STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510522	A. BUILDING: _____ B. WING _____	C 07/19/2025

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ARBOR TERRACE GLENVIEW	4700 W LAKE AVENUE GLENVIEW, IL 60025

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A 000	Initial Comment Facility Reported Incident of 10/23/24 #IL179890 - 295.6000 a)1) cited Facility Reported Incident of 6/25/25 #IL195558 - 295.4010 cited	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: General Violation Section 295.4010 Service Plan a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the Act) The establishment shall respect and accept the resident's choices regarding the service plan. b) The service plan shall be developed by: 1) The resident, resident's representative or any individual requested by the resident; 2) The manager or manager's designee; and 3) A registered nurse, if the resident is receiving nursing services or medication administration or is unable to direct self-care. c) The service plan shall be signed and	A4010		

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A4010	Continued From page 1 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 revised, if necessary, immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000). f) Based on the physician's assessment, the service plan may provide for the disconnection or removal of any kitchen appliance. (Section 15 of the Act) g) Service plans shall address: 1) The level of service the resident is receiving, including: A) assistance with activities of daily living; B) dietary needs, if the establishment provides therapeutic diets; and 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;	A4010		

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A4010	Continued From page 2 4) Any risk being negotiated; and 5) Whether the resident requires medication reminders, supervision of self-administered medication, or medication administration. h) The service plan shall include all support services provided or arranged for by the establishment. 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. This requirement is NOT MET as evidenced by: Based on interview and record review, the establishment staff failed to safely transfer a resident per the service plan from wheelchair to bed and failed to use a gait belt during transfer. This failure applied to one (R2) of three residents reviewed for accidents and resulted in R2 sustaining a right hip and femur fracture. Findings include: R2 was a 97-year-old female residing in the memory care unit of the establishment with diagnoses that included: Hypertension, GERD, Dementia, Hyperlipidemia, and Depression. R2	A4010		

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A4010	Continued From page 3 was accepted into hospice on January 08, 2025, due to her significant decline. R2 expired at the facility on 7/2/25. Facility reported incident documents that on 6/25/25, E5 (Caregiver) was attempting to transfer (R2) to the bed from her wheelchair without the use of a gait belt and the resident fell on to the floor on her right side. The caregiver does not work during this time and was picking up the shift ...The nurse on duty performed an evaluation on (R2) and it was noted that the resident complained of pain in her right leg ...X-ray determined a fracture of the right proximal femur ...(E6 / Memory Care Director) provided caregiver with additional training on proper transferring techniques, and the use of a gait belt ... (E6) conducted interviews with the staff. The caregiver stated that a transfer belt was not used to transfer (R2). The caregiver also was not familiar with transferring this resident due to primarily working a different shift. The caregiver picked up this shift and this was her first time working with the resident. The caregiver normally works overnights and does limited transfers. The caregiver was trained on proper transfer techniques and use of gait belt for future instances ...Addendum 6/30/2025 The caregiver assisting (R2) was (E5). On 6/30/2025 Arbor Terrace Glenview separated employment with (E5). Review of employee file E5 documents that E5 received the following training as part of New Hire Orientation (hire date: 2/4/25): Cognitive Care/Dementia, Resident Rights, and completed a Resident Assistant Orientation Post Test. E5 was not interviewable during this survey. Facility provided E5's investigation statement,	A4010		

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A4010	Continued From page 4	A4010		

which read: At approximately 6:40PM the resident stated she was ready to go to bed for the evening. I took the resident to her room to begin assisting with PM care. I then proceeded to transfer the resident from the wheelchair to the bed. While transferring the resident I was trying to remove the residents pants and the resident fell.

Xray report dated 6/27/25 12:16:40 AM documents that R2 was found to have an impacted intertrochanteric fracture with varus deformity of the right hip and impacted intertrochanteric fracture of the right proximal femur with varus deformity.

R2's service plan dated 6/27/25 documents that R2 needs complete assistance with majority of individual task using hand-under-hand assistance and cueing with staff initiating and helping to complete the task; generally incontinent of bowel AND bladder, requires complete assistance with all care related to incontinence, including hygiene, clothing, briefs, and nighttime changes. Documents R2's SLUMS Score of 22/30 (mild neurocognitive impairment or mild cognitive impairment).

7/18/25 at 2:25PM, E7 (LPN) confirmed that for residents who require gait belts, they are available in the rooms. We get an alert (pointing to LED screen at nurses' station) as soon as a call light goes off so that we can respond right away.

7/18/25 at 2:31PM, E8 (Caregiver) said, I've worked here about two years. We have regular training, like twice a week and on (online program). We always access the chart to see what care needs the resident has; especially since I am only here twice a week, I am

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A4010	Continued From page 5 constantly checking it so that I know what care a resident needs. Gait belts are provided by physical therapy, and they are available. Resident's should be helped right away when they call for assistance. E8 added that if a resident requires a two-person assist caregivers can use their radio to call for help so they don't have to leave the resident to seek help. 7/18/25 at 3:17PM E1 (Executive Director) was asked about staff that had been terminated related to incidents (including E5 Caregiver). E1 said, I thought that I couldn't have them working with my residents anymore ...for E5 it did not seem right with the training. She had some attendance issues. She typically worked overnight so she was not as familiar with the resident. Because there were issues with attendance (for her) and then with the performance, I would say that it was just too much. So, the decision was made to terminate her employment. Facility Inservice dated June 2024, titled Abuse and Neglect Prevention: Illinois Resident Rights, includes, "Neglect can also happen when a trusted caregiver does not help a person with their activities of daily living or protect them from harm. Neglect can cause physical harm, pain, and emotional distress.	A4010		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: General Violation Section 295.6000 Resident Rights	A6000		

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A6000	Continued From page 6 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: 1) The right to live in an environment that promotes and supports each resident's dignity, individuality, independence, self-determination, privacy, and choice and to be treated with consideration and respect; This requirement is NOT MET as evidenced by: Based on interview and record review, the establishment failed to ensure the resident's right to be cared for with dignity and respect by not being assisted to the restroom as requested. This failure applied to one (R1) of three residents reviewed for resident rights. Findings include: R1 is a 91-year-old female residing in the establishment since September of 2024. R1 has medical diagnoses that include: Spinal Stenosis, Arthritis due to other bacteria, left knee, Chronic diastolic congestive heart failure, Exudative age-related macular degeneration, bilateral, stage unspecified, Idiopathic gout, left ankle and foot, Unsteadiness on feet, Muscle weakness, generalized, and Other abnormalities of gait/mobility. R1 has a documented SLUMS Score of 27/30 (normal cognition, dated 10/6/24). Facility reported incident of 10/23/24 documents: R1 reported that she was assisted to bed during the second shift after completing her shower. She woke up in the middle of the night and needed to	A6000		

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use the bathroom to have a bowel movement. Two resident assistants arrived to respond to her call bell. When she asked for assistance up from her bed, she was told they could not assist her up from her bed and was told to evacuate her bowels in her diaper and they would then clean her up ...Upon interview of one of the resident assistants, she stated that they did advise (R1) to evacuate her bowels in her diaper ...
Conclusion: Based upon the explanation of the resident and one of the resident assistants, (R1) was not provided the care that she needed in the way in which she wanted to receive care by being assisted to the commode. Action Taken: Both resident assistants who together attended to the call bell for (R1) to assist her with toileting in the middle of the night were terminated from Arbor Terrace Glenview.

Facility investigation report documents that during interview with R1, R1 was embarrassed because she could not help herself get to the bathroom.

Staff involved were identified as E3 (Caregiver) and E4 (Caregiver). Review of employee files document that both E3 and E4 were terminated

E3 and E4 were not interviewable during this investigation.

Review of employee files for E3 and E4 document that training was completed on resident rights and on providing assistance with personal care during their time employed at the establishment.

R1's service plan dated 10/6/24 documents that R1 is continent of bowel and bladder but needs assistance to transfer on and off the commode. Service plan also documents that R1 is at risk for

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A6000	Continued From page 8	A6000		

falls and requires physical assistance of one person to safely transfer to and from the bed, chair, or commode.

7/18/25 at 2:25PM, E7 (LPN) stated that resident call lights should be answered immediately, and resident's should always be helped to the bathroom if they request it.

7/18/25 at 2:31PM, E8 (Caregiver) confirmed that resident's should be helped right away when they call for assistance. E8 added that if a resident requires a two-person assist caregivers can use their radio to call for help so they don't have to leave the resident to seek help.

7/18/25 at 3:17PM E1 (Executive Director) was asked about terminating E3 and E4's employment. E1 said, I thought that I couldn't have them working with my residents anymore. They verbalized their thought process, and it is completely unacceptable to tell a resident to evacuate their bowels on themselves. One of them said that she has been allowed to do that at other places she had worked but that is not acceptable here. I put together the packet with resident rights information and in-serviced them both on how that is not what we do here. Ultimately, I decided it was best to terminate their employment.

Facility Inservice dated June 2024, titled Abuse and Neglect Prevention: Illinois Resident Rights, includes, "Neglect can also happen when a trusted caregiver does not help a person with their activities of daily living or protect them from harm. Neglect can cause physical harm, pain, and emotional distress.