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A 000	Initial Comment Entity Reported Incident Investigation: IL00200718- Unsubstantiated 295.6010 a) 2) Complaint Investigation: IL00200051/ 2681527- Substantiated 295.2050 a) b) 295.4010 a) b) 1) 2) 3) c) IL00202021/ 2696424- Unsubstantiated 295.1100 e)	A 000		
A1100	Section 295.1100 Alzheimer's and Related Dementias Special Car This Regulation is not met as evidenced by: VIOLATION Section 295.1100 Alzheimer's Disease and Related Dementias Special Care Disclosure An establishment that offers, advertises or markets to provide care for persons with Alzheimer's disease and related dementias through an Alzheimer's special care program shall disclose to the Department and to a potential or actual resident of the establishment the following information in writing: e) The establishment's minimum and maximum staffing ratios, specifying the general licensed health care provider to resident ratio and the trainee health care provider to resident ratio; These requirements were not met as evidenced by:	A1100		

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A1100	Continued From page 1 Based on interview and record review, the establishment failed to specify staff to resident ratio as required, this deficient practice has the probability to affect all 8 residents. Findings include: Establishment document titled "Alzheimer's Care Disclosure Statement" emailed to writer by E1 (Executive Director) on 5/29/26 did not specify staffing ratio. On 5/29/26 at 12:29pm, E22 (Reminiscence Coordinator) said there is always one staff and a second one that is in the unit during meals. During the incontinence care observation on 5/28/26 R3 and R6 required two-person assistance during transfer using the Hoyer lift.	A1100		
A2050	Section 295.2050 Incident and Accident Reporting This Regulation is not met as evidenced by: TYPE 1 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	A2050		

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A2050	Continued From page 2 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. These requirements were not met as evidenced by: Based on interview and record review the establishment failed to report to the Department as required a resident fall incident with major injury. This deficient practice affected one (R1) of three residents reviewed for fall. This failure creates the substantial probability of severe harm to a resident or residents. Findings include: R1's Incident Report sent to the Department stated in part: Sent: 5/10/24 4:38pm Date of Occurrence: 5/8/24 Incident Description ....Fell out of bed on May 8 ...sustained closed fracture of the right hip ... Initial: Yes Final: Yes On 5/28/26 at 11:00am, E1 (Executive Director) said, incident report is sent to the Department within 24 hours of incident.	A2050		
A4010	Section 295.4010 Service Plan	A4010		

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A4010	Continued From page 3 This Regulation is not met as evidenced by: TYPE 1 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) e) The service plan shall be reviewed and	A4010		

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revised if necessary immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000).

These requirements were not met as evidenced by:

Based on observation, interview and record review, the establishment failed to:
-Implement adequate fall precautions for one (R1) resident who has history of fall with hip fracture.
-Revise fall interventions for two (R7, R8) residents
-Ensure service plan were signed by Resident/ Resident Representative for one (R1) resident.
These deficient practices creates a substantial probability of severe harm to a resident or residents.

Findings include:

An onsite visit was conducted on 5/28/26 and 5/29/26. Establishment documents and Residents Electronic Health Records were reviewed. Observations and interviews were also conducted.

R1
R1 moved to the Assisted Living floor on 4/24/24. R1's listed diagnoses include but were not limited to Unspecified Dementia, Osteoarthritis, and Repeated Falls. R1's FAST (Functional Assessment Staging of Alzheimer's Disease) score was 4, indicating mild Dementia.

R1's Progress notes at move in (4/24/24) documented R1 was 91 years, R1 used

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wheelchair for mobility, and alert oriented x1 -2. R1 moved from a skilled facility. R1's Physician Assistant notes documented R1 had history of fall resulting in a fracture of hip in January 2024.

R1 incurred several falls while at the establishment. These falls are the following:
- 5/3/24 at 0441, R1 was found on the floor at the foot of the bed. R1 stated she was going to the restroom and fell.
- 5/5/24 at 3:35pm, per witness, R1 was trying to stand up, then when she tried to get down, the chair moved back, and she slid to the floor
- 5/8/24 at 6:30am, R1 was found on the floor by staff, R1 stated, "I think I fell from the bed." This fall resulted in fracture of right hip. R1 underwent surgery and returned to the community on 5/10/24.

R1's Incident Report sent to the Department stated in part:
Sent: 5/10/24 4:38pm
Incident Description: ..... Fell out of bed on May 8 ...sustained closed fracture of the right hip ...
Resident is mostly in the wheelchair
Recommendations to the family for a hospital bed and floor mats for resident. Resident will have more frequents checks and will be assisted up earlier in the morning.

These interventions were not added to the service plans after R1 went back to the community on 5/10/24.

R1's Service plan with focus on Fall stated but not limited to the following interventions:
Goal: My fall risk will be minimized by increased supervision thought the next review date (initiated 4/24/24)
Interventions:

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-Care Managers to check on me at frequent intervals throughout the day to see if I need any assistance and to offer me reassurance.
-Care Managers to check on me frequently throughout the overnight hours and to assist me to use the bathroom during those times.
-Remind me to use assistive devices wheelchair and care managers to assist (R1) to lock her wheelchair before she stands up and sits down to help prevent the wheelchair from moving out under her.
Mobility- I need physical assist of 1 person with mobility (Date initiated: 4/24/24)
Transferring- I need physical assist of 1 person with my transferring (Date initiated: 4/24/24)
Service plan fall interventions were last updated on 5/6/24.

On 5/29/26 at 10:36am, Z1 (Family Member) said that at R1's move in, establishment representative which could be E18 (Former Wellness Director) was notified by Z1 that R1 needed a netted bed rail because of R1's history of falling out of bed. Z1 said the establishment agreed to it, but it was later removed because according to establishment, it was a form of restraints. As alternative to the netted bed rail, a pillow will be placed instead. Z1 said she did not agree to this. Z1 also said service plan was not signed.

There were no interventions reflecting the use of netted rails or its alternatives on R1's service plan and on the clinical notes reviewed.

On 5/29/26 at 10:41am, E18 was interviewed. E18 is longer affiliated with the establishment. E18 said, netted bed rail is considered restraints and would not have been allowed. As an alternative, the use of hospital bed that goes all

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the way to the ground and fall mats will be used. These would have been explained to the family. E18 also said, "Have the care manager check every couple of hours ... toileting schedule for her. Or if awake gets her out of bed, give her snacks and until they are tired."

R1's notes documented that on 5/14/24, R1 was sent to the hospital due to change of condition, admitted for Urinary Tract Infection. R1 did not return to the community. Succeeding notes indicated R1 went to a rehab facility. Z1 confirmed R1 went to a skilled facility, R1 was admitted to hospice care and passed away in June 2024.

Establishment's Policy and Procedure titled "Individualized Service plan" stated in part;

Procedure:
ISP development is a collaborative process with input from an
Interdisciplinary Team (IDT) that may include but is not limited to:
a. Resident, resident's responsible party or family

7. Documentation
e. The resident and/or responsible party signs the ISP as required by state/ province regulation.

On 5/29/26 at 9:30am, E1 (Executive Director) said service plan is to be signed by resident or resident representative. E1 confirmed R1's service plan was not signed by R1 or R1's representative.

R7
R7 is 96 years old. R7 moved to the community on 8/30/25. R7's diagnoses include but are not limited to Diverticulosis of Intestines and Fracture

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of superior rim of right pubis.

On 5/28/26 at 9:08am, R7 was observed seated in a wheelchair, R7 denied any issue.

R7's progress notes documented:
On 5/8/26 at 10:30am, CNA called and alerted writer that resident had fallen ...observed resident laying on the floor on her back by the sink in her room. R7 complained of headache, pain in the groin area, and on the right side. R7 was sent to the hospital, admitted with close fracture of right superior ramus pubis.

On 5/28 /26 R7's Electronic Health Record was reviewed. There was no fall intervention/ revision on R7 service plan.

R8
R8 is 97 years old. R8 moved to the community on 5/15/26. R8's diagnoses include but are not limited to Unspecified Dementia and Atrial Fibrillation.

On 5/28/26 at 12:29pm, R8 was observed in the living room, bruise, cuts and bandage were noted on R8's face. R8 used wheelchair for mobility.

R8's Progress Notes documented the following falls:
-5/15/2026 10:00 AM unwitnessed fall in resident's room, found on floor by a care manager ...noted resident sitting on his bottom ...stated " I fell off my bed." ... states his lower back hurts around his waist. Some redness noted on his lower middle part of back near spine.
-5/18/26 11:34pm Fall unwitnessed with injury. Noted on bedside floor, lying on his back with left eye lower part tear and is bleeding. verbalized "I tried to get up and reached for my walker and

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then this happened." Upon assessment, resident in pain to his left leg and stated his whole body hurts. Left eye periorbital swelling, left eye lower part with tear and bleeding.
-05/20/2026 9:15 PM Fall was unwitnessed in resident's room. Care manager found resident lying on floor ...noted him lying on his right side. Resident has two skin tears on his forehead. One in the middle and one on the right side. Sent to the hospital. Hospital diagnoses include facial contusion, multiple skin tears/skin avulsion, status post fall
-5/20/2026 03:30AM Fall was unwitnessed in hallway ...During the shift, resident was noted on the floor. Immediate assessment was completed. Skin tear noted on the left elbow region with bleeding observed.
-05/25/2026 7:55PM unwitnessed in resident's room, per resident, he was trying to turn on the shower.

R8's service plan with focus on fall was revised was on 5/17/26.
Fall Risk (Date initiated: 5/15/26). Interventions: I am at risk for fall due to my weakness.
I have had an actual fall (Date Initiated 5/15/26). Interventions:
-Remind me to use pull cord for any assistance I may need (Revision on 5/17/26).
-Remind me to always use my walker at all times. (Date Initiated 5/15/26).

No other fall interventions are implemented for fall prevention.

Additional Activity of Daily Living interventions noted on R8's service plan were R8 required one staff assistance with bathing, dressing, toileting, mobility and transfer.

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A4010	Continued From page 10 On 12/29/26 at 12:21pm, E14 (Lead Care Manager) said R8 uses wheelchair for long distances and walker for short distances. On 5/29/26 at 12:29pm, E22 (Reminiscence Coordinator) said, when there is a fall, notes are updated by E22 with interventions and later documented on the service plan. It will typically documented on the service plan next day. On 5/29/26 at E1 (Executive Director) said, this procedure on updating service plan is the same in the Assisted Living.	A4010		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr This Regulation is not met as evidenced by: TYPE 1 VIOLATION Section 295.6010 Abuse, Neglect, and Financial Exploitation Prevention and Reporting a) When the establishment has a reasonable belief that a resident has been the victim of abuse, neglect, or financial exploitation, the establishment shall: 2) Investigate and develop a written report within 14 days after the initial report. The establishment shall send the written report to the Department 24 hours after it is completed and shall maintain a copy of the written report on the premises for 12 months after the date of the report. These requirements were not met as evidenced	A6010		

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A6010	Continued From page 11	A6010		

by:

Based on interview and record review, the establishment failed to submit a final report concerning an allegation of missing property (cash) to the Department within the required 14-day time frame and failed to conduct employee interviews following report of missing cash. This deficient practice affected one (R2) of three residents reviewed.
This failure creates a substantial probability of severe harm to a resident or residents.

Findings include:

According to R2's face sheet, R1 was 84 years old. R2 moved to the community on 9/3/25. R1's diagnoses include but are not limited to Mild Cognitive Impairment of Uncertain of Unknown Etiology, and Essential Hypertension. R2's FAST (Functional Assessment Staging of Alzheimer's Disease) score/stage was 3, which indicated-Early Dementia. R2 had a cardiac arrest and passed away on 4/2026.

Initial Incident report dated 2/20/26 was sent to the Department. It documented that on 2/20/26 at 1:47pm, R2's family member reported missing cash amounting to $106 was missing from R2's wallet, an investigation will be conducted.

Final report was sent on 3/12/26, 19 days after the initial report.
The report documented, "On 2/20/26 (R2) went to lunch with (Z7- Family Member). Upon return to the room, (Z7) found that the cash from (R2's) wallet was not there. She reported that to the concierge. The Concierge informed (Executive Director), and we initiated the investigation for allegation of misappropriation of property. The

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room was searched, with no result. The ED called (Z7) on the 20th to take statement but could only leave a message. On Monday, the 23rd of February the ED was able to speak with Z7 and confirmed that she did not think money was stolen, she just wanted someone to follow up with her if the money had been removed for safekeeping by the nurse or other team member. The investigation was closed without substantiation."

On 5/28/26 at 11:00am, E1 (Executive Director) said R2 was unable to say what happened to the money. On E1's interview with Z7, Z7 also claimed R2 was not sure where the money went. E2 was asked if staff who had access to R2's apartment, or who may have worked with R2 were interviewed, E1 said, "No".

There were 2-3 days in between the time the missing money was reported to the time Z7 responded to E1's call. There was no staff interview conducted to investigate what happened to the missing cash.

The final incident report was not sent to the Department in a timely manner. E1 said, Initial report is sent to the Department within 24 hours of the incident, establishment conduct investigation. Final report will be sent within 14 days.