STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510218	A. BUILDING: _____ B. WING _____	C 05/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE PATH SENIOR LIVING	555 FOXWORTH BLVD LOMBARD, IL 60148

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A 000	Initial Comment Facility Reported Incident: Facility Reported Incident of 3/16/2026/IL201115 - 295.2050a)b), 295.4010a)c), 295.9040a) Facility Reported Incident of 3/23/2026/IL200897 - 295.2050a)b), 295.4010a)c), 295.9040a)	A 000		
A2050	Section 295.2050 Incident and Accident Reporting This Regulation is not met as evidenced by: Violation 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. These REQUIREMENTS were not met as evidence by: Based on interview and record review, the facility failed to report an incident that resulted in resident unknown injury to Illinois Department of Public Health (IDPH) within 24 hours of the incident/accident for one (R1) of four residents	A2050		

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A2050	Continued From page 1 reviewed for reporting. Findings include: R1 is an 87-year-old female, with move in date of 6/4/2020 and diagnosis that include Alzheimer's Disease, Unspecified, Repeated Falls, Need For Assistance with Personal Care, Osteoporosis, Hypertension, Dementia In Other Diseases Classified Elsewhere, Severe, with Agitation, Depression, Unspecified, Other Abnormalities of Gait and Mobility, Muscle Weakness, Anxiety Disorder, Unspecified R1 currently resident in facility. Initial and final Facility Reported incident submitted to IDPH on 3/17/2026 at 4:14pm by E12, LPN documents in part: Event: 3/16/2026 at 8:00pm R1 right shoulder /arm swelling/severe pain Describe occurrence: Resident was observed in severe pain related to her right shoulder/arm swelling. Unable to move right arm. X-Ray was done tonight in the facility. Sent to local hospital for further evaluation and test. Diagnosis: R Humerus Fracture Nursing notes documents in part: E9, LPN at 3/14/2026 at 3:52am old bruise in healing stages noted to right arm. No signs of pain or discomfort noted. Left VM for MD. E16, Registered Nurse (RN) on 3/15/2026 at 10:40am Resident with edema to RUE. When resident RUE is raised and abducted resident will flinch groan in pain, Resident is on ATC Tylenol. 1031 LM for Doctor. E2 DON was notified at 1040. E13, LPN on 3/16/2026 at 1:50pm Right Arm	A2050		

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A2050	Continued From page 2	A2050		

swelling noted, appeared to have pain with movement, warm to touch. VS- T-97.5 BP-127/81 P-84 RR-16 O2-96%RA. Dr. notified, still awaiting follow up at this time. DON aware, stated she will also be reaching out to PCP.

On 5/15/2026 at 12:49pm R1 fidgety and unable to answer questions. R1 mumbling incomprehensible words. R1 dressed groomed and sitting in dining room eating lunch with assistance. R1 was not able to state how she sustained a shoulder injury as reported on 3/16/2026.

Facility Investigation documents in part: R1, Date of Report: 3/17/2026 Date of Injury Found: 3/15/2026 Incident Type: Injury of Unknown Origin - Right Humerus Fracture
Summary of Incident: On 3/17/2026, an investigation was initiated after it was identified that R1 sustained a right humerus fracture. The origin of the injury is unknown at this time.

Background: R1 diagnosis of Osteoporosis, increased risk for fractures. No recent falls or reported incidents involving trauma prior to discovery of injury.
Investigation Details: E8 (3/14/2026 -3?15/2026): reported during morning care, she observed swelling in the resident's right arm when assisting her out of bed. This finding was reported to E3. E3 (3/14/26 & 3/15/2026) reported that on 3/15/2026 around 6am, E8 reported that R1's right upper arm swelling to her. E3 reported that when she saw R1 her right upper arm was swollen, and she was holding onto her right arm. E3 reported immediately to E16. E16 (3/14/2026 & 3/15/2026) Reported on 3/15/2026, E3 reported to her that E8 said R1's arm was swollen.

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A2050	Continued From page 3 On 5/15/2026 at 1:05pm E3, Resident Services Coordinator, stated she was familiar with R1 and 3/16/2026 incident. E3 stated, R1 is very impulsive and very confused. She tries to sit up. R1 had pain and swelling in her shoulder. E3 stated she was not sure how that (injury) happened. There was not bruising just swelling. R1 has osteoporosis and sleeps on her arm. If R1 fell, she could not get herself back up. She used to walk. On 5/16/2026 at 10:22am E7, Resident Partner stated, she is familiar with R1. I do not remember when it was, but I remember her arm looked swollen. There was no bruising just swollen. I was wondering if she had an infection. R1 did not have a fall and there was not one in the record that I know about. R1 was not able to say anything that happened. I don't know if I was the first that saw it, but I know I was not the only person that saw it. When I saw it I told the nurse I think E13, Licensed Practical Nurse (LPN). I took care of her on 3/16/2026 but the night shift or hospice got her ready. I could see that her arm looked fat compared to the other arm. I just told the nurse; I felt it to see if it was warm. The nurse moved it to see if she was having pain. I do not know if she had this on the weekend, I saw her the morning of 3/16/2026. R1 was in the activity room in her high back chair and dressed when I initially saw her. On 5/16/2026 at 10:44am E8, CNA stated, she is familiar with R1. E8 stated she remembers swelling in arm, I do not remember exactly which arm. I worked overnight and when I came in she was in the bed sleep, I saw it in the morning when I got her up and dressed for the morning shift. As I was getting her dressed, she was making noise like it was hurting. I did not see any discoloration	A2050		

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A2050	Continued From page 4	A2050		

but could tell it was hurting as I was getting her dressed. I have been taking care of her for a few years. I reported it immediately to our supervisor, E3 (Resident Services Coordinator). I got her up about 5:00am and E3) came in about 6:00am. That was the first time I saw her that morning. The pm shift gets her ready for bed. I did not hear she had a fall everyone acted like they did not know what was going on. I left before the nurse got there. The next night R1 was still at the facility. I had R1 Saturday March 14, 2026, and Sunday, March 15, 2026, overnight. On Monday, March 16, 2026, night when I came in R1 had been sent to the hospital. Saturday night 3/14/2026 into Sunday morning 3/15/2026 E8 saw R1's arm was swollen and on Sunday morning 3/15 before E8 left E8 told E3 about R1's arm. When E8 came on Sunday night R1 was still at the facility. Me and my co-workers discussed trying to figure out what was going on. E8 was asking what happened and they had her all day, and they said nothing happened. E8 asked E11, CNA because she took care of her that day Saturday and Sunday during the day. E8 stated, she was not sure who put her to bed that night, but E8 was talking to E11 about it. If a resident has an injury, we report it to the nurse. We will fill out a report if there is a fall. For this we report to the nurse if we see something suspicious or something wrong. R1 is verbally combative but not physically combative. She does not physically resist care. R1 was gone for a few months and when she returned, she was mostly bedbound. She stayed in bed all night. She was not getting up like she use to. R1 is mostly non-verbal; she says random words; she cannot have a conversation.

On 5/16/2026 at 1:40pm, E2, Director of Assisted Living and Memory Care stated, she is familiar

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A2050	Continued From page 5	A2050		

with R1 and incident of 3/16/2026. One of the nurses found swelling to her arm and she had a previous fracture not too long ago and had a metal rod due to previous fracture. She was hospitalized and had surgery and came back. Swelling appeared after her return to facility. Reached out to get an x-ray and it seemed like she was not in any pain. R1 is non-verbal. I do not believe there was any recent fall or incident. X-ray result was sent out due to an acute fracture. We did full investigation to try and determine the cause, she did not have the strength to get up from a fall, no suspicion of any injury. Findings were unknown. She has a history of osteoporosis, but unable to determine what happened. It was E15, RN that reported it to me and reached out to the doctor for stat x-ray. R1 was sent out while x-ray was actually being completed. I got a phone call from CNA and said x-ray tech advised she be sent out from when tech was taking x-ray. R1 was sent out and hospitalized with an acute fracture and required surgery and ended up in rehab. Investigation was done. Reportable reported to state within 24 hours of incident. The nurse will send in the report after they get info if resident is to be hospitalized. If CNA sees something abnormal, they should report to their nurse immediately any skin abnormality or anything so the nurse can come assess. CNA will submit a statement for falls witnessed or unwitnessed. If they (RP) find any type of skin, swelling or anything will report to the nurse and nurse will come and do an assessment. If found, the first caregiver should have reported to nurse or to me. They could report to E3, but we advise it be reported to nurse or to E2. At the time because she had not had a recent fall thought there was malfunction in equipment (internal) so x-ray was ordered. If resident is crying out or has swelling, that should

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A2050	Continued From page 6	A2050		

be reported. I am not sure when it was presented. Any acute pain, lack of ROM suspicion of injury that would be reported.

On 5/16/2026 at 2:38pm E1, Executive Director stated, injuries are reported within 24 hours of the injury findings. Send resident to the hospital and wait for admitting diagnosis, if no diagnosis will send the reportable to state to stay within timeframe. We report a major bruise 1/4 size and cannot be justified how it could have happened. Based on the note thought it was from injury from before and just got irritated, I would not know how she got the bruise. I am not sure if it should been reported, I need to read through our policy. She had swelling on 3./15/26 that should have been reported. I am not sure why the nurse did not send the report. It was brought to my attention on the March 16th or March17th when it was confirmed there was a fracture.

During course of the survey calls attempted to the following staff without success: E11, Resident Partner left message on 5/16/2026 at 5:50pm, voice mail full, E12, Licensed Practical Nurse left message on 5/16/2026 at 11:08am and 5:49pm, left messages, and E13, Licensed Practical Nurse left message on 5/16/2026 at 11:08am and 5/17/2026 at 2:34pm voice mail full

Facility Policy:
Incident and Accident Reporting dated 2/2026 documents in part: An incident report is a form filled out to record details of an unusual event that occurs. This report is filled out in "Clarity" when an event occurs that harms an individual, a potential for harm or anytime an emergency cord, pendant is responded to. This includes all falls and injuries not only to residents, visitors and staff. Incident reports must be completed

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A2050	Continued From page 7 promptly with all circumstances surrounding the event, while details are fresh in the staffs' mind. Of course, this should after stabilizing the incident. Details are important as there always liability issues. Additional documentation is to be entered into Resident's EMR. In the event a staff member notices an injury to a resident, such as bruising, skin tear, swelling, complaining of pain, the Nurse must be notified immediately. If the resident cannot report how the injury occurred, an investigation must be conducted. If it is still unclear as to how the injury occurred, an incident report must be filled out as "injury of unknown origin" and sent to the within 24 hours. Incident reports deemed to be sent to state, must be sent within 24 hours. Follow up must be filled in whether they went to the hospital, first aid was administered, nurse assessment, etc. If the follow up cannot be obtained within 24 hours, the report must be sent to state and once follow up is recorded on the incident report, the accident and incident report must also be sent to state that follow up has been completed.	A2050		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 2 Violation 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	A4010		

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A4010	Continued From page 8	A4010		

the resident. (Section 15 of the Act) The establishment shall respect and accept the resident's choices regarding the service plan.

c) The service plan shall be signed and dated by all individuals involved in its development.

This REQUIREMENT was not met as evidenced by:

Based on observation, interview and record review, the facility failed to follow a resident's service plan to keep three (R1, R4, R5) of four residents in a safe supervised environment while residing in the facility and failed to ensure one resident (R4) of four residents service plan was signed and dated by R4's POA (Power of Attorney). These failures have the potential to affect all 24 residents residing in the memory care unit. This failure creates a substantial probability of harm to a resident or residents.

Findings include:

R1 is an 87-year-old female, with move in date of 6/4/2020 and diagnosis that include Alzheimer's Disease, Unspecified, Repeated Falls, Need For Assistance with Personal Care, Osteoporosis, Hypertension, Dementia In Other Diseases Classified Elsewhere, Severe, with Agitation, Depression, Unspecified, Other Abnormalities of Gait and Mobility, Muscle Weakness, Anxiety Disorder, Unspecified

R1 currently resident in facility

R1's Individualized Service Plan (ISP) dated 4/7/2026 documents in part Activity: Transfer Service Provided/Assistance Level: Assist Notes: Unwitnessed fall 8/29/2025 Cause: unknown;

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A4010	Continued From page 9	A4010		

found lying on back. Intervention: Staff educated on frequent monitoring and redirecting to an activity. Resident redirected to activities for close monitoring. Unwitnessed fall 9/1/2025 Cause: unknown found lying on the floor of her apt. Intervention: staff educated to ensure resident is wearing nonskid socks at all times. Staff advised to assist resident to common area after R&S for closer monitoring. 9/9/2025 Cause: unknown, found on the floor outside elevators Intervention: Gait assessed by NOD (nurse on duty), encourage participation in group activities for close supervision. 12/27/2025 unwitnessed fall Cause: unknow found sitting on the floor Intervention: direct supervision initiated.

R4 is an 84-year-old male, with move in date of 1/21/2026 and diagnosis that include Alzheimer's Disease, Unspecified, Hypertension, and Chronic Obstructive Pulmonary Disease

R4 currently resides in the facility.

R4's Individualized Service Plan (ISP) dated 1/21/2026 documents in part R4's POA date and signature line blank

R4's ISP dated 1/21/2026 documents in part: Activity: Cognitive and Psychiatric Care Service Provided/Assistance Level: Required redirection, Wandering/Elopement Risk Notes: Resident requires some redirecting due to frequent wandering. Staff will monitor for unmet need, will redirect resident, and will ensure wander guard remains on R ankle.

R5 is a 90-year-old female, with move in date of 12/24/2025 and diagnosis that include Hypertension, Anxiety Disorder, Unspecified, Depression, Unspecified, Atrial Fibrillation - Afib,

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A4010	Continued From page 10 Dementia, Unspecified Severity, Without Beh/Psych/Mood/Anxiety, Pain in Right Knee, Pain in Left Knee, Rheumatoid Arthritis, Unspecified, Unsteadiness on Feet, Other lack of Coordination R5's Individualized Service Plan (ISP) dated 12/24/2025 documents in part: Activity: Mobility Provided/Assistance Level: Assist, Fall Risk Notes: Resident uses her wheelchair for mobility at this time. PT/OT requested to have gait safety and balance assessed with functional mobility, safety awareness & memory/cognition. On 5/15/2026 at 12:38pm tour of activity room (common area) no staff present in activity room The following residents were in the activity without supervision: R5 sitting in wheelchair dressed, groomed, wearing shoes. R5 able to self-propel in wheelchair. R5 stated she is doing okay. R5 was looking for staff to see when activity was going to start but stated, no one is in here. R1 sitting in high back wheelchair very frigidity and leaning forward. R4 dressed, groomed, wearing shoes and sitting in wheelchair was alert with mild confusion but able to answer questions. R4 stated he lived in independent care and he is now over here (Memory Care). During the time of 12:38 and 12:45pm staff came in periodically to drop off a resident then left and room unattended with residents present. On 5/15/2026 at 1:05pm E3, Resident Services Coordinator, stated we try to keep residents in the activity room. She is a high risk for falls and we always keep her with us in the high back chair in the activity room. On 5/15/2026 at 3:20pm R1, R4, and R5 in activity room without staff present. Total of 14	A4010		

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residents in activity room with no staff present. 2 residents in high back wheelchair. R1 leaning back and forth in chair and frigidity. R1 dressed, groomed with one shoe on and one shoe off. R1 was unable to answer any questions due to cognitive decline.

On 5/15/2026 at 3:25pm E5, Certified Nursing Assistant (CNA) stated, for high risk fall residents, we keep them in the common area. If residents are in the activity room someone always in the activity room. The activity person was just here but should have let us know that she was leaving. E5 stated, she was walking by and did not see anyone in here so she came in. R1 will not sit still, she needs someone with her at activities.

On 5/16/2026 at 1:23pm E6, Certified Nursing Assistant (CNA) stated, there is always someone in the activity room if a resident is in there because some residents try to get up and they are a fall risk, so we have to watch them. If I step out I have to call for another resident partner to come into the room.

On 5/16/2026 at 1:40pm, E2, Director of Assisted Living and Memory Care stated, there should be one of our CNA or RPs in activity room supervising residents. Staff in room for supervision of the residents. We do not have a policy but strongly advise that residents in room are supervised. Ensure safety and keep an eye on them to monitor resident behavior and resident needs. We highly encourage our high fall risks to be in activity room for supervision. If R1 is in activity room, should there be a staff member in the room. E2 stated, yes, there should be R1 is a high fall risk. Staff should page someone to come and relieve them if the staff have to leave. Resident service plans are updated annually and

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A4010	Continued From page 12 after significant changes in resident. E2 stated she signs off, the resident or POA and E1 have to sign off as well on all resident service plans Facility Policy Assessment And Service Plan Development dated 5/16 documents in part: Policy: It is the policy of The Memory Care Program of Lexington Square to conduct assessments and service plans within the time frames specified by the Assisted Living/ALZ and Shared Housing Establishment Code of the Illinois Department of Public Health. Procedure: 1. An interview with a potential resident will be conducted prior to move-in with a focus on resident service needs. The Client Assessment will be completed and the findings used in the development of the initial service plan as applicable. Once the client assessment is completed, the Move-In-Coordinator will ensure the document is signed by the Resident or Resident's representative prior to move in. 3. The service plan will be developed by the resident; resident's representative and any individual requested by the resident and Program Supervisor. Illinois Long-Term Care OMBUDSMAN PROGRAM RESIDENTS' RIGHTS | LONG-TERM CARE dated (Rev. 11/18) documents (in part): Your rights to safety Your facility must be safe, clean, comfortable and homelike. Illinois Department of Public Health Assisted Living in Illinois documents (in part) In Illinois, assisted living facilities are required to provide a safe environment for residents. This includes adherence to building codes related to accessibility, fire safety, and sanitation, such as adequate lighting, ventilation, and emergency	A4010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510218	A. BUILDING: _____ B. WING _____	C 05/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE PATH SENIOR LIVING	555 FOXWORTH BLVD LOMBARD, IL 60148

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A4010	Continued From page 13 exits, including smoke detectors and fire extinguishers. Facilities must also ensure that the environment is safe, clean, comfortable, and homelike, with reasonable arrangements to meet residents' needs and choices.	A4010		
A9040	Section 295.9040 Environmental Requirements This Regulation is not met as evidenced by: Type 2 Violation Section 295.9040 Environmental Requirements a) The establishment shall be kept in a clean, safe and orderly condition and in good repair. This REQUIREMENT was not met as evidenced by: Based on observation, interview and record review, the facility failed to provide one (R4) of four residents' a safe environment. This failure creates a substantial probability of harm to a resident or residents. Findings include: R4 is an 84-year-old male, with move in date of 1/21/2026 and diagnosis that include Alzheimer's Disease, Unspecified, Hypertension, and Chronic Obstructive Pulmonary Disease R4's Service Plan dated 1/21/2026 documents in part: Activity: Communication, Service Provided/Assistance Level: Independent Uses Phone Notes: Resident is able to use his phone	A9040		

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A9040	Continued From page 14	A9040		

for communication. Resident is reminded to use his pendant for communication with staff.

On 5/15/2026 at 2:51pm tour of resident rooms conducted with E4, Certified Nursing Assistant. E4 stated, R4 is fairly new and sometimes does not want to use his walker. He takes directions well and can let you know what he needs. I do not recall him having any falls. R4's room was clean and without clutter or debris. Pull cord in bathroom tied up and not reachable if resident falls. E4 stated R4 likes to hold grip part by toilet, pull cord should be extended in case he fell he could pull the cord.

On 5/16/2026 at 1:17pm R4 alert and has some confusion, but able to answer questions and make his needs known. R4 dressed, groomed and wearing shoes. R4 with wobbly gait ambulating in room without walker. R4 stated, he does not need to use walker while in his room, but he will use walker when he goes out of his room. R4's room was clean and without debris or clutter. Pull cord in bathroom remained tied up and out of reach. R4 stated, cord has been like that.

On 5/16/2026 at 1:40pm, E2, Director of Assisted Living and Memory Care stated, residents get help by pressing pendant or pulling the pull cord. There are pull cords in each room by the bed, bathroom and living area cords should be hanging and be able to be reached by the resident. Once pulled it will alert staff to come.

On 5/16/2026 at 2:38pm E1, Executive Director stated that the high functioning residents can use the pull cord, and they have pendants. One next to toilet, next to bed and depending on size of the apartment there is one in the living room. Cords

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A9040	Continued From page 15 should be hanging not tied up. put over head of the bed to reach. 24-hour emergency response logs not provided during the course of the survey. Facility Policy 24 -Hour Emergency Response dated 5/17 documents in part: Procedure: All dwelling units are equipped with emergency pull cords (Memory Care) as well as pendants worn by the Assisted Living Residents. These pendants are supplied by Lexington Square and are mainly worn during the night a) Pulling the cord will activate the system in the main office who will notify staff over the radio. This will summon a designated staff person. This emergency system is to be used for any emergency need, maintenance, health care, or personal need. Illinois Long-Term Care OMBUDSMAN PROGRAM RESIDENTS' RIGHTS | LONG-TERM CARE dated (Rev. 11/18) documents (in part): Your rights to safety Your facility must be safe, clean, comfortable and homelike. Illinois Department of Public Health Assisted Living in Illinois documents (in part) In Illinois, assisted living facilities are required to provide a safe environment for residents. This includes adherence to building codes related to accessibility, fire safety, and sanitation, such as adequate lighting, ventilation, and emergency exits, including smoke detectors and fire extinguishers. Facilities must also ensure that the environment is safe, clean, comfortable, and homelike, with reasonable arrangements to meet residents' needs and choices.	A9040		