/5/2026 (later discovered to have been signed 3/19/2026) documents: 2/20/26 Incontinence care: extensive assistance - needs assistance in cleaning and changing incontinence products. Service plan also documents: 2/20/26 Bathing - Extensive assistance required to complete bathing task. Behaviors: 2/23/26 One to one supervision required to address behaviors. Exhibits inappropriate behavior: entering other resident apartments, taking things belonging to others, wandering aimlessly, showing anger, striking care	A4060		

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staff, resident to resident incident, taking thermostats off apartment wall and common area walls.

R3's Nursing home psychiatry note dated 2/10/2026 lists diagnoses managed during visit as anxiety, insomnia, unspecified psychosis and dementia with behavioral disturbances and documents in part: Patient observed in the dayroom, calm on approach but confused with incoherent speech unable to provide personal history. Patient is a new admission to the facility. Per staff report, he continues to exhibit behavioral disturbances, including wandering into other residents' rooms, picking up their belongings, becoming angry when redirected, banging doors, yelling and swinging at staff. Yesterday, patient struck a staff member and threw his glasses across the room. This morning he attempted to hit a nurse and spat out his medications. Mood improved by nursing care and activities. This has been going on multiple days. Appetite is good, sleep is generally ok. History obtained from interview with staff and chart review. Patient and staff deny significant side effects from medications.

R3's progress note dated 2/9/2026 documents: Note Text: resident wandering into other residents' rooms and becoming angry when asked to leave. Banging on doors and yelling. RA attempted to shower resident after lunch. He started out allowing RA to assist with undressing but as soon as she tried to wash him he struck her and yelled. "What are you trying to do kill me" He also threw his glasses across the room.

R3 progress note dated 2/18/2026 documents in part: 10:40 - Nurse received call from RA she needed assistance with resident. He was in the

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A4060	Continued From page 25	A4060		

apartment of another resident and she wanted him out. He was sitting on the bed. Nurse attempted explaining to resident that he was in another person's apartment to which he responded "so what, I don't care what you say". RA and nurse attempted to get him to stand to which he just relaxed his legs and he was set back on the bed. At that time he started hitting and grabbing staff. Staff made another attempt to have him stand to which he relaxed his legs, and staff set him on the floor. Additional staff member got a wheelchair. The 3 staff member placed him in the wheelchair. Resident continued to fight staff. When he was sat down in wheelchair he slid down to where his buttocks were barely on the chair. Staff was able to transport resident to his apartment. He then stood up. Yelled and swore at staff. He saw nurse's name badge and I told him I was a nurse and his mood changed completely. He became calm, walked across his room without further incident.

R3 progress note dated 2/18/2026 documents Resident Assistant/RA reported that resident hit another RA and the activities staff member. Resident was agitated and walking around the dining room tearing apart tissue boxes and putting pieces in his mouth. Nurse responded and resident was sitting at table at this time. The resident was redirected by the nurse and became agitated. The nurse stepped aside and let the resident wander the dining room.

R3 progress note dated 2/18/2026 documents: Resident grabbed ahold of another resident's wheelchair and was trying to pull her away from the dinner table while she was eating. This Registered Nurse/RN had to remove the resident's hands from her wheelchair and lead him away from her. He then walked up to a chair

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and picked it up slamming it onto the floor. He then told the nurse to move. This resident will continue to be monitored. Needs constant supervision and redirection.

R3 progress note dated 2/19/2026 documents: Resident is alert to self and verbally responsive/forgetful. Resident observe to be wandering around the hallway pacing back and forth and opening other resident's door. Resident was redirected to dining room to eat dinner with fair appetite. Drank apple juice and cup of water. Resident observed to take his scheduled medications crush with applesauce. Resident was taken to the washroom and room by Certified Nursing Assistant/CNA and resident observed by CNA was urinating in the carpet. Resident then became agitated and started ripping out thermostat in his room and Apple hallway Thermostat. Called maintenance but no available at this time. Notified security and assisted living manager aware of behavior.

R3 progress note dated 2/20/26 documents: 11:00 Another resident's family came into visit, and this resident chased them down the hall attempting to follow them into the other resident's apartment. The family was able to get the door shut and locked. This resident then banged on the door. After a few bangs he left the area. As he walked back down the hall he banged on doors that were locked. When he got to the activity room he started clapping his hands loudly in other residents' faces. When he was escorted out of the activity room he started banging on counters and yelling. Telling staff members they were "stupid". Staff were able to persuade resident to sit down and have lunch.

R3 progress note dated 2/20/2026 documents:

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A4060	Continued From page 27	A4060		

after lunch resident wandering up and down the hallways banging on doors. Attempted to open the door to the unit and started yelling and continuing to bang when he discovered it was locked. Resident attempted to pull off the thermostat on the Cherry Hall. Nurse was right behind him and was able to get him to stop before he could pull it off. After talking for about 10 minutes nurse was able to get him to come back down the hall. At this time he is ambulating up and down the halls. Stopping at some door and attempting to open them.

R3 progress note dated 2/22/2026 documents: 10:30 - Heard screaming and responded immediately this resident was in another room. The other resident was the one screaming. R2 stated she came out of the bathroom and R3 was standing in R2's room. R2 asked R3 to leave he would not, and he grabbed R2's arms. When nurse attempted to get resident to leave, R3 sat on the floor. 3 staff members had to escort R3 out of the room because R3 would not cooperate. While dragging him out of the room he grabbed and punched this nurse in the abdomen. Once he was out of the room this nurse called 911 to send him out for evaluation. Police and ambulance were here and took a report. Emergency medical transport/EMT transferred resident to hospital. Doctor notified. Wife arrived while EMT and police were here, and she was notified. Resident was sent with a petition for mental health services.

R2 progress note dated 2/22/2026 documents: 10:30 - Nurse heard resident scream out and responded immediately. There was another resident in her room. He had one of her pillows and she was trying to get him to leave. Nurse and 2 other staff members removed the other resident

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A4060	Continued From page 28 (R3). Resident stated "R3 grabbed my arms and wouldn't let go. Skin assessment done. There are no marks on R2's skin. On 3/20/2026, at 10:16 am, E2 Assisted Living Memory Care Director stated R3 did have behaviors. R3 was constant locomotion, packing, R3 would go into other rooms frequently, he would refuse care. The things we put in place to prevent these behaviors were to verbally redirection, engagement and activities. R3 did have a one on one caregiver briefly to acclimate to the community. It was later disclosed to me that R3's wife was locking him in the house when R3 was at home. So R3 was trying to leave the home as well. I was not here when R3 had the resident-to-resident verbal altercation to our knowledge. The nurse did a head-to-to toe on the R2, but the nurse could hear R2 telling R3 to get out of her room. From what I know R3 went into R2's room and was holding one of her pillows and R2 was telling him to get out. The care staff went to intervene and R3 would not leave the apartment. They called security. They were able to assist him out of the apartment and R3 became combative with the staff. R3 hit the nurse E3 Registered Nurse RN. E3 is here today. That is when 911 was called. R3's wife was here. Staff tried to call R3's wife but she was in route and arrived when EMS arrived. R3 did not return to facility after that incident. So, when we originally spoke with family after admitting and discontinuing one-to-one companion they were in agreement to the plan and were fine with everything. When I talked to them about some potentially behavioral health interventions like seeing neurology then they said no, and it took too long to get into neurology. I was able to request some previous documents from prior primary care provider/PCP, and it was pretty	A4060		

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A4060	Continued From page 29	A4060		

apparent R3 had some previous behaviors that were not discussed prior to admitting to facility. R3 had been physically aggressive towards the wife on previous occasions but the family had denied it. We were working on a plan to discharge R3 safely, including him being required to have one to one supervision and the family did not agree to that. It was their decision not to have him return back here.

On 3/20/2026, at 11:28 am, E3 RN stated: I was here when there was a resident-to-resident altercation between R3 and R2. I heard a yell, so I went tearing down the hall. R2 said "R3 attacked me". Those were her words. There was already an aid in the room when I arrived. That aid was E7 Certified Nursing Assistant/CNA. E7 CNA was closer to the room than I was. R3 was standing in her room holding a pillowcase with some clothing items in it when I arrived and he was not touching R2 at that time. I tried to get R3 to follow me out of the room and R3 would not come. R3 sat himself down on the floor. Again, I tried to get R3 to leave. R2 was yelling. R2 was scared. We literally pulled R3 out of the room E7 CNA and I so we could get R3 away from R2. R3 punched me in the gut while we were doing that. I was not hurt; I was just shocked. It scared me. I left R3 with the aid and called 911 and sheriff's office. There was a police report made on R3 hitting R2. R2 did say R3 hit R2. R3 grabbed her forearms as R2 was sitting in the wheelchair per her report. I did a full skin assessment; there were no bruises. I even had next shift do one to make sure no bruises developed later. I reported this to E2 Assisted Living Memory Care Director that R3 hit R2. R3 did not say that he hit R2. R3's communication skills were not good. Emergency Medical Services/EMS took R3 to hospital. R2 did not go out to the hospital but was offered. Both

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A4060	Continued From page 30 families and both doctors were notified. R2's family was notified that R2 claimed R3 grabbed her forearms.	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; This requirement was not met as evidenced by: Based on record review and interviews the establishment failed to keep one (R1) of five residents reviewed free from abuse. This failure creates a substantial probability of severe harm to a resident or residents. Findings include: R2 is a 98-year-old resident admitted to the establishment on 4/30/2025 with diagnoses including but not limited to hypertensive heart disease without heart failure and adjustment	A6000		

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A6000	Continued From page 31	A6000		

disorder.

R3 is a 79-year-old resident admitted to the establishment on 1/30/2026 with diagnoses including but not limited to dementia with behavioral disturbances and psychosis and no longer resides in the establishment.

R3 admit physician assessment dated 1/27/26 documents summary of applicant's condition as severe major neurocognitive disorder due to Alzheimer's with behavioral disturbances.

Service plan documents behavior care plan initiated 2/23/2026 which is after the resident-to-resident altercation although behaviors were documented since admission.

R3 progress note dated 2/18/2026 documents in part: 10:40 - Nurse received call from RA she needed assistance with resident. He was in the apartment of another resident and she wanted him out. He was sitting on the bed. Nurse attempted explaining to resident that he was in another person's apartment to which he responded "so what, I don't care what you say". RA and nurse attempted to get him to stand to which he just relaxed his legs and he was set back on the bed. At that time he started hitting and grabbing staff. Staff made another attempt to have him stand to which he relaxed his legas and staff set him on the floor. Additional staff member got a wheelchair. The 3 staff member placed him in the wheelchair. Resident continued to fight staff. When he was sat down in wheelchair he slid down to where his buttocks were barely on the chair. Staff was able to transport resident to his apartment. He then stood up. Yelled and swore at staff. He saw nurse's name badge and I told him I was a nurse and his mood changed

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A6000	Continued From page 32	A6000		

completely. He became calm, walked across his room without further incident.

R3 progress note dated 2/18/2026 documents Resident Assistant/RA reported that resident hit another RA and the activities staff member. Resident was agitated and walking around the dining room tearing apart tissue boxes and putting pieces in his mouth. Nurse responded and resident was sitting at table at this time. The resident was redirected by the nurse and became agitated. The nurse stepped aside and let the resident wander the dining room.

R3 progress note dated 2/18/2026 documents: Resident grabbed ahold of another resident's wheelchair and was trying to pull her away from the dinner table while she was eating. This Registered Nurse/RN had to remove the resident's hands from her wheelchair and lead him away from her. He then walked up to a chair and picked it up slamming it onto the floor. He then told the nurse to move. This resident will continue to be monitored. Needs constant supervision and redirection.

R3 progress note dated 2/19/2026 documents: Resident is alert to self and verbally responsive/forgetful. Resident observe to be wandering around the hallway pacing back and forth and opening other resident's door. Resident was redirected to dining room to eat dinner with fair appetite. Drank apple juice and cup of water. Resident observed to take his scheduled medications crush with applesauce. Resident was taken to the washroom and room by Certified Nursing Assistant/CNA and resident observed by CNA was urinating in the carpet. Resident then became agitated and started ripping out thermostat in his room and Apple hallway

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A6000	Continued From page 33	A6000		

Thermostat. Called maintenance but no available at this time. Notified security and assisted living manager aware of behavior.

R3 progress note dated 2/20/26 documents: 11:00 Another resident's family came into visit, and this resident chased them down the hall attempting to follow them into the other resident's apartment. The family was able to get the door shut and locked. This resident then banged on the door. After a few bangs he left the area. As he walked back down the hall he banged on doors that were locked. When he got to the activity room he started clapping his hands loudly in other residents' faces. When he was escorted out of the activity room he started banging on counters and yelling. Telling staff members they were "stupid". Staff were able to persuade resident to sit down and have lunch.

R3 progress note dated 2/20/2026 documents: after lunch resident wandering up and down the hallways banging on doors. Attempted to open the door to the unit and started yelling and continuing to bang when he discovered it was locked. Resident attempted to pull off the thermostat on the Cherry Hall. Nurse was right behind him and was able to get him to stop before he could pull it off. After talking for about 10 minutes nurse was able to get him to come back down the hall. At this time he is ambulating up and down the halls. Stopping at some door and attempting to open them.

R3 progress note dated 2/22/2026 documents: 10:30 - Heard screaming and responded immediately this resident was in another room. The other resident was the one screaming. R2 stated she came out of the bathroom and R3 was standing in R2's room. R2 asked R3 to leave he

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A6000	Continued From page 34	A6000		

would not, and he grabbed R2's arms. When nurse attempted to get resident to leave, R3 sat on the floor. 3 staff members had to escort R3 out of the room because R3 would not cooperate. While dragging him out of the room he grabbed and punched this nurse in the abdomen. Once he was out of the room this nurse called 911 to send him out for evaluation. Police and ambulance were here and took a report. Emergency medical transport/EMT transferred resident to hospital. Doctor notified. Wife arrived while EMT and police were here, and she was notified. Resident was sent with a petition for mental health services.
R3's Nursing home psychiatry note dated 2/10/2026 documents in part: Patient observed in the dayroom, calm on approach but confused with incoherent speech unable to provide personal history. Patient is a new admission to the facility. Per staff report, he continues to exhibit behavioral disturbances, including wandering into other residents' rooms, picking up their belongings, becoming angry when redirected, banging doors, yelling and swinging at staff. Yesterday, patient struck a staff member and threw his glasses across the room. This morning he attempted to hit a nurse and spat out his medications. Mood improved by nursing care and activities. This has been going on multiple days. Appetite is good, sleep is generally ok. History obtained from interview with staff and chart review. Patient and staff deny significant side effects from medications.

R2 progress note dated 2/22/2026 documents: 10:30 - Nurse heard resident scream out and responded immediately. There was another resident in her room. He had one of her pillows and she was trying to get him to leave. Nurse and 2 other staff members removed the other resident

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A6000	Continued From page 35	A6000		

(R3). Resident stated "R3 grabbed my arms and wouldn't let go. Skin assessment done. There are no marks on R2's skin.

On 3/20/2026, at 10:16 am, E2 Assisted Living Memory Care Director stated R3 did have behaviors. R3 was constant locomotion, packing, R3 would go into other rooms frequently, he would refuse care. The things we put in place to prevent these behaviors were to verbally redirection, engagement and activities. R3 did have a one on one caregiver briefly to acclimate to the community. It was later disclosed to me that R3's wife was locking him in the house when R3 was at home. So R3 was trying to leave the home as well. I was not here when R3 had the resident-to-resident verbal altercation to our knowledge. The nurse did a head-to-to toe on the R2, but the nurse could hear R2 telling R3 to get out of her room. From what I know R3 went into R2's room and was holding one of her pillows and R2 was telling him to get out. The care staff went to intervene and R3 would not leave the apartment. They called security. They were able to assist him out of the apartment and R3 became combative with the staff. R3 hit the nurse E3 Registered Nurse RN. E3 is here today. That is when 911 was called. R3's wife was here. Staff tried to call R3's wife but she was in route and arrived when EMS arrived. R3 did not return to facility after that incident. So, when we originally spoke with family after admitting and discontinuing one-to-one companion they were in agreement to the plan and were fine with everything. When I talked to them about some potentially behavioral health interventions like seeing neurology then they said no, and it took too long to get into neurology. I was able to request some previous documents from prior primary care provider/PCP, and it was pretty

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A6000	Continued From page 36	A6000		

apparent R3 had some previous behaviors that were not discussed prior to admitting to facility. R3 had been physically aggressive towards the wife on previous occasions but the family had denied it. We were working on a plan to discharge R3 safely, including him being required to have one to one supervision and the family did not agree to that. It was their decision not to have him return back here.

On 3/20/2026, at 11:28 am, E3 RN stated I was here when there was a resident-to-resident altercation between R3 and R2. I heard a yell, so I went tearing down the hall. R2 said "R3 attacked me". Those were her words. There was already an aid in the room when I arrived. That aid was E7 Certified Nursing Assistant/CNA. E7 CNA was closer to the room than I was. R3 was standing in her room holding a pillowcase with some clothing items in it when I arrived and he was not touching R2 at that time. I tried to get R3 to follow me out of the room and R3 would not come. R3 sat himself down on the floor. Again, I tried to get R3 to leave. R2 was yelling. R2 was scared. We literally pulled R3 out of the room E7 CNA and I so we could get R3 away from R2. R3 punched me in the gut while we were doing that. I was not hurt; I was just shocked. It scared me. I left R3 with the aid and called 911 and sheriff's office. There was a police report made on R3 hitting R2. R2 did say R3 hit R2. R3 grabbed her forearms as R2 was sitting in the wheelchair per her report. I did a full skin assessment; there were no bruises. I even had next shift do one to make sure no bruises developed later. I reported this to E2 Assisted Living Memory Care Director that R3 hit R2. R3 did not say that he hit R2. R3's communication skills were not good. Emergency Medical Services/EMS took R3 to hospital. R2 did not go out to the hospital but was offered. Both

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A6000	Continued From page 37	A6000		

families and both doctors were notified. R2's family was notified that R2 claimed R3 grabbed her forearms.

On 3/20/2026, at 1:53 pm, R2 stated yes a while back I had a man (R3) come into my room and grab me. It threw me a bit at my age. I ended up on the floor. It happened so fast I don't remember the particulars. R3 was taken away and hopefully they shot him. R3 wasn't very nice. I feel safe here now. I am a little bit Irish so I know how to protect myself. A good kick will always work. I should have kicked him.

Abuse, Neglect, and Exploitation Policy with revision date of 9/20/24 documents in part:
The components of the Community abuse prohibition plan are discussed herein:
1. B. Prospective residents will be screened to determine whether the Community has the capability and capacity to provide the necessary care and services for each resident admitted to the facility.
1. An assessment of the individual's functional and mood/behavioral status, medical acuity, an special needs will be reviewed prior to admission.
II. Employee Training
C. Training topics will include
1. Prohibiting and preventing all forms of abuse, neglect, misappropriation of resident property, and exploitation
5. Understanding behavioral symptoms of residents that may increase the risk of abuse and neglect such as:
a. Aggressive and/or catastrophic reactions of residents
b. Wandering ore elopement-type behaviors
c. resistance to care
d. outbursts or yelling out; and
e difficulty in adjusting to new routines or staff.

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A7000	Secton 295.7000 Resident Records	A7000		

This Regulation is not met as evidenced by:
Section 295.7000 Resident Records

a) Service delivery contracts and related documents executed by each resident or resident's representative shall be maintained by the establishment from the date of execution until three years after the date the contract is terminated. (Section 105 of the Act)
b) An establishment shall maintain a resident's record that contains at least the following:
5) Documentation of orientation to the evacuation plan;

This requirement was not met as evidenced by:

Based on record review and interview, the establishment failed to provide documentation of resident emergency and evacuation plan orientation for five (R1, R2, R3, R4, and R5) of five residents reviewed.

This failure has the probability to affect all residents in the establishment.

Findings include:

R1 is an 81-year-old resident admitted to the establishment on 1/22/2025 with diagnoses including but not limited to hypothyroidism and seizures. Resident Record reviewed. No documentation of orientation to the evacuation plan.

R2 is a 98-year-old resident admitted to the

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GREENFIELDS OF GENEVA	ON801 FRIENDSHIP WAY GENEVA, IL 60134

(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
A7000	Continued From page 39	A7000		

establishment on 4/30/2025 with diagnoses including but not limited to hypertensive heart disease without heart failure and adjustment disorder. Resident Record reviewed. No documentation of orientation to the evacuation plan.

R3 is a 79-year-old resident admitted to the establishment on 1/30/2026 with diagnoses including but not limited to dementia with behavioral disturbances and psychosis and no longer resides in the establishment. Resident Record reviewed. No documentation of orientation to the evacuation plan.

R4 is an 86-year-old resident admitted to the establishment on 5/28/25 with diagnoses including but not limited to migraine and anxiety disorder. Resident Record reviewed. No documentation of orientation to the evacuation plan.

R5 is a 96-year-old resident admitted to the establishment on 10/21/25 with diagnoses including but not limited to severe protein-calorie malnutrition and chronic kidney disease. Resident Record reviewed. No documentation of orientation to the evacuation plan.

Surveyor was not provided with evacuation orientation for R1, R2, R3, R4, and R5.

On 3/19/2026, at 2:37 pm, E1 Interim Administrator stated E2 stated we do not have any signed resident orientations for any of the residents requested.

On 3/20/2026, at 9:16 am, (with E1 Interim Administrator present) E2 stated we do not have a new resident orientation signature page for the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GREENFIELDS OF GENEVA	ON801 FRIENDSHIP WAY GENEVA, IL 60134

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A7000	Continued From page 40 resident orientation that we do upon admission. We do not have them sign anything when we do orientation with them. We do evacuation drills. We also have an intro to new residents monthly.	A7000		