STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL5106197	A. BUILDING: _____ B. WING _____	C 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD PLACE	1879 CHESTNUT AVE GLENVIEW, IL 60025

(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 . Facility Reported Incident Survey IL201146 295.4010 g) 1) A) C) 2) 3) h)	A 000		
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; h) The service plan shall include all support services provided or arranged for by the establishment. This requirement is NOT MET as evidenced by:	A4010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL5106197	A. BUILDING: _____ B. WING _____	C 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD PLACE	1879 CHESTNUT AVE GLENVIEW, IL 60025

(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
A4010	Continued From page 1 Based on observations, interviews, and record review, the facility failed to update service plans and include health related services needed by the resident. This applies to 3 of 3 residents (R1, R2 and R3) reviewed for accidents and supervision. This failure creates a substantial probability of harm to all 3 residents. Findings include: 1) On 4/15/26 at 1:50 PM, observed R2 walking in the hallway. R2 was alert and disoriented to her surroundings. Observed that at times R2 walked into the wall, hit the wall, took couple steps backward and turned sideways and continued her walk. Observed R2 mumbling but cannot make needs known. R2's face-sheet showed R2 was admitted on 9/1/25 with diagnoses to include Al Zheimer's disease . R2's code status was DNR, not on hospice. R2's service plan showed R2 ambulates independently. Fall assessment done on 9/10/25 showed a score of 17 (fall risk) and fall assessment score on 10/7/25 was 22 (high fall risk). Incident reports show R2 had falls on 4/13/26, 4/4/26, 3/30/26, 3/27/26, 3/21/26, 3/20/26 in the last couple months. R2's service plan dated 4/15/26 does not specify any personalized fall precautions. 2) On 4/15/26 at 2:00 PM, observed R3 sitting on his recliner in his room. R3 was clean and well groomed and had a private caregiver (E7) with him. R3 was alert, oriented to people, and could answer some simple questions. R3 stated he was doing well and didn't want to talk further. E7 (R3's private caregiver) stated R3's gait was unsteady.	A4010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL5106197	A. BUILDING: _____ B. WING _____	C 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD PLACE	1879 CHESTNUT AVE GLENVIEW, IL 60025

(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
A4010	Continued From page 2 E7 stated, R3 falls more at night than during the day. E7 stated, at night R3 does not have any private caregiver. E7 stated, R3 gets up at night and walks in the room and falls at times. E7 stated R3's last fall was last week and that R3 had no injuries. R3's face-sheet showed R3 was admitted on 9/13/25 with diagnoses to include depression, anxiety, diabetes mellitus type 2. R3's code status was DNR. Not on hospice. Incident report showed R3 had falls on 3/28/26, 3/26/26, 3/10/26, 2/19/26, 2/1/26 in the last couple months. R3's Fall risk assessment score on 2/20/26 was 18 (high fall risk). R3's Service Plan dated 4/15/26 showed no personalized interventions to prevent falls. 3) R1's face-sheet showed R1 was admitted on 11/23/21 with diagnoses to include dementia, encephalopathy and depression. Incident reports showed R1 had a fall on 3/20/26, 1/28/26, 9/22/25 and 7/4/25. The fall on 3/20/26 resulted in fracture of right femur. The fall on 1/28/26 resulted in swollen forehead and bleeding nose. The fall on 7/4/25 resulted in minor cut on nose bridge and upper lip. On 9/22/25, R1 lost her balance and fell backwards hitting the back of her head. R1's Service Plan revised on 4/15/26 does not specify any fall precautions tailored for R1. On 4/15/26 at 2:19 PM, E5 (RCA-Resident Care Assistant) stated other than watching the residents she doesn't know of any fall precautions for any residents. On 4/15/26 at 2:25 PM, E6 (RCA) and E4 (RCA) stated to prevent the residents from falling, as much as possible staff try to keep the residents within sight, which is always not possible.	A4010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL5106197	A. BUILDING: _____ B. WING _____	C 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD PLACE	1879 CHESTNUT AVE GLENVIEW, IL 60025

(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
A4010	Continued From page 3 On 4/15/26 at E3 (RCM-Resident Care Manager) stated fall precautions for the residents include keeping them in activities, but for most part they are not engaged in the activity. Hence the residents get up and walk around. E3 stated the activities are for the higher functioning residents and that there is rarely anything for the confused residents to keep them occupied. E3 stated residents with memory issues should have activities to engage them and keep them occupied. Observed the life engagement personnel doing a word puzzle game for the residents. There were about 25-30 residents in the room. About 4-5 residents were actively participating in the game. The rest were sitting on their wheelchair or dozing in their wheelchair or walking around. On 4/15/26 at 3:00 PM, the above findings were reviewed with E1 (Executive Director) and E2 (Clinical Services Director). They stated the activities are for the higher functioning residents and that there is rarely anything for the confused residents to keep them occupied. E3 stated residents with memory issues should have activities to engage them and keep them occupied.	A4010		