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CEDAR LAKE ASSISTED LIVING	777 CHURCH STREET LAKE ZURICH, IL 60047

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A 000	Initial Comment Facility Reported Incident of 4/26/2026 IL201685 295.4010d) - Repeat Violation Facility Reported Incident of 3/21/2026 IL200979 - no findings Facility Reported Incident of 3/22/2026 IL200915 295.4000c)d)f)g)i) 295.4010d) - Repeat Violation Facility Reported Incident of 3/7/2026 IL200723 - no findings	A 000		
A4000	Section 295.4000 Physician/s Assessment This Regulation is not met as evidenced by: TYPE 2 VIOLATION Section 295.4000 Physician's Assessment c) A physician's assessment shall be completed by a physician upon identification of a significant change in the resident's condition. d) When a physician's assessment is conducted pursuant to this Part, all current negotiated risk agreements shall be renegotiated as necessary. f) It is the responsibility of the resident or his/her representative to have physician's assessments and reassessments completed. g) Establishments may develop their own tools for evaluating their residents; however, the establishment evaluation does not replace the	A4000		

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requirement for a physician's assessment. Documentation of evaluations and re-evaluations may be in any form that is accurate, that addresses the resident's condition, and that incorporates the physician's assessment.

i) The establishment shall have policies in place to respond to the gradual deterioration of a resident's ability to carry out the activities of daily living that may accompany the aging process.

These regulations were NOT MET as evidenced by:

Based on interview and record review, the establishment failed to obtain an updated physician's assessment after a significant change in physical, cognitive, and functional condition for one (R3) of four residents reviewed for physician assessment. This failure resulted in R3's physician's assessment not accurately reflecting R3's current mobility, cognition, fall risk, and need for assistance after R3 experienced repeated falls and staff identified a change in condition. This failure creates the substantial probability of harm to a resident or residents.

Findings include:

R3 was admitted to the establishment on 10/25/23 with diagnoses including dementia, hypertension, and major depressive disorder.

Review of R3's most recent physician's assessment, dated 11/3/2025, documented R3 as independent with ambulation, independent with transfers, and independent with toileting. The cognitive status score was left blank on the assessment.

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A4000	Continued From page 2 The establishment did not provide documentation of an updated physician's assessment after R3 experienced repeated falls and a decline in physical, cognitive, and functional status. Review of R3's fall history showed R3 had the following falls: " On 1/10/26 at 7:15 AM, R3 fell in the bedroom. The establishment documented no injury. Interventions included frequent checks for 72 hours, reorientation/training on the call bell/alert system, family discussion, resident education, safe staffing review, and staff education. " On 2/8/26 at 7:30 PM, R3 fell in the bedroom. The establishment documented no injury and no immediate action. The intervention documented was that the resident care plan was updated with interventions to encourage R3 to use an assistive device when ambulating in the apartment. " On 3/4/26 at 1:15 AM, R3 fell in the bathroom. The establishment documented no injury. Actions taken included reminding R3 to use her walker, placing R3 on alert charting, frequent checks for 72 hours, and reorientation/training on use of the call/safety system. " On 3/4/26 at 2:20 PM, R3 fell in the apartment. The establishment documented no injury and no immediate action. Interventions included resident education, staff education, resident to call for assistance when toileting, and staff to proactively ask R3 if she needed assistance with toileting. " On 3/4/26 at 11:30 PM, R3 fell in the apartment. The establishment documented interventions including resident education, staff education, resident to call for assistance when toileting, and staff to proactively ask R3 if she needed assistance with toileting.	A4000		

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A4000	Continued From page 3 " On 3/5/26 at 7:45 PM, R3 fell in the movie theater. The establishment documented interventions including education for R3 to call for assistance with transfers/mobility. " On 3/13/26 at 8:30 AM, R3 fell in the bedroom. The establishment documented no injury. R3 was placed on alert charting, frequent checks for 72 hours, and reoriented/trained on use of the call/safety system. " On 3/22/26 at 8:00 PM, R3 fell in the movie theater. The establishment documented 911 was called immediately. Review of the Serious Incident Investigation Form for the 3/22/26 fall showed R3 was in the movie theater with other residents watching a movie. The form documented R3 started to get up and started walking without her walker, lost her balance, and fell on her left side, hitting her head on the floor. The form documented R3 was observed in a left side-lying position with blood on the left side of her forehead and right hand. The form identified head injury with or without loss of consciousness, internal injury or bleeding identified as subdural hematoma, and injury requiring hospital or emergency room evaluation/admission. The form documented R3 was assessed by the nurse, the physician/provider was notified by fax on 3/22/26, family was notified on 3/22/26, and R3 was sent to the emergency department/hospital. Review of the nursing progress note dated 3/22/26 at 11:24 PM showed R3's granddaughter called to update the nurse on duty of R3's status. The note documented the hospital diagnosed R3 with a brain bleed but stated it looked chronic due to R3's history of falls. The note also documented that the hospital stated a follow-up CT could be completed if needed and follow-up with	A4000		

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neurology. The note documented that the establishment determined that R3 did not meet requirements at that time to be readmitted to the establishment due to high risk of bleeding and continued falls, and the granddaughter was informed R3 would relay to the hospital that admission was required until the establishment could determine a future plan of care for R3.

6/6/26 at 2:18 PM, E8 (Licensed Practical Nurse), stated R3 was walking and ambulating by herself up until around February/March, after she had fallen ill with a respiratory virus. E8 stated that after the virus was resolved, R3 was weak and did not want to use her walker and was not at all as she previously was in terms of functional ability. E8 said, "She forgot about her walker" and started having falls after this decline.

6/6/26 at 2:42 PM, E7 (Registered Nurse), stated R3 used the walker but would often forget that she needed to use the walker and added, "I would remind her a lot actually." E7 stated that R3 was very forgetful, very unsteady on her feet, and would try to balance herself but really couldn't. E7 said that R3 had an obvious decline and was becoming weaker and more forgetful and had poor safety awareness.

The November 2025 physician's assessment did not reflect R3's current condition after the repeated falls, increased weakness, unsteady ambulation, forgetfulness, poor safety awareness, and failure to consistently use her assistive device. Establishment was asked to provide any physician assessments conducted after this date; no additional assessments were provided during the survey.

6/6/26 at 3:45PM, E5 (Director of Resident Care)

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said that physician assessments are done annually and if there's a change in condition. It may be more, but the DON would handle that because she handles anything clinical. It's up to nursing to contact the primary care provider and DON communicates with the physician.

6/6/2026 at 2PM, E1 (Executive Director) said that a recommendation was made for hospice to R3's family but they declined. After R3's last hospitalization, the hospital communicated that she had an increased need for more assistance. The daughter said that she would stay in the room without bringing anyone else on board and we told her that we could not do that, then she agreed to take her to the acute rehab. We don't do negotiated risk. There was a lot of resistance from the family. When asked if the establishment had provided a discharge notice for R3 prior to the hospitalization. E1 said that R3 wasn't identified for a 30-day notice and that physical therapy (PT) was added to her plan of care; "we had to give the interventions time to work, and PT is usually 12 weeks, so we check in with them at about four weeks to see if they are progressing.

6/6/2026 at 4:32PM, E2 (Director of Nursing /RN) said, I started May 1st. Physician assessments are only done upon admission and annually. We would reach out to the physician, and we may have the family assist with that. If family takes them out on a visit, then we would not be privy to any notes if they don't share with us. When it comes to deciding if they are no longer appropriate, we cannot make that decision here, it has to go to Regional. If the family is not responsive, then we send it off to Regional.

Establishment was asked to provide any written policies regarding physician assessments, and

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A4000	Continued From page 6 they provided the Resident Move In Process revised August 2025, which indicates under "Assessment" that the community will follow state regulation related annual physician certification.	A4000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: TYPE 1 VIOLATION - REPEAT VIOLATION Section 295.4010 Service Plan a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the Act) The establishment shall respect and accept the resident's choices regarding the service plan. b) The service plan shall be developed by: 1) The resident, resident's representative or any individual requested by the resident; 2) The manager or manager's designee; and 3) A registered nurse, if the resident is receiving nursing services or medication administration, or is unable to direct self-care. c) The service plan shall be signed and dated by all individuals involved in its development.	A4010		

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A4010	Continued From page 7 d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act) e) The service plan shall be reviewed and revised if necessary immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000). 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; 4) Any risk being negotiated; and i) Nothing in this Part limits a resident's ability to direct his or her own care and negotiate the terms of his or her own care. Residents have the right to refuse certain services or approaches that would otherwise be recommended based on the physician's assessment if the resident has received clear information regarding the risks and benefits of such a choice and the choice does not put other residents or staff at risk. Disclosure of the risks of refusing services or approaches must be documented in the service plan.	A4010		

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A4010	Continued From page 8 These regulations were NOT MET as evidenced by: Based on interview and record review, the establishment failed to review and revise service plans with individualized fall interventions for two (R1, R3) of four residents reviewed for service plans. This failure resulted in R1's service plan not being updated after a fall with injury and R3's service plan not being updated after repeated falls with a significant change in physical, cognitive, and functional condition. This failure creates a substantial probability of severe harm to a resident or residents. Findings include: R1 is a 93-year-old female who was originally admitted to the facility on November 17, 2022, with diagnoses including, but not limited to, spinal stenosis, osteoarthritis, and a right hip fracture. The establishment submitted a Facility Reportable Incident dated April 26, 2026, indicating: R1 sustained a fall requiring emergency transfer to a local hospital. Hospital records documented a closed left hip fracture resulting from the fall. R1's Service Plan, signed May 26, 2026, reads no documented fall-related interventions or modifications implemented following April 26, 2026 fall and resulting left hip fracture. On June 6, 2026, at 11:30 a.m., E2 (Director of Nursing), said, when a new intervention is added, a revised service plan is printed and signed because a modification or new intervention has been implemented. R1 was readmitted to the facility on May 26, 2026, after completing several	A4010		

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weeks of skilled therapy. E2 acknowledged updating the service plan on May 26, 2026; however, no new fall interventions were documented related to the April 26, 2026 fall that resulted in a left hip fracture. I do not see any updates listed as new fall interventions. I missed developing an entry for fall interventions.

On June 6, 2026, at 12:48 p.m., E1 (Executive Director), said, the service plan should incorporate new fall interventions after a resident sustains a fall. I do not see any new fall interventions after April 26, 2026. I do not know if the service plan was updated.
R3 was admitted to the establishment on 10/25/23 with diagnoses including dementia, hypertension, and major depressive disorder.

Review of R3's most recent physician's assessment, dated 11/3/2025, documented R3 as independent with ambulation, independent with transfers, and independent with toileting. The cognitive status score was left blank on the assessment.

Review of R3's service plan signed 3/3/25 showed R3 had dementia. The service plan documented R3 had mild communication impairment and may have occasional difficulty communicating and receiving information. The service plan documented R3 had short-term memory impairment, occasional forgetfulness, and needed reminders by resident assistant. Under Mobility/Ambulation showed R3 used a cane for mobility. The service plan documented R3's level of assistance for mobility/ambulation as "Reminders" and documented R3 may require prompts/cues for safety and did not require physical assistance. Review of the service plan under Escorts showed R3's level of assistance for

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escorts was independent and R3 did not require assistance with escorting. Review of the service plan under Transferring showed R3's level of assistance for transferring was independent and R3 did not require assistance with transferring. Review of the service plan under Toileting showed R3's level of assistance for toileting was independent and R3 did not require assistance with toileting. Review of the service plan under Emergency Response showed R3's level of assistance was independent and R3 did not require assistance with using the community response system. The service plan documented R3 had a pendant that she would use to call for assistance as needed.

R3's Service Plan signed on 3/3/25 included:
Fall Prevention Plan showed the establishment documented R3's assessment indicated a potential fall risk. The plan documented the community team would check for appropriate lighting, clutter, and spills in the apartment; encourage proper footwear/non-skid footwear; educate R3 to push the pendant as needed for assistance with mobility; and make wellness checks every shift for resident-specific prevention/interventions.

Review of R3's recent fall history showed R3 had the following falls:
o On 1/10/26 at 7:15 AM, R3 fell in the bedroom. The establishment documented no injury. Interventions included frequent checks for 72 hours, reorientation/training on the call bell/alert system, family discussion, resident education, safe staffing review, and staff education.
o On 2/8/26 at 7:30 PM, R3 fell in the bedroom. The establishment documented no injury and no immediate action. The intervention documented was that the resident care plan was updated with

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interventions to encourage R3 to use an assistive device when ambulating in the apartment.
o On 3/4/26 at 1:15 AM, R3 fell in the bathroom. The establishment documented no injury. Actions taken included reminding R3 to use her walker, placing R3 on alert charting, frequent checks for 72 hours, and reorientation/training on use of the call/safety system.
o On 3/4/26 at 2:20 PM, R3 fell in the apartment. The establishment documented no injury and no immediate action. Interventions included resident education, staff education, resident to call for assistance when toileting, and staff to proactively ask R3 if she needed assistance with toileting.
o On 3/4/26 at 11:30 PM, R3 fell in the apartment. The establishment documented interventions including resident education, staff education, resident to call for assistance when toileting, and staff to proactively ask R3 if she needed assistance with toileting.
o On 3/5/26 at 7:45 PM, R3 fell in the movie theater. The establishment documented interventions including education for R3 to call for assistance with transfers/mobility.
o On 3/13/26 at 8:30 AM, R3 fell in the bedroom. The establishment documented no injury. R3 was placed on alert charting, frequent checks for 72 hours, and reoriented/trained on use of the call/safety system.
o On 3/22/26 at 8:00 PM, R3 fell in the movie theater. The establishment documented 911 was called immediately.

Review of the fall history showed R3's most current service plan was signed on 3/3/25. After this date, R3 sustained six additional falls, including three falls on 3/4/26, one fall on 3/5/26 in the movie theater, one fall on 3/13/26 in the bedroom, and one fall on 3/22/26 in the movie theater. The establishment did not provide

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documentation of a revised service plan after the repeated falls on 3/4/26, 3/5/26, 3/13/26, or 3/22/26 that addressed R3's repeated falls, forgetfulness, poor safety awareness, increased weakness, unsteady ambulation, and failure to consistently use her walker.

The establishment also provided an unsigned service plan with an effective date of 2/25/26 at 1:41 PM. This service plan documented additional fall-related information and interventions; however, the plan was not signed, and the establishment did not provide documentation that the plan was reviewed with or agreed to by R3 or R3's representative.

The unsigned service plan of 2/25/26 does indicate that R3 does not require assistance with ambulation and does not require reminders to use pendant appropriately. It also documents multiple prior falls and injuries, including: 11/24 possible fall with head laceration, sent to ER; 12/30/25 rib fracture of unknown cause; R3 requires safety checks, therapy, wheelchair escorts to meals; repeated education to use walker/call for assistance. It is to be noted that this service plan includes interventions that rely on education/reminders despite R3's documented forgetfulness and poor safety awareness.

Review of the Serious Incident Investigation Form for the 3/22/26 fall showed R3 was in the movie theater with other residents watching a movie. The form documented R3 started to get up and started walking without her walker, lost her balance, and fell on her left side, hitting her head on the floor. The form documented R3 was observed in a left side-lying position with blood on the left side of her forehead and right hand. The form identified head injury with or without loss of

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consciousness, internal injury or bleeding identified as subdural hematoma, and injury requiring hospital or emergency room evaluation/admission. The form documented R3 was assessed by the nurse, the physician/provider was notified by fax on 3/22/26, family was notified on 3/22/26, and R3 was sent to the emergency department/hospital. It is to be noted that staff were not present during this fall and witness accounts were provided from other residents who were in the theatre at the time of R3's fall.

Review of the nursing progress note dated 3/22/26 at 9:33 PM showed R3 was in the movie theater watching a movie and started to get up and walk on her own without her walker or pressing the pendant for help. The note documented R3 lost her balance, fell on her left side, and hit her head on the floor. The note documented R3 was observed lying on her left side with blood on the left side of her forehead, a laceration measuring 4 x 4 cm, and blood on her right hand. The note documented 911 was called immediately.

Review of the nursing progress note dated 3/22/26 at 11:24 PM showed R3's granddaughter called to provide an update. The note documented the hospital diagnosed R3 with a brain bleed but stated it looked chronic due to R3's history of falls. The note also documented that the hospital stated a follow-up CT could be completed if needed and follow-up with neurology. The note documented that the establishment determined R3 did not meet requirements at that time to be readmitted to the establishment due to high risk of bleeding and continued falls, and the granddaughter was informed the establishment would relay to the

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	ASL510098	A. BUILDING: _____ B. WING _____	C 06/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LAKE ASSISTED LIVING	777 CHURCH STREET LAKE ZURICH, IL 60047

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hospital that admission was required until the establishment could determine a future plan of care for R3.

6/6/26 at 2:18 PM, E8, Licensed Practical Nurse, stated R3 was walking and ambulating by herself up until around February/March after she had fallen ill with a respiratory virus. E8 stated that after the virus was resolved, R3 was weak, did not want to use her walker, and was not as she previously was in terms of functional ability. E8 stated, "She forgot about her walker," and stated R3 started having falls after this decline. E8 stated they keep fall risk residents close to the nurses' station. E8 stated she ordered physical therapy for R3 herself.

6/6/26 at 2:42 PM, E7, Registered Nurse, stated R3 used the walker but would often forget that she needed to use the walker. E7 stated, "I would remind her a lot actually." E7 stated R3 was very forgetful, very unsteady on her feet, and would try to balance herself but really could not. E7 stated R3 had an obvious decline and was becoming weaker and more forgetful. E7 stated the caregivers would watch R3 more frequently and R3's daughter was staying with her in the apartment. E7 stated if staff gave R3 the walker, she would use it. E7 stated R3 had poor safety awareness.

6/6/26 at 2:00 PM, E1, Executive Director, stated a recommendation was made for hospice to R3's family but the family declined. E1 stated that after R3's last hospitalization, the hospital communicated that R3 had an increased need for more assistance. E1 stated physical therapy was added to R3's plan of care and stated, "We had to give the interventions time to work, and PT is usually 12 weeks, so we check in with them at

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A4010	Continued From page 15 about four weeks to see if they are progressing." E1 stated R3 was not identified for a 30-day notice prior to the hospitalization. The establishment's documented interventions relied on R3 remembering to use her walker, remembering to press her pendant, calling for assistance, and following resident education. However, staff interviews identified R3 was forgetful, frequently forgot to use her walker, was very unsteady, had poor safety awareness, and had an obvious decline. The establishment failed to revise R3's service plan with individualized interventions to address R3's repeated falls, increased need for assistance, poor safety awareness, unsteady ambulation, forgetfulness, and failure to consistently use her walker. Establishment provided their Care Plan policy revised on February 1, 2023, which includes: Policy Using the Community's Electronic Health Record (EHR), the Director of Nursing will develop an individualized, comprehensive Care Plan for each Resident based on the physician's assessment / history and physical information, Resident / Resident representative interview and the assessment completed in the EHR. Care plan tasks will be mutually agreed upon by the Community and the Resident or Resident representative and serves as a basis for the service delivery contract between the Provider and the Resident The Care Plan is designed to be Resident Directed and meet the specific needs and preferences of the Resident and serves as a communication tool for team members that assists the providing quality, individualized care. At Spectrum, we believe that Care Plans: o Are Resident Directed and describe the	A4010		

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A4010	Continued From page 16 Resident's preferences ... o Are signed by appropriate family members/personal representatives ... o Are continuously updated to ensure we provide the care the Resident requires. Procedure 1. The Care Plan is developed by: a. The Resident; b. The Resident's representative or any individual requested by the Resident; c. Appropriate Community team member which may include but is not limited too; Executive Director, of Resident Care /Manager of Memory Care / Manager of Assisted Living, Director, Nursing, Director, Food & Beverage, Director, Entertainment & Programming, or contracted vendors such as Home Health, Hospice, or Therapy as appropriate. 2. The Care Plan along with the Assessment is reviewed and revised upon admission, within 30 days of admission, every 3 months for Resident residing in Memory Care or every 6 months for Resident residing in Assisted Living or following a change in condition. (State regulations may require more frequent reviews.) 3. The Care Plan is reviewed with the Resident / Resident Representative upon completion ...6. The Care Plan will be signed and dated by all individuals involved in its development ...8. Care plans will be available in the EHR and a copy kept in an area available to team members providing care and in a manner to protect personal information to ensure ease of accessibility ... Please note: o A thorough reassessment should be completed prior to the Care Plan review. o Residents have the right to refuse certain services or approaches that would otherwise be recommended based on the Resident Assessment; if the Resident has received clear	A4010		

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A4010	Continued From page 17 information regarding the risks and benefits of such a choice and the choice does not put other Residents or team members at risk. o Disclosure of the risks of refusing services or approaches must be documented in the Care Plan.	A4010		