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CHURCHILL PLACE MEMORY CARE	190 GENEVA ROAD GLEN ELLYN, IL 60137

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comment . Annual Licensure Survey conducted. Entity Reported Incident Survey Conducted # IL00200641 - Substantiated. VIOLATIONS: 1. 295.2000 a) c) 3) 4) 2. 295.3000 a) 3. 295.3040 section 955.165 a) d) 1) 4. 295.4010 g) 1) A) C) 2) 3) 5. 295.4060 i) 1) B) 2) c) 6. 295.6000 a) 13)	A 000		
A2000	Section 295.2000 Residency Requirements This Regulation is not met as evidenced by: . Type 2 Violation Section 295.2000 Residency Requirements. a) No individual shall be accepted for residency or remain in residence if the establishment cannot provide or secure appropriate services, if the individual 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 75(a) of the Act)	A2000		

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A2000	Continued From page 1 c) A person shall not be accepted for residency if: 3) The person requires total assistance with 2 or more activities of daily living; 4) The person requires the assistance of more than one paid caregiver at any given time with an activity of daily living. This requirement is not met as evidenced by: Based on observation, interviews and record review, the establishment failed to ensure residents are appropriate to live in an assisted living or shared housing environment. This applies to 2 of 4 residents (R3 and R4) from the sample of 4 and 17 of 17 residents (R5 - R21) from the supplemental sample reviewed for residency requirements. This failure creates a substantial probability of harm to the residents. Findings include: 1) On 4/1/26 at 12:55 PM observed R5 being toileted by E5 (RCA-Resident Care Assistant). E5 propelled R5 in her wheelchair to the toilet. E5 helped R5 stand and pivot to transfer R5 to the toilet. Observed that R5 is wobbly and unsteady while standing. Also heard R5 complaining of feeling dizzy and pain in her left leg while standing. R5 appeared very tired and exhausted by the time she was done toileting. On 4/9/26 at 9:40 AM, R5's records were reviewed. R5's face-sheet showed R5 was an 88 years old male admitted on 11/18/25 with	A2000		

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diagnoses to include dementia, anxiety, hypertension, depression and psychosis. R5's service plan dated 4/3/26 showed R5 required physical assist from staff for bathing, grooming, dressing, toileting and mobility.

2) On 4/1/26 at 1:11 PM, observed E3 (RCA) assist R11 get up from her chair in the dining room using a gait belt. Observed R11's gait was unsteady. E3 held onto the gait belt with one hand and supported R11 with the other around R11's back, slowly walked R11 to the den/activity room and assisted R11 sit on a couch.

On 4/9/26 at 2:15 PM R11's records were reviewed. R11's face-sheet showed R11 was a 94 years old female admitted on 10/4/23 with diagnoses to include cognitive deficit, hypertension, spondylosis and anemia. R11's service plan dated 10/17/25 showed that R11 needed physical assist from staff for bathing, dressing, grooming and evacuation during an emergency.

3) On 4/1/26 at 1:14 PM observed E3 toileting R20. Observed R20 was unsteady as she stood holding onto the bar. E3 held R20 with one hand and wiped R20's bottoms with the other hand. As E3 was fastening the tabs of the brief, observed E3 supported R20 with her knees to prevent R20 from falling. Observed R20 unable to stand on her own.

On 4/9/26 at 4:00 PM R20's records were reviewed. R20's face-sheet showed R20 was a 93 years old female admitted on 1/28/24 with diagnoses to include dementia, Alzheimer's disease. R20's service plan dated 11/14/25

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showed R20 needed physical assist from staff for bathing, toileting, transfers, mobility, oral care and evacuation in an emergency.

4) On 4/1/26 at 1:24 PM observed E4 and E5 toilet R13. Observed R13 was very resistant to care. Observed that R13 needed two people to toilet her. After using the toilet, E4 cleaned R13 from the front and E5 cleaned her from behind. Together they applied a brief on R13.

On 4/9/26 at 2:45 PM R13's records were reviewed. R13's face-sheet showed R13 was a 91 years old female admitted on 1/18/24 with diagnoses to include Type 2 diabetes mellitus, hypertension, bilateral cataract and atherosclerosis. R13's service plan dated 4/3/26 showed R13 needed physical assist for bathing, emergency evacuation, dressing, grooming, oral care, toileting and transfers.

5) On 4/1/26 at 1:30 PM E3 attempted to toilet R16. Observed R16 could not stand on his own. E3 assisted R16 stand with a gait belt. Observed R16 was unsteady as he stood.

On 4/9/26 at 3:30 PM R16's records were reviewed. R16's face-sheet showed R16 was an 81 years old male admitted on 6/16/25 with the diagnoses to include dementia and hypertension. R16's service plan dated 1/30/26 showed R16 needed physical assistance from staff for mobility, transfers, bathing, grooming, dressing, toileting and evacuation during an emergency.

6) On 4/9/26 at 9:00 AM R3's records were reviewed. R3's face-sheet showed R3 was a 94 years old female admitted on 7/29/24 with

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diagnoses to include cognitive impairment, hypertension, atrial fibrillation, depression, congestive heart failure and cerebral infarction. R3's service plan dated 3/19/26 showed R3 required physical assist from staff for bathing, grooming, dressing, toileting and mobility. R3's Service plan showed R3 needed total assist for evacuation in an emergency.

7) On 4/9/26 at 4:15 PM R4's records were reviewed. R4's face-sheet showed R4 was a 72 years old female admitted on 7/2/24 with the diagnoses to include dementia, osteoporosis, pulmonary nodule and heartburn. R4's service plan dated 3/30/26 showed R4 needed physical assist from staff for bathing, toileting, oral care and emergency evacuation.

8) On 4/9/26 at 1:00 PM R6 was R6's records were reviewed. R6's face-sheet showed R6 was a 88 year old female admitted on 11/15/23 with diagnoses to include dementia, depression and psychosis. Her Service plan dated 3/2/26 showed R6 required physical assist from staff for mobility, bathing, transfers, dressing, grooming and toileting. It showed R6 required physical assist from staff for evacuation during an emergency.

9) On 4/9/26 at 1:15 PM R7's records were reviewed. R7's face-sheet showed R7 was a 90 year old female admitted on 8/5/25 with diagnoses to include mild cognitive impairment, pneumonia, cerebral ischemia, congestive heart failure and osteoarthritis. R7's service plan dated 3/5/26 showed R7 needed physical assist from staff for mobility, bathing, transfers, emergency evacuation, dressing, grooming and toileting.

10) On 4/9/26 at 1:30 PM R8's records were

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reviewed. R8's face-sheet showed R8 was an 88 year old male admitted on 7/5/24 with diagnoses to include Alzheimer's disease, atherosclerosis and anxiety. R8's service plan dated 4/26/25 26 showed R8 needed physical assist for mobility, bathing, transfers, emergency evacuation, dressing, grooming and toileting.

11) On 4/9/26 at 1:45 PM R9's records were reviewed. R9's face-sheet showed R9 was an 81 years old female admitted on 10/1/25 with diagnoses to include dementia, behavioral disturbances, congestive heart failure, depression, atrial fibrillation. osteoarthritis and anxiety. R9's Service plan dated 10/21/25 showed R9 needed physical assist with bathing, dressing, toileting, mobility and evacuation during emergency.

12) On 4/9/26 at 2:00 PM R10's records were reviewed. R10's face-sheet showed R10 was an 87 year old female admitted on 9/29/25 with diagnoses to include Alzheimer's disease, hypertension and hypothyroidism. R10's service plan dated 10/7/25 showed R10 needed total assist for evacuation in an emergency situation.

13) On 4/9/26 at 2:30 PM R12's records were reviewed. R12's face-sheet showed R12 was a 74 years old female admitted on 11/4/24 with diagnoses to include major neurocognitive disorder, depression, colitis, fibromyalgia, heartburn and Gastroesophageal reflux. R12's service plan dated 11/28/25 showed that R12 needed physical assist for evacuation during an emergency.

14) On 4/9/26 at 3:00 PM R14's records were reviewed. R14's face-sheet showed R14 was a 72 years old female admitted on 6/5/25 with the

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diagnoses to include dementia, hypertension hyperlipidemia and pre-diabetes. R14's service plan dated 1/15/26 showed that R14 needed physical assist for evacuation during an emergency.

15) On 4/9/26 at 3:15 PM R15's records were reviewed. R15's face-sheet showed R15 was a 73 year old male admitted on 1/31/22 with the diagnoses to include Diabetes Mellitus and dementia. R15's service plan dated 10/28/25 showed R15 required total assist for bathing, dressing, grooming, oral care, toileting and emergency evacuation.

16) On 4/1/26 at 10:30 AM R17's records were reviewed. R17's face-sheet showed R17 was an 88 years old male admitted on 8/4/25 with the diagnoses to include dementia, chronic kidney disease, diabetes mellitus, cerebral infarction and hypertension. R17's service plan dated 9/26/25 showed that R17 needed physical assist from staff for bathing, dressing, toileting, transfer and evacuation during an emergency.

17) On 4/1/26 at 10:45 AM R18's records were reviewed. R18's face-sheet showed R18 was an 87 years old female admitted on 8/2/25 with diagnoses to include dementia, heart failure, osteoporosis, anxiety, hypertension and atherosclerosis. R18's service plan dated 9/26/25 showed R18 needed physical assist from staff for bathing and evacuation during an emergency.

18) On 4/9/26 at 3:45 PM R19's records were reviewed. R19's face-sheet showed R19 was an 82 year old female admitted on 12/30/25 with the diagnoses to include Alzheimer's disease, psychosis, hypertension and atrial fibrillation. R19's service plan dated 4/3/26 showed R19

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A2000	Continued From page 7 needed physical assistance from staff for bathing, grooming, toileting and evacuation during an emergency. On 4/1/26 at 11:00 AM E3 (RCA) and E4 (RCA) stated R3, R4, R5, R6, R7, R8, R9, R11, R12, R13, R17, R18, R20 and R21 required total assist for bathing, grooming, dressing, oral care, toileting and mobility. E3 and E5 stated R10, R14, R15, R16 and R19 required total assist for bathing, grooming, dressing, oral care and toileting. E3 & E4 stated R12 and R15 required to be fed during meals. On 4/1/26 at 11:00 AM E3 (RCA) and E4 (RCA) stated R6, R8 and R21 needed two persons for transfers. R21 required 2 persons for showers per E3 and E4. On 4/1/26 at 11:30 AM E3 (RCA), E4 (RCA) and E5 (RCA) stated R3 - R21 required total assist during an emergency evacuation. Record review of R3 through R21 showed R3 - R21 required total assist during an emergency evacuation. On 4/11/26 at 4:00 PM, reviewed the above findings with E1 (Executive Director). E1 in agreement with the findings.	A2000		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: . Type 2 Violation	A3000		

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A3000	Continued From page 8 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 is not met as evidenced by: Based on observations, interviews and record reviews, the establishment failed to ensure employees performed hand hygiene appropriately during resident care. This has the probability of cross-contamination and risk of infection for residents. This applies to 3 of 3 residents (R5, R13 and R20) reviewed for hand hygiene. Findings include: 1) On 4/1/26 at 12:55 PM observed R5 being toileted by E5 (RCA-Resident Care Assistant). E5 pushed R5's wheelchair to the toilet, wore gloves, assisted R5 to stand, pulled R5's pants and diaper down and assisted R5 to sit on the toilet. As E5 was waiting, she opened a new packet of wipes and answered her walkie-talkie with the same gloves and no hand hygiene. After R5 was done passing urine and stool, E5 assisted R5 to stand and wiped her bottoms. E5 applied new clean briefs and assisted R5 wash hands with the same soiled gloves and no hand hygiene. E5 used one pair of gloves for the whole procedure with no hand hygiene or change of gloves in	A3000		

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between.

2) On 4/1/26 at 1:14 PM observed E3(RCA) wore gloves and assisted R20 to sit on the toilet. R20 passed urine and stool. With the same gloves and no hand hygiene E3 assisted R20 to stand. E3 held onto R20 with one hand and wiped R20's bottoms with the other hand. In the process, with the same soiled gloves E3 touched R20's back. Also, E3 opened the closet door to get clean brief and wipes. With the same gloves and no hand hygiene E3 applied clean briefs on R20. Then E3 flushed the toilet, pulled the pants up for R20, put the footrest back on the wheelchair, removed the gait belt from R20 and put it on E3's shoulder - all with same soiled gloves and no hand hygiene. E3 wheeled R20 out of the toilet and then removed her gloves and washed hands.

3) On 4/1/26 at 1:24 PM observed E4 (RCA) and E5 (RCA) toilet R13. E4 and E5 wore gloves, E4 removed R13's soiled brief and did not change gloves or do hand hygiene. Together they assisted R13 to sit on the toilet. After using the toilet, E4 cleaned R13 from the front and E5 cleaned her from behind as R13 was very feisty and resisting care. With same soiled gloves, E4 and E5 applied new briefs on R13. R13 held onto R5's hands. After the toileting was done, E5 came out of the toilet with R13 holding onto her hands without doing hand hygiene or removing gloves and E5 walked resident to the den.

Facility policy on 'Standard Precautions' updated on 3/26/21 showed on page 36 and 37, " standard precautions will be used in the care of all residents regardless of their diagnosis or infection status. Standard precautions include hand hygiene. Hand hygiene to be performed before having direct contact with the residents,

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A3000	Continued From page 10 after contact with blood or body fluids, if the hands are moving from a contaminated body site to a clean body site during resident care and after removing gloves." On 4/10/26 at 4:00 PM, reviewed the above findings with E1 (Executive Director). E1 stated employees are educated and expected to follow standard precautions while caring for the residents.	A3000		
A3040	Section 295.3040 Health Care Worker Background Check This Regulation is not met as evidenced by: . Type 3 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. Section 955.165 Fingerprint-Based Criminal History Records Check a) Educational entities, other than secondary schools, and health care employers are required to check the Health Care Worker Registry before allowing a student to enter a training program or hiring an employee to determine: d) Any student, applicant, or employee to whom the Act and this Part apply and who desires to be	A3040		

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A3040	Continued From page 11 included on the Department of Public Health's Health Care Worker Registry shall authorize the Department of Public Health or its designee to request a fingerprint-based criminal history records check to determine if the individual has a conviction for a disqualifying offense by completing and signing an authorization and disclosure form. This authorization shall allow the Department of Public Health to request and receive information and assistance from any State or governmental agency. (Section 33(b) of the Act) 1) A health care employer may initiate a fingerprint-based criminal history records check required by the Act or this Part for any of its employees or volunteers to whom the Act and this Part apply. This requirement was not met as evidenced by: Based on interviews and record reviews, Establishment failed to conduct a finger-print based criminal history records check for 1 of 3 employees reviewed for healthcare workers background check. Findings include: On 4/9/26 at 10:08 AM personnel file of E9 (RCA-Resident Care Assistant) was reviewed. E9's file did not include documentation of healthcare worker's background check. On 4/9/26 at 10:15 AM, E6 (STC - Staff Development Coordinator) stated she was not sure if it was done and that she could not find any document to support healthcare workers	A3040		

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A3040	Continued From page 12 background check for E9. On 4/9/26 at 12:30 PM E1 (ED) stated Establishment was required to conduct a finger-print based criminal history records for all staff upon hire.	A3040		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 2 Violation . Section 295.4010 Service Plan 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; This requirement is NOT MET as evidenced by:	A4010		

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A4010	Continued From page 13 Based on observations, interview, and record review, the facility failed to provide health related services as mentioned in the service plan. This applies to 1 of 1 residents reviewed for oxygen monitoring in a sample of 4. This failure creates a substantial probability of harm to the residents. Findings include: On 4/1/26 at 11:00 AM observed R3 sitting on her wheelchair in the den. R3 was on continuous oxygen via nasal canula and she had a portable oxygen concentrator hung behind her wheelchair. Observed that the concentrator was off and the power cord was disconnected and on the floor. E3 (RCA-Resident Care Assistant) agreed that the oxygen concentrator was not working and E3 reconnected the cord to the machine. Then the battery charging symbol on the screen was visible. On 4/9/26 at 9:00 AM R3's records were reviewed. R3's service plan dated 3/19/26 showed staff nurse will collect and record R3's oxygen saturation each morning. Her vital signs in the EMR (electronic medical record) included oxygen saturation for 1/11/26 at 10:56 PM = 92%, 7/27/25 at 6:00 AM = 98% and 7/6/25 at 5:00 AM = 98%. The monthly hand-written vital signs sheets binder included vital signs taken monthly for all residents for January 2026 and February 2026. Both documents did not include oxygen saturation for R3. The service plan also showed staff to ensure that R3's oxygen concentrators are charged and working. R3's progress notes for last 3 months did not show any records of Oxygen saturation.	A4010		

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	ASL510038	A. BUILDING: _____ B. WING _____	04/10/2026

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A4010	Continued From page 14 On 4/9/26 at 11:15 AM E8 (LPN-Licensed Practical Nurse) stated she does not check E3's oxygen saturation on a daily basis. On 4/9/26 at 11:25 AM, E2 (Clinical Services Director) stated any resident on continuous O2, must be monitored daily. E2 stated, monitoring oxygen saturation for R3 is more important as she retains fluids and was on diuretics.	A4010		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Type 3 Violation Section 295.4060 Alzheimer's and Dementia Programs i) Training requirements for individuals working in a special program: 1) Manager qualifications and training: B) The manager or supervisor must complete, in addition to the training required in subsection (i)(2) of this Section and in Section 295.3020, six hours of annual continuing education regarding dementia care. 2) Staff training: C) Direct care staff must annually complete 12 hours of in-service education regarding Alzheimer's disease and other related dementia disorders.	A4060		

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A4060	Continued From page 15 This requirement is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure employees completed the required in-service annually for the dementia program. This applies to 3 of 3 employees (E1, E9 and E10) reviewed for staff training in a sample of 9. Findings include: On 4/9/26 at 10:08 AM employee files were reviewed with E6 (Staff Development Director). It showed the following nursing staff completed less than 12 hours and managers less than 18 hours of the required annual in-service related to Dementia disorders. 1) E1 (Executive Director) DOH: 10/2/23 completed 7 hours of dementia related in-service from 10/2/24 to 10/2/25. 2) E9 (RCA-Resident Care Assistant) DOH: 4/18/22 completed 6.6 hours of dementia related in-service from 4/1/25 to 4/1/26. 3) E10 (LPN-Licensed Practical Nurse) DOH: 3/1/24 completed 6.6 hours of dementia related in-service from 3/1/25 to 3/1/26. On 4/9/26 at 10:15 AM, E6 (Staff Development Director) stated the nursing staff have completed the required 7 hours of training in memory care. On 4/9/26 at 1:00 PM the above findings were reviewed with E1 (Executive Director). E1 in agreement with the findings.	A4060		

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A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: . Type 2 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 is not met as evidenced by: Based on interviews and record reviews, establishment failed to provide a safe environment for residents with dementia and neglected to protect them from elopement. This applies to 2 of 3 residents (R1 and R2) reviewed for neglect. Findings include: 1) Incident report investigation showed, on 8/2/25, at 6:38 PM, R2 was assisted into the gated and locked courtyard of the establishment. At 7:17 PM the caregiver went to assist another	A6000		

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A6000	Continued From page 17	A6000		

staff. Meanwhile R2 was able to get the gate open. A neighbor across the facility observed R2 standing on the sidewalk outside of the gate, who brought R2 back to the establishment via the front door. The investigation report showed there were landscapers working in the patio area the previous day and they did not secure the gates properly.

On 4/1/26 at 9:30 PM R2's face-sheet showed R2 was a 77 years old female admitted on 4/10/25 with diagnoses to include Alzheimer's disease, chronic kidney disease and rheumatoid arthritis. R2's service plan dated 2/4/26 addressed the risk of elopement and showed establishment to provide assistance to manage exit seeking behavior.

2) Entity Reported Incident dated 3/9/26 # IL00200641 showed R1 eloped from the facility on 3/8/26 and the family members found him and brought R1 back to the facility.

On 4/1/26, R1's face-sheet showed R1 was an 80 year old male admitted on 1/13/26 with diagnoses to include dementia, diabetes mellitus, hypertension, hyperlipidemia, depression and psychosis. R1's physician's assessment dated 1/9/26 showed that he had a behavior of wandering and exit seeking. His service plan dated 1/28/26 showed R1 was at risk of elopement and the community was to provide assistance to manage his wandering and exit seeking behaviors.

On 4/7/26 at 1:30 PM, E11 (LED-Life Engagement Director) stated E11 was the manager on duty on 3/8/26. E11 stated he did not hear the alarm when it went off. As E11 was

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A6000	Continued From page 18	A6000		

coming out of his office to go home, he realized that there was a door alarm going on. E11 stated the door showed 0 seconds, which means the alarm went on for more than 15 seconds. E11 stated he went outside and checked the front courtyard and the parking lot in the back. E11 did not see any resident outside the building. He came back in and asked the staff to do a head count, when they realized R1 was not in the building. E11 stated they did a thorough search of the building but could not find R1. Then E11 called the E1 (ED-Executive Director) and 911. E1 (ED) called the family.

On 4/7/26 at 1:30 PM E11 (LED) stated it was negligence on the staff's part to not have heard the alarm. Staff should be paying more attention and be more careful to the alarms when it goes off.

On 4/7/26 at 12:45 PM E1 (ED) stated she reviewed the scenario on the security camera. E1 stated on 3/8/26 at 6:08 PM R1 touched the door. The alarm went off. R1 stepped back. In a few seconds R1 tried the door again and the door was unlocked as it should be in case of an emergency. R1 walked out. E1 stated caregivers and some other residents were in the den in activities. Nobody paid attention to the alarm. There were about 6-7 staff. E1 stated staff must be more attentive to the door alarms.