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INDIGO AT BARTLETT (THE)	1035 SOUTH ROUTE 59 BARTLETT, IL 60103

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A 000	Initial Comment Change of Ownership Survey Section 295.2040c)1)2)3)e)g)h) Section 295.2050a)b)c) Section 295.2060a)b)1)2) Section 295.3000a)b)f)1) Section 295.3020a)1)2)3)4)5)6)b)1)2)3)4)5)6) Section 295.3040 Section 295.4010 a)b)1)2)3)c)d)e)g)1)2)3)4)5)h) Section 295.4050 Section 295.4060d)1)2)3) Section 295.6000a)13) Complaint Investigation 2575200/IL194089 - No Violations Facility Reported Incident 5/12/25 IL192067 Section 295.4010 a)b)1)2)3)c)d)e)g)1)2)3)4)5)h) Facility Reported Incident 6/10/25 IL194232 Section 295.4010 a)b)1)2)3)c)d)e)g)1)2)3)4)5)h) Section 295.2050a)b)c) Facility Reported Incident 6/10/25 IL194236 Section 295.2050a)b)c) Section 295.6000a)13)	A 000		
A2040	Section 295.2040 Disaster Preparedness This Regulation is not met as evidenced by: General Violation Section 295.2040 Disaster Preparedness c) At least six drills shall be conducted per year on a bimonthly basis. At least two of the drills shall be conducted during the night when residents are sleeping. All drills shall be held	A2040		

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A2040	Continued From page 1 under varied conditions to: 1) Ensure that all personnel on all shifts are trained to perform assigned tasks; 2) Ensure that all personnel on all shifts are familiar with the use of the fire fighting equipment in the facility; 3) Evaluate the effectiveness of disaster plans, procedures and training ... e) Drills shall include residents, establishment personnel, and other persons in the establishment ... g) Drills shall involve the actual evacuation of residents to an assembly point as specified in the emergency plan and shall provide residents with experience using various means of escape. If an establishment has an evacuation capability classification of impractical, those residents who cannot meaningfully assist in their own evacuation or who have special health problems shall not be required to participate in the drill; however, other requirements of the Life Safety Code will apply. h) A written evaluation of each drill shall be submitted to the establishment manager and shall be maintained for one year from the date of the drill. The evaluation shall include the date and time of the drill, names of employees participating in the drill, and identification of any residents who received assistance for evacuation. This requirement was not met, as evidenced by: Based on interview and record review, the establishment failed to ensure at least two of the	A2040		

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A2040	Continued From page 2	A2040		

drills, conducted during the night when residents were sleeping, included residents and involved their actual evacuation to an assembly point. They failed to ensure drill evaluations identified any residents who received assistance for evacuation. The failure to include and evacuate residents with drills conducted during hours of sleep creates a substantial probability of severe harm to a resident or residents and staff, in that emergency situations can occur during any time of the day, and if staff did not practice how to respond to and manage cognitively impaired residents awakened out of sleep, lack of preparedness may increase the risk of injury or death.

The findings include:

On 6/30/25, a Change of Ownership survey was initiated, with a look back period of 8/1/24.

Fire and Tornado drills were reviewed and showed the following drills were conducted during hours of sleep, but there was no documentation the drill involved or evacuated residents to an assembly point:

Fire
9/3/24 5:30 AM 3rd shift
12/6/24 4:37 AM 3rd shift, showed "simulated"
3/3/25 5:15 AM 3rd shift, showed "no resident participation overnight"
6/18/25 4:23 AM 3rd shift

Tornado
2/14/25 5:00 AM 3rd shift

The following drill evaluations did not identify any residents who received assistance for evacuation:

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A2040	Continued From page 3 Fire 9/3/24 5:30 AM 3rd shift 12/6/24 4:37 AM 3rd shift 3/3/25 5:15 AM 3rd shift 4/22/25 1:20 PM 1st shift 5/14/25 4:35 PM 2nd shift 6/18/25 4:23 AM 3rd shift Tornado 2/14/25 5:00 AM 3rd shift - no resident participation On 7/3/25 at 2:48 PM, concerns were shared with E1 (Interim Executive Director), E9 (Director of Operations), and E14 (Regional Nurse Specialist) and confirmed. The establishment policy titled Tornado Drills - Illinois (Effective/Revised Date 10/1/22) showed: Policy: Jaybird Senior Living communities shall conduct tornado drills per regulation and ensure drill documentation and critique of the drill is maintained. Procedure: Tornado drill will be conducted on each shift during the month of February annually. Evaluation of each drill shall be completed and maintained by the director/designee. Drill will include: ...Residents needing assistance during drill ... The establishment policy titled Evacuation and Disaster - Illinois (Effective/Revised Date 10/1/22) showed: ...Procedure: ...Drills: Fire, Drills shall occur per policy. Flooding, other emergency disaster: At lease 6 other drills per year shall occur; two of which must be during the night when residents are sleeping ...They should be documented on the appropriate drill form and include all participants; documentation must include date and time of the drill and identify any	A2040		

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A2040	Continued From page 4 residents who received assistance for evacuation.	A2040		
A2050	Section 295.2050 Incident and Accident Reporting This Regulation is not met as evidenced by: Type 3 Violation Section 295.2050 Incident and Accident Reporting a) An establishment shall report to the Department any serious incident or accident. For the purposes of this Section, "serious" means any incident or accident that causes physical or emotional harm or injury to a resident. A change in an individual's (resident's) condition that is due to health or medical decline is not a reportable incident or accident. b) The report shall be made by contacting the Department of Public Health Division of Assisted Living via email at DPH.LTCAL@illinois.gov or as requested by the Department within 24 hours after the occurrence of the incident or accident. 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 47 Ill. Reg. 13264, effective August 30, 2023) This requirement was not met, as evidenced by: Based on interview and record review, the	A2050		

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A2050	Continued From page 5	A2050		

establishment failed to report to the Department serious incidents or accidents that cause physical harm or injury to the resident or did not report them within 24 hours. This applies to 3 of 6 residents (R1, R3, R5) reviewed for this requirement.

The findings include:

There was no documentation to show the following incidents or accidents that caused physical harm or injury were reported to the Department or they were not reported within 24 hours after the occurrence of the incident or accident:

1. R1's Progress Note, dated 11/26/24 at 1:56 AM, showed R1 had a fall on 11/25/24 at 7:30 PM that resulted in a small cut to the top of the head. The note showed the Power of Attorney (POA) declined hospital evaluation.

R1's Progress Note, dated 1/23/25 at 2:39 AM, showed R1 presented with purple bruising to the left thigh from a fall that occurred on 1/19/25. R1's Progress Note, dated 1/19/25 at 8:22 PM, showed R1 had a fall that showed no signs of injury at the time.

R1's Progress Note, dated 2/24/25 at 4:02 PM, showed R1 complained of pubis pain and the right leg showed outer rotation during a physical therapy session. R1's Progress Note, dated 2/25/25 8:31 AM, showed a new order for a pelvic x-ray.

R1's Progress Note, dated 3/1/25 at 1:03 PM, showed an x-ray was completed. X-ray results, dated 3/1/25, showed no acute pelvic injuries.

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A2050	Continued From page 6	A2050		

R1's Incident/Accident Report, dated 5/19/25 at 1:30 PM, showed report was not made to the Department within 24 hours, with confirmation date/time as 5/22/25 at 2:21 PM. The report showed R1 punched R2 on the back.

R1's Progress Note, dated 6/19/25 at 2:42 PM, showed R1 had a fall that resulted in superficial abrasions/redness on the right scapular region and left elbow, and reported hitting R1's head. The note showed emergency services were called, but the POA declined hospital evaluation, before the services arrived.

2. R3's Progress Note, dated 4/19/25 at 2:09 PM, showed R3 presented with bruises to both arms and legs, an abrasion to the left forearm, right leg near knee, right shoulder, and left upper arm, with complaints of mild pain and soreness to the arms and legs.

3. R5's Progress Note, dated 8/5/24 at 12:00 PM, showed R5 had a fall that resulted in a bump the back of R5's head with complaint of pain, but the POA declined to send R5 to the hospital for evaluation.

R5's Progress Note, dated 10/7/24 at 9:00 PM, showed R5 had a fall that resulted in lower back pain and redness to the left elbow, but the POA declined to send R5 to the hospital for evaluation.

R5's Progress Note, dated 11/25/25 at 8:15 PM, showed R5 had a fall that resulted in no complaint of pain but significant difficulty walking and was sent to the hospital for evaluation.

On 7/3/25 at 2:48 PM, concerns were shared with E1 (Interim Executive Director), E9 (Director of Operations), and E14 (Regional Nurse Specialist)

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A2050	Continued From page 7 and confirmed.	A2050		
A2060	Section 295.2060 Quality Improvement Program This Regulation is not met as evidenced by: General Violation Section 295.2060 Quality Improvement Program a) The establishment shall establish an effective quality improvement program that encompasses oversight and monitoring, resident satisfaction, and ongoing quality improvement and implementation of any plan that addresses improved quality services. The quality improvement process implemented by the establishment must benchmark performance, be customer centered, be data driven, and focus on resident satisfaction. (Section 30(a) of the Act) For the purpose of this Section, "benchmark" means creating points of reference from which measurements can be made. b) A system shall be in place to facilitate the detection of issues and problems, to expedite the implementation of action, and to resolve problems. 1) Data analysis shall be used to identify and implement changes that will improve performance or reduce the risk of additional events. 2) The establishment shall maintain documentation that shows that data analysis has occurred and that actions, as appropriate, have been implemented to address identified issues	A2060		

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A2060	Continued From page 8	A2060		

and to resolve problems, as well as any follow-up actions taken by the establishment.

c) The existence, results, and process of a quality improvement program cannot be used as evidence in any civil or criminal court proceeding.

d) The result of the quality improvement program cannot be the sole basis for citing a violation.

This requirement was not met, as evidenced by:

Based on interview and record review, the establishment failed to follow their policy and state regulation when they did not follow a quality improvement program to mark performance and show the implementation of process improvement and utilize a grievance process to detect and resolve issues and problems. This failure creates a substantial probability of harm to a resident or residents, in that it cannot be determined if the establishment is aware of and addressing the needs and concerns of residents and that effect residents and ensures resident rights are not deprived.

The findings include:

The establishment was not able to provide documentation of an intact Quality Assurance (QA) or Complaint/Grievances process.

On 7/2/25 at 1:50 PM, E9 (Director of Operations) indicated, he was not able to find a complaint/grievance binder, and unable to verify if there were any grievances since 8/1/24.

On 7/3/25 at 2:48 PM, E9 indicated he was not

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A2060	Continued From page 9 able to find a QA binder and a committee was not in practice, but he planned to train E1 (Interim Executive Director) in the QA process, in the upcoming week. The establishment policy titled Quality Improvement Program (Effective/Revised Date: 10/1/22) showed: Policy: Jaybird Senior Living communities shall follow a quality program that marks performance and shows the implementations of process improvement. Procedure: ...Jaybird communities utilize a grievance process, offering forms for any visitor, resident, staff to provide feedback to improve process, detect issues and problems and resolve those problems. Monthly at a minimum, the community shall complete a quality assurance meeting that then entails the plans for improvement. After completing the quality assurance meeting the documentation shall be kept in the Quality binder and maybe stored in the shared drive as well ... The establishment policy titled Complaint/Grievance (Effective/Revised Date: 3/15/2022) showed: Policy: To ensure complaints regarding Jaybird Senior Living Communities are resolved in a timely and appropriate manner for employees for residents that have concerns or complaints ...Procedure:...1) A facility complaint form should be filled out by the resident, resident representative, or employee and given to the supervisor of the department or to the Assisted Living Director ...9) Finalized resident complaints will be kept by the director in the complaint log binder.	A2060		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng	A3000		

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A3000	Continued From page 10 This Regulation is not met as evidenced by: General 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) b) The establishment shall have on duty at all times at least one direct care staff person who has obtained cardiopulmonary resuscitation (CPR) training specific to adults, which includes a demonstration of the individual's ability to perform CPR, and who has current certification in CPR... f) In addition to the information required in subsection (e) of this Section, the file for each direct care employee shall contain documentation of: 1) Current certification in CPR, if applicable; ... (Source: Amended at 28 Ill. Reg. 14593, effective October 21, 2004) This requirement was not met, as evidenced by: Based on interview and record review, the establishment maintained a nurse who's license	A3000		

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A3000	Continued From page 11 expired. They failed to ensure they had on duty at all times at least one direct care staff person who obtained cardiopulmonary resuscitation (CPR) training specific to adults, which included a demonstration of the individual's ability to perform CPR. They failed to maintain an employee file that contained documentation of current CPR certification. This applies to 2 of 21 employees (E8, E10) reviewed for this requirement and has the potential to affect all residents that reside in the establishment. Requirements were not met due to the conduct of the establishment or its staff, when a nurse did not ensure their professional license was in good standing, and the establishment continued to employee the nurse until it was brought to their attention during the survey. The findings include: Professional License: On 6/30/25, nurses' licenses were checked for active status on the state professional license look-up website, and E8 (Licensed Practical Nurse), date of hire 9/17/24, License # 043127325, showed license "Not Renewed", "expired 2/28/25". The establishment job description, titled Licensed Practical Nurse - Care (Created/Revised June 2022), showed: ...Required Education and Experience: Licensed Practical Nurse license in good standing with applicable state.	A3000		

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The establishment nurse schedule was reviewed from 8/1/24 forward and showed E8 performed duties as a Licensed Practical Nurse with an expired license from 3/1/25 until 6/28/25.

On 6/30/25 at 1:17 PM, E1 (Interim Executive Director) indicated, she was unaware of the expired license and agreed to remove E8 from the schedule.

Email communication with E1, dated 7/9/25 at 1:09 PM, showed staff were required to submit a copy of their professional license upon renewal. E1 indicated, E15 (Previous Business Office Manager) managed employee records and the nurse and caregiver schedule, up until her last day of 5/22/25, and E1 recently took on those duties.

CPR Coverage:

On 7/7/25, direct care staff CPR certifications were reviewed and compared to the Nursing and Resident Assistant schedules for August 2024 to June 2025.

E10's CPR Certification of Completion from International CPR Institute, completion 1/7/24 and expiration 1/7/26, did not indicate return demonstration was part of the course, as state regulation requires. The course website https://www.icpri.com/online-courses/ was reviewed and showed the course was on-line only. For this reason, E10 was not factored as part of direct staff CPR certified coverage.

The following dates/times could not be verified that a direct care CPR certified staff person was on duty:

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A3000	Continued From page 13 August 2024 All day: 8/1-8/31 September 2024 All day: 9/1-9/30 October 2024 All day: 10/1, 10/4, 10/6-10/8, 10/11, 10/13-10/15, 10/18, 10/20-10/22, and 10/25-10/29. 7:00 AM-7:00 PM: 10/2-10/3, 10/5, 10/9-10/10, 10/12, 10/16-10/17, 10/19, 10/23-10/24, and 10/30-10/31 November 2024 All day: 11/1, 11/4-11/5, 11/8, 11/10-11/12, 11/15, 11/17-11/19, 11/22, 11/24-11/26, and 11/29. 7:00 AM-7:00 PM: 11/2-11/3, 11/6-11/7, 11/9, 11/13-11/14, 11/16, 11/20-11/21, 11/23, 11/17-11/28, and 11/30 December 2024 All day: 12/1-12/3, 12/6, 12/8-12/10, 12/13, 12/15-12/17, 12/20, 12/22-12/24, 12/27, and 12/29-12/31. 7:00 AM-7:00 PM: 12/4-12/5, 12/7, 12/11-12/12, 12/14, 12/18-12/19, 12/21, 12/25-12/26, and 12/28 January 2025 All day: 1/3, 1/5-1/7, 1/10, 1/12-1/14, 1/17-1/21, 1/24-1/28, and 1/30-1/31. 7:00 AM-7:00 PM: 1/1-1/2, 1/4, 1/8-1/9, 1/11, 1/15-1/16, 1/22-1/23, and 1/29 February 2025 All day: 2/2-2/4, 2/7, 2/9-2/11, 2/14, 2/16-2/18, 2/21, 2/23-2/25, and 2/28. 7:00 AM-7:00 PM: 2/1, 2/5-2/6, 2/8, 2/12-2/13, 2/15, 2/19-2/20, 2/22 and 2/26-2/27	A3000		

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	ASL510493	A. BUILDING: _____ B. WING _____	C 07/10/2025

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A3000	Continued From page 14 March 2025 All day: 3/2-3/4, 3/7, 3/9-3/11, 3/14, 3/16-3/18, 3/21, 3/23-3/25, 3/28, 3/30-3/31. 7:00 AM-7:00 PM: 3/1, 3/5-3/6, 3/8, 3/12-3/13, 3/15, 3/19-3/20, 3/22, 3/26-3/27 and 3/29 April 2025 All day: 4/1, 4/4, 4/6-4/8, 4/10-4/11, 4/13-4/15,4/18, 4/21, 4/25, and 4/27. 7:00 AM-7:00 PM: 4/2-4/3, 4/5, 4/9, 4/12, 4/16-4/17, 4/19-4/20, 4/22-4/24, 4/26, and 4/28-4/30 May 2025 All day: 5/4, 5/9, 5/11, 5/18, 5/23, and 5/25 7:00 AM-7:00 PM: 5/1, 5/3, 5/7-5/8, 5/11, 5/14-5/15, 5/17, 5/21-5/22, 5/28-5/29, and 5/31. 7:00 PM-11:00 PM: 5/19-5/20, 5/26-5/27, and 5/30. 7:00 PM-7:00 AM: 5/2, 5/5-5/6, 5/12-5/13, and 5/16 June 2025 All day: 6/1, 6/6, 6/15, 6/20, and 6/29 7:00 AM-7:00 PM: 6/4-6/5, 6/11-6/12, 6/14, 6/18-6/19, 6/25-6/26, and 6/28. 7:00 PM-11:00 PM: 6/2-6/3, 6/8-6/10, 6/13, 6/16-6/17, 6/22-6/24, 6/27, and 6/30 On 7/7/25 at 4:03 PM, E1 (Interim ED) indicated, she was not certain how the establishment previously ensured the regulation was met, but since she now managed the schedule, planned to schedule a CPR class as soon as possible. Employee Records: On 6/30/25, CPR cards were requested from the establishment for direct care staff, and E1 had to search for and try to obtain cards. On 7/7/25 at 4:03 PM, E1 indicated, nurses and	A3000		

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A3000	Continued From page 15 resident assistants are required to be CPR certified. Email communication with E1, on 7/8/25 at 11:22 AM, showed E1 indicated, she provided all the cards she could find.	A3000		
A3020	Section 295.3020 Employee Orientation and Ongoing Training This Regulation is not met as evidenced by: General Violation Section 295.3020 Employee Orientation and Ongoing Training a) Each new employee shall complete orientation within 10 days after the starting date of employment that includes: 1) The establishment's philosophy and goals; 2) Promotion of resident dignity, independence, self-determination, privacy, choice, and resident rights; 3) Confidentiality of resident records and resident information; 4) Hygiene and infection control; 5) Abuse and neglect prevention and reporting requirements; and 6) Disaster procedures. b) Each employee shall also complete	A3020		

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A3020	Continued From page 16 orientation within 30 days after the starting date of employment that includes: 1) Orientation to the characteristics and needs of the establishment's residents; 2) The significance and location of resident service plans; 3) Internal establishment requirements and the establishment's policies and procedures; 4) The employee's job responsibilities and limitations; 5) CPR and emergency procedures for medical events, if applicable; and 6) Training in assistance with activities of daily living appropriate to the job ... This requirement was not met, as evidenced by: Based on interview and record review, the establishment failed to ensure new employees completed the required training topics within 10 and 30 days after starting employment. This applies to 6 of 8 employees (E3, E4, E5, E6, E7, E8) reviewed for this requirement. This failure has the potential to affect all residents that reside in the community and creates a substantial probability of harm to a resident or residents, as the required training ensures staff have the skills and knowledge critical to resident safety and well-being. The findings include:	A3020		

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A3020	Continued From page 17 The following new employees did not complete the noted training topics, within 10 days after their starting date of employment: E3 (Registered Nurse), DOH 6/18/25 - due by 6/28/25 -The establishment's philosophy and goals -Confidentiality of resident records and resident information E6 (Licensed Practical Nurse - LPN), DOH 4/7/25 - due by 4/17/25 -Abuse and neglect prevention and reporting requirements - Disaster procedures The following new employees did not complete the noted training topics, within 30 days after their starting date of employment: E4 (Resident Assistant), DOH 2/10/25 - due by 3/12/25 -CPR and emergency procedures for medical events E5 (Resident Assistant), DOH 5/5/25 - due by 6/4/25 -CPR and emergency procedures for medical events E6 (LPN), DOH 4/7/25 - due by 5/7/25 -CPR and emergency procedures for medical events -Training in assistance with activities of daily living appropriate to the job E7 (Resident Assistant), DOH 3/3/25 - due by 4/2/25 -CPR and emergency procedures for medical events	A3020		

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A3020	Continued From page 18 E8 (Licensed Practical Nurse), date of hire (DOH) 9/17/24 - due by 10/17/24 -The employee's job responsibilities and limitations On 7/3/25 at 2:48 PM, concerns were shared with E1 (Interim Executive Director), E9 (Director of Operations), and E14 (Regional Nurse Specialist) and confirmed.	A3020		
A3040	Section 295.3040 Health Care Worker Background Check This Regulation is not met as evidenced by: Type 2 Violation Section 295.3040 Health Care Worker Background Check An establishment shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code. (Source: Amended at 36 Ill. Reg. 13632, effective August 16, 2012) Section 955.145 Employment Verification a) Each health care employer or its designee shall provide an employment verification and update the demographic information for each employee and each contracted or subcontracted worker no less than annually. (Section 33(i) of the Act) 1) The health care employer or	A3040		

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A3040	Continued From page 19 its designee shall log into the Health Care Worker Registry through a secure login in a method prescribed by the Department. (Section 33(i) of the Act) 2) The health care employer or its designee shall indicate employment and termination dates (separation dates) within 30 days after hiring or terminating an employee. (Section 33(i) of the Act) 3) The health care employer shall provide the employment category and type. (Section 33(i) of the Act) b) Failure to comply with this Section constitutes a licensing violation. A fine of up to $500 may be imposed upon a health care employer for failure to maintain these records. (Section 33(i) of the Act) c) The information required in this Section shall be used by the Department of Public Health to notify any current employer of any disqualifying offenses that are reported by the Illinois State Police. (Section 33(i) of the Act) (Source: Amended at 49 Ill. Reg. 7999, effective May 22, 2025) This requirement was not met, as evidenced by: Based on interview and record review, the establishment failed to log into the HCWR and indicate employment dates, category and type, within 30 days after hiring two employees. They failed to provide an annual HCWR employment verification for an employee. This applies to 3 of 8 employees (E1, E5, E7) reviewed for this	A3040		

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A3040	Continued From page 20 requirement. The failure to meet this requirement creates a substantial probability of harm to a resident or residents in that the establishment may not be notified of any disqualifying offenses that are reported by the state police. The findings include: There was no documentation to show the establishment provided employment verification and update the demographic information within 30 days of starting employment and annually for the following employees: -E1(Interim Executive Director) - Date of Hire (DOH) 8/1/20 On 6/30/25, the HCWR was searched and showed the Last Employment Verification was blank. -E5 (Resident Assistant) - DOH 5/5/25 On 6/30/25, the HCWR was searched and showed the Last Employment Verification was dated 3/12/24. -E7 (Resident Assistant) - DOH 3/3/25 On 6/30/25, the HCWR was searched and showed the Last Employment Verification was dated 9/5/23. On 7/3/25 at 2:48 PM, concerns were shared with E1 (Interim Executive Director), E9 (Director of Operations), and E14 (Regional Nurse Specialist) and confirmed.	A3040		
A4010	Section 295.4010 Service Plan	A4010		

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A4010	Continued From page 21 This Regulation is not met as evidenced by: General 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. 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)	A4010		

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A4010	Continued From page 22 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 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; 3) Staff responsible for the provisions of the service plan; ... 5) Whether the resident requires medication reminders, supervision of self-administered medication, or medication administration. h) The service plan shall include all support services provided or arranged for by the establishment ... This requirement was not met, as evidenced by: Based on interview and resident, the establishment failed to ensure the service plan was signed and dated by all individuals involved in its development; failed to ensure it was	A4010		

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A4010	Continued From page 23	A4010		

reviewed and updated as needed; and failed to ensure it addressed necessary components and support services. This applies to 6 of 6 residents (R1, R2, R3, R4, R5, R6) reviewed for this requirement. These failures have the potential to affect all residents in the establishment and creates a substantial probability of severe harm to a resident or residents, in that it cannot be determined if the establishment is aware of addressing the needs and safety concerns of the resident. The establishment failed to review and update interventions for multiple fall incidents for R1 who had a fall that resulted in fractured ribs, and for R4 who had hip fracture but undetermined if related to a fall.

The findings include:

1) R1's FRI 6/10/25 IL194232 and FRI 6/10/25 IL194236 was investigated and R1 was reviewed as part of the CHOW survey.

R1's medical record showed R1 moved into the memory care establishment on 10/4/24 and has multiple diagnoses, including atherosclerotic heart disease, need for assist with personal care, abnormalities of gait and mobility, dysphagia, unspecified fall, osteoarthritis, benign prostatic hyperplasia, and Alzheimer's disease.

R1's Initial Service Plan, was dated 10/3/24, and the most recent Service Plan was completed 6/10/25.

-R1's 10/3/24 service plan was not reviewed, and interventions updated for fall incidents that occurred between October and June. R1's Progress Notes showed falls on 11/10/24, 11/22/24, two falls on 11/26/24, 1/15/25, 1/18/25,

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A4010	Continued From page 24 1/19/25, 1/26/25, 1/27/25, 1/29/25, 2/19/25, two falls on 2/22/25, 4/20/25, and 4/27/25, some of which resulted in physical harm or injury. -R1's 6/10/25 service plan showed R1 wanders into R2's room but did not address an incident of physical abuse between R1 and R2 and the need to monitor and keep them separated. R1's Incident/Accident Report, date/time of occurrence 5/19/25 at 1:30 PM, showed R1 was seen punching R2 on the back. -R1's 6/10/25 service plan showed R1 is total assist with medication administration but showed the staff responsible for the provision as the resident assistant. Establishment policy showed medication administration can only be done by a licensed health care professional. -R1's 6/10/25 service plan did not address the reason for and use of psychotropic medication. R1's Physician Order Review, print date 7/2/25, showed R1 takes as needed lorazepam (antianxiety), scheduled mirtazapine (antidepressant), and scheduled sertraline (antidepressant). These medications increase the risk of falls, and R1 has a history of falls. -R1's 6/10/25 service plan did not address the amount, type, and frequency psychiatric services. R1's Clarity visit notes showed psychiatric medication management services since 3/4/25. 2) R2's medical record showed R2 moved into the memory care establishment on 3/25/25 and has multiple diagnoses, including hypertension, diabetes mellitus type 2, insomnia, depression, and Alzheimer's disease. -R2's Service Plan, dated 3/27/25, was not signed	A4010		

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A4010	Continued From page 25 by the manager, registered nurse, or resident's representative. -R2's service plan showed R2 is total assist with medication administration but showed the staff responsible for the provision as the resident assistant. Establishment policy showed medication administration can only be done by a licensed health care professional. -R2's service plan did not address the reason for and use of psychotropic medication. R2's Physician Order Review, print date 7/2/25, showed R2 takes scheduled trazadone (antidepressant). -R2's service plan was not reviewed, and interventions updated for a fall incident. R2's Progress Note, dated 4/17/25 at 6:14 AM, showed R2 had a fall. -R2's 3/27/25 service plan did not address an incident of physical abuse between R1 and R2 and the need to monitor and keep them separated. R2's Incident/Accident Report, date/time of occurrence 5/19/25 at 1:30 PM, showed R1 was seen punching R2 on the back. 3) R3's FRI 5/12/25 IL192067 was investigated and R3 was reviewed as part of the CHOW survey. R3's medical record showed R3 moved into the memory care facility on 12/2/24, was admitted to hospice on 5/10/25, passed away on 5/15/25 and had multiple diagnoses, including atrial fibrillation, hypertension, chronic systolic congestive heart failure, age related osteoporosis, repeated falls, depression, and unspecified signs and symptoms involving cognitive function and awareness.	A4010		

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A4010	Continued From page 26 -R3's Initial Service Plan, dated 12/3/24, or most recent service plan, dated 5/10/25, was not signed by the manager, registered nurse, or resident's representative. -R3's 12/3/24 service plan was not reviewed, and interventions updated for fall incidents that occurred between December and May. R3's Progress Notes showed falls on 12/20, 12/23, 2/9, 4/5, 4/12, 4/20, 4/29, 5/1, and 5/2. -R3's 5/10/25 service plan showed R3 was total assist with medication administration but showed the staff responsible for the provision as the resident assistant. Establishment policy showed medication administration can only be done by a licensed health care professional. -R3's service plan did not address the reason for and use of psychotropic medication. R3's May 2025 electronic Medication Administration Record (eMAR) showed R3 took hospice comfort medications - as needed lorazepam (antianxiety) and as needed morphine (analgesic opioid). -R3's 5/10/25 service plan inaccurately showed R3 was independent with transfers and could toilet with minimal assist with cues. R3's Progress Notes, reviewed for 5/10/25, showed R3 required a hoyer lift. 4) R4's medical record showed R4 moved into the memory care establishment on 5/23/24 and has multiple diagnoses, including primary open-angle glaucoma, anxiety, depression, and Parkinsonism. -R4's Service Plan, dated 10/28/24, was not signed by the manager, registered nurse, or	A4010		

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A4010	Continued From page 27	A4010		

resident's representative.

-R4's service plan showed R4 was total assist with medication administration but showed the staff responsible for the provision as the resident assistant. Establishment policy showed medication administration can only be done by a licensed health care professional.

-R4's service plan did not address the reason for and use of psychotropic medication. R4's Physician Order Review, print date 7/2/25, showed R2 takes scheduled fluoxetine (antidepressant) and as needed lorazepam (antianxiety).

-R4's service plan was not reviewed, and interventions updated for fall incidents that occurred between May 2024 to July 2025. R4's Progress Notes, showed falls on 11/15/24, 1/23/25, 2/3/25, 3/29/25, 5/9/25, 5/20/25, and 7/1/25.

-R4's service plan did not address the amount, type, and frequency psychiatric services. R4's medical record showed psychiatric medication management services through Clarity since 1/21/25.

5) R5's medical record showed R5 moved into the memory care establishment on 6/20/24, is on hospice, and has multiple diagnoses, including general muscle weakness, unsteadiness on feet, chronic kidney disease, anxiety disorder, and cognitive communication deficit.

-R5's Service Plan, dated 10/28/24, and the most recent service plan, dated 12/10/24, was not reviewed, and interventions updated for fall incidents that occurred between October 2024

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A4010	Continued From page 28	A4010		

and July 2025 and showed R5 as a fall potential. R5's Progress Notes showed falls on 11/1, 11/24, 11/25, 12/6, 12/15, 12/30, 1/5, and 3/20.

-R5's 12/10/24 service plan showed R5 was total assist with medication -administration but showed the staff responsible for the provision as the resident assistant. Establishment policy showed medication administration can only be done by a licensed health care professional.

-R5's 12/10/24 service plan did not address the reason for and use of psychotropic medication. R5's Physician Order Review, print date 7/2/25, showed R5 takes hospice comfort medications - as needed lorazepam (antianxiety) and as needed morphine (analgesic opioid).

-R5's 12/10/24 service plan did not address the provider, amount, type, and frequency of hospice services. R5's December 2024 Progress Notes showed R5 has hospice services through St. Croix hospice.

6) R6's medical record showed R6 moved into the memory care establishment on 1/18/24, was on hospice, passed away on 12/26/24 and had multiple diagnoses, including hypertension, unsteadiness on feet, abnormalities of gait and mobility, history of falling, and dementia.

-R6's Initial Service Plan, dated 8/16/24, was not signed by the resident's representative.

-R6's most recent service plan, dated 12/23/24, showed R6 was total assist with medication administration but showed the staff responsible for the provision as the resident assistant. Establishment policy showed medication administration can only be done by a licensed

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A4010	Continued From page 29 health care professional. -R6's Service Plans, dated 8/16/24 and 12/23/24, were not reviewed, and interventions updated for a fall incident that occurred. R6's Progress Notes dated 8/20/24 and 12/6/24 showed R6 had falls, and the 12/6 fall resulted in a fracture to the left wrist and left hip. During interview on 7/2/25 at 1:30 PM, Z1 (Health Care Coord at Riverglen of St. Charles - Jaybird) assisted the establishment with gathering documentation and confirmed she provided all signed service plans that she could find. On 7/3/25 at 2:48 PM, concerns were shared with E1 (Interim Executive Director), E9 (Director of Operations), and E14 (Regional Nurse Specialist) and confirmed. The establishment policy titled Falls Prevention and Reduction (Effective/Revised Date: 10/15/22) showed: ...Procedure: 1) ...the nurse will conduct a falls assessment, evaluate potential interventions to reduce or eliminate the risk, educate the resident and/or resident's representative and make recommendations for preventative actions the resident can take ...3) The nurse will incorporate any interventions to prevent or reduce the risk of falls into the resident's service plan and will communicate these interventions to staff providing services to the resident. The establishment policy titled Medications - Illinois (Effective/Revised Date: 10/1/22) showed: ...Administration: 1) Licensed health care professional only may administer medications ...	A4010		

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A4050	Continued From page 30	A4050		
A4050	Seciton 295.4050 Tuberculin Skin Test Procedures This Regulation is not met as evidenced by: Type 2 Violation Section 295.4050 Tuberculin Skin Test Procedures Tuberculin skin tests for employees and residents shall be conducted in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696). Section 696.140 Screening for Latent Tuberculosis Infection (LTBI) and Active Tuberculosis (TB) Disease A TB screening test shall be used when screening persons for latent TB infection (LTBI). Persons who have signs and symptoms of active TB disease or a positive TB screening test result shall complete a diagnostic evaluation for active TB disease in accordance with the Centers for Disease Control and Prevention (CDC) guidelines, Targeted Tuberculin Testing and Treatment of Latent Tuberculosis Infection and Guidelines for Health-Care Settings. a) Screening for Latent TB Infection ... 2) Workers and clients at health care settings and other residential settings serving high-risk groups shall be screened in accordance with this subsection (a)(2) and the following CDC guidelines: Targeted Tuberculin Testing and Treatment of Latent Tuberculosis Infection; Guidelines for Health-Care Settings;	A4050		

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A4050	Continued From page 31 Prevention and Control of Tuberculosis in Correctional and Detention Facilities: Recommendations from CDC ... C) All clients in non-acute care residential health care settings serving high-risk groups shall obtain an entry TB screening according to the healthcare facility written protocol. Routine periodic screening shall be determined by completing a Department approved a risk assessment tool performed in cooperation with the local TB control authority. The TB Risk Assessment Form is available on the Department's website at https://dph.illinois.gov/content/dam/soi/en/web/idph/files/forms/tuberculosis-risk-assessment.pdf. This requirement was not met, as evidenced by: Based on interview and record review, the establishment failed to ensure new residents were administered an entry TB screen. This applies to 3 of 6 residents (R1, R4, R5) reviewed for this requirement. This failure creates a substantial probability of harm to a resident or residents, in that it poses an undue risk of infection to residents. The findings include: There was no documentation to show the following residents had a TB screen upon entry: R1 (move in date 10/4/24) had a negative chest x-ray on 6/11/25, which was 250 days post move in. R4 (move in date 5/23/24) had a negative quantiferon gold blood test on 10/5/23, which was 231 days prior to move in.	A4050		

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A4050	Continued From page 32 R5 (move in date 6/20/24) had a negative chest x-ray 4/12/25, which was 296 days post move in. On 7/2/25, Z1 (Health Care Coord at Riverglen of St. Charles - Jaybird) assisted with gathering resident records and indicated she provided all documentation available. On 7/3/25 at 2:48 PM, concerns were shared with E1 (Interim Executive Director), E9 (Director of Operations), and E14 (Regional Nurse Specialist) and confirmed. The establishment policy titled Illinois Tuberculosis Infection Control Plan (Revised 8/2022) showed: ...Screening and Management of TB Infection ...Resident: Residents who's test appears non-negative or exhibit symptoms after admission will be referred to their physician for examination and to confirm or rule out TB ...	A4050		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Type 2 Violation Section 295.4060 Alzheimer's and Dementia Programs d) Individual residents shall be assessed prior to admission to the establishment using any one or a combination of the following assessment tools, based on the resident's condition and stage in the disease process:	A4060		

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A4060	Continued From page 33 1) Functional A) Functional Activities Questionnaire (FAQ) B) Physical Self-Maintenance Scale (PSMS); Activities of Daily Living C) Instrumental Activities of Daily Living (IADL) D) Clock Drawing Task (CDT) E) Progressive Deterioration Scale (PDS) F) Functional Assessment Staging (FAST) 2) Cognitive A) Allen Cognitive Disabilities Theory B) Alzheimer's Disease Assessment Scale, Cognitive Subsection (ADAS-Cog) C) Blessed Information-Memory Concentration Test (BIMC) D) Short Test of Mental State (STMS) E) Clinical Dementia Rating Scale (CDR) F) Mini-Mental State Examination (MMSE)	A4060		

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A4060	Continued From page 34 3) Global A) Clinical Global Impression of Change (CGIC) B) Clinical Interview-Based Impression (CIBI) C) Global Deterioration Scale (CDS) D) Brief Cognitive Rating Scale (BCRS) (to use with Global Deterioration Scale) (Source: Amended at 28 Ill. Reg. 14593, effective October 21, 2004) This requirement was not met, as evidenced by: Based on interview and record review, the establishment failed to ensure memory care residents were assessed for cognitive and/or physical function, prior to admission, using any one or a combination of the approved assessment tools. This applies 4 of 6 residents (R1, R3, R4, R5) reviewed for this requirement. This creates a substantial probability of harm to a resident or residents, in that the establishment did not assess 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 findings include: Resident medical records were reviewed and there was no documentation to show the following resident's cognitive and/or physical	A4060		

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A4060	Continued From page 35 function was assessed, prior to admission, to determine if the resident was appropriate for residency: R1 (moved in 10/4/24) - Global Deterioration Scale (GDS) was completed 6/10/25 R3 (moved in 12/2/24) - GDS 5/10/25 R4 (moved in 5/23/24) - GDS 10/28/24 R5 (moved in 6/20/24) - GDS 12/4/24 During interview on 7/2/25 at 1:30 PM, Z1 (Health Care Coord at Riverglen of St. Charles - Jaybird), who assisted with gathering resident records and indicated she provided all documentation available. During interview, on 7/10/25 at 2:00 PM, E16 (Regional Nurse), indicated they discovered assessments were not completed when they did resident record audits, so they made sure to complete them upon discovery.	A4060		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: General 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:	A6000		

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A6000	Continued From page 36 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 interview and record review, the establishment failed to ensure a resident remained free of abuse, when a resident punched another resident on the back. This applies to 1 of 5 residents (R2) reviewed for this requirement. Failure to ensure resident remain free of abuse creates a substantial probability of harm to a resident or residents. The resident who was punched reported initial pain, but there were no signs of injury. The findings include: On 6/30/25, an investigation of Facility Reported Incident 6/10/25 IL194236 was initiated. R1's and R2's Incident/Accident Report, date/time 5/19/25 at 1:30 PM, showed R1 was witnessed punching R2 on the back, while in the dining room. During interview with E12 (Resident Assistant), on 7/3/25 2:00 PM, E12 indicated, she was coming out of a resident's room and witnessed the incident and immediately separated the two residents. E12 indicated, she did not see anything to prompt R1 to punch R2. During interview with E6 (Licensed Practical Nurse), on 7/8/25 at 10:38 AM, E6 indicated, she was informed of the incident by E12 and immediately assessed both residents, starting with R2. E6 indicated, R2 first reported pain, which did not remain, and there were no signs of	A6000		

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A6000	Continued From page 37 injury. E6 indicated, R1 had agitation toward R2, because R2 resided in R1's old room. E6 indicated, R1 was monitored to keep R1 from entering R2's room, but this incident occurred in the dining room.	A6000		