STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	6022161	A. BUILDING: _____ B. WING _____	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENDALE SIX CORNERS	4715 WEST IRVING PARK RD CHICAGO, IL 60641

(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
A2040	Section 295.2040 Disaster Preparedness This Regulation is not met as evidenced by: Type 1 Violation Section 295.2040 Disaster Preparedness e) Drills shall include residents, establishment personnel, and other persons in the establishment. g) Drills shall involve the actual evacuation of residents to an assembly point as specified in the emergency plan and shall provide residents with experience using various means of escape. If an establishment has an evacuation capability classification of impractical, those residents who cannot meaningfully assist in their own evacuation or who have special health problems shall not be required to participate in the drill; however, other requirements of the Life Safety Code will apply. h) A written evaluation of each drill shall be submitted to the establishment manager and shall be maintained for one year from the date of the drill. The evaluation shall include the date and time of the drill, names of employees participating in the drill, and identification of any residents who received assistance for evacuation. These requirements are not met as evidenced by: Based on interview and record review, the establishment failed to complete drills with actual evacuation involving residents. This failure creates the substantial probability of severe harm or death to a resident or residents.	A2040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	6022161	A. BUILDING: _____ B. WING _____	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENDALE SIX CORNERS	4715 WEST IRVING PARK RD CHICAGO, IL 60641

(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
A2040	Continued From page 1 Findings include: Fire Drills were completed on the following dates and shifts: First shift: 2/26/26 11:30am, 12/14/25 10:00am, 11/12/25 12:00pm, 1/20/26 9:30am Second shift: 3/26/26 4:00pm, 12/18/25 5:30pm, 11/20/25 4:30pm, 1/15/26 4:15pm Third shift: 12/12/25 2:00am, 11/5/25 2:30am Silent drill with overhead Strobes, 1/17/26 5:56am These documents did not indicate if resident evacuations were done and how long it took to complete evacuations. It also did not document what assistance required by each resident who participated. There was a documentation of Evacuation of residents completed on 2/29/25, which lasted for 36 minutes. On 4/21/26 at 1:20pm, E12 (Plant Operations Technician), said they have not done a drill with evacuation this year. The last evacuation drill was completed in February 2025.	A2040		
A3040	Section 295.3040 Health Care Worker Background Check This Regulation is not met as evidenced by: Type 2 Violation Section 295.3040 Health Care Worker Background Check An establishment shall comply with the Health Care Worker Background Check Act and the	A3040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	6022161	A. BUILDING: _____ B. WING _____	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENDALE SIX CORNERS	4715 WEST IRVING PARK RD CHICAGO, IL 60641

(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
A3040	Continued From page 2 Health Care Worker Background Check Code. (Source: Amended at 36 Ill. Reg. 13632, effective August 16, 2012) Section 955.165 Fingerprint-Based Criminal History Records Check a) Educational entities, other than secondary schools, and health care employers are required to check the Health Care Worker Registry before allowing a student to enter a training program or hiring an employee to determine: 1) Whether a fingerprint-based criminal history records check has previously been conducted, which is indicated by the identifier of "FEE_APP" or "CAAPP". c) Educational entities and health care employers shall conduct Internet searches on certain web sites, including without limitation the Illinois Sex Offender Registry, the Department of Corrections' Sex Offender Search Engine, the Department of Corrections' Inmate Search Engine, the Department of Corrections Wanted Fugitives Search Engine, the National Sex Offender Public Registry, and the website of the Health and Human Services Office of Inspector General to determine if the applicant has been adjudicated a sex offender, has been a prison inmate, or has committed Medicare or Medicaid fraud, or shall conduct similar searches as provided by the web-based application. (Section 15 of the Act) Section 955.145 Employment Verification a) Each health care employer or its designee shall provide an employment verification and	A3040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	6022161	A. BUILDING: _____ B. WING _____	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENDALE SIX CORNERS	4715 WEST IRVING PARK RD CHICAGO, IL 60641

(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
A3040	Continued From page 3 update the demographic information for each employee and each contracted or subcontracted worker no less than annually. (Section 33(i) of the Act) 1) The health care employer or its designee shall log into the Health Care Worker Registry through a secure login in a method prescribed by the Department. (Section 33(i) of the Act) 2) The health care employer or its designee shall indicate employment and termination dates (separation dates) within 30 days after hiring or terminating an employee. (Section 33(i) of the Act) 3) The health care employer shall provide the employment category and type. (Section 33(i) of the Act) b) Failure to comply with this Section constitutes a licensing violation. A fine of up to $500 may be imposed upon a health care employer for failure to maintain these records. (Section 33(i) of the Act) c) The information required in this Section shall be used by the Department of Public Health to notify any current employer of any disqualifying offenses that are reported by the Illinois State Police. (Section 33(i) of the Act) (Source: Amended at 49 Ill. Reg. 7999, effective May 22, 2025) These requirements are not met as evidenced by: Based on interview and record review, the establishment failed to ensure the 6 internet searches for two (E10, E11) employees were	A3040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	6022161	A. BUILDING: _____ B. WING _____	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENDALE SIX CORNERS	4715 WEST IRVING PARK RD CHICAGO, IL 60641

(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
A3040	Continued From page 4	A3040		

completed prior to employee hire or start date. Establishment also failed to update Registry Portal within 30 days of employee's hire date for five (E7, E8, E9, E10, E11) employees. This deficient practice affected 5 of 5 employees reviewed .
This failure creates the substantial probability of harm to a resident or residents.

Findings include:

An onsite visit was conducted on 4/21-4/23/26. Interviews conducted, and records were reviewed.

E7 (Caregiver) was hired on 11/4/25.
E8 (Caregiver) was hired on 8/20/25.
E9 (Caregiver) was hired on 11/13/25.
E10 (Caregiver) was hired on 10/7/25.
E11 (Caregiver) was hired on 9/9/25.

E10 and E11 Health Care Worker Registry documents indicated the 6 required internet searches were completed on 4/21/26. The day of survey entrance.

The start date of these employees E7, E8, E9, E10, and E11 did not reflect on the Health Care Worker Registry documents provided for review.

On 4/21/26 at 4:44pm, E20 (Business Office Manager) confirmed E10 and E11 internet searches were done as stated and should have been done before the employees started working with residents. E20 also confirmed verifications of these employees were not done within 30 days of hire per requirements.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	6022161	A. BUILDING: _____ B. WING _____	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENDALE SIX CORNERS	4715 WEST IRVING PARK RD CHICAGO, IL 60641

(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
A4000	Continued From page 5	A4000		
A4000	Section 295.4000 Physician/s Assessment	A4000		

This Regulation is not met as evidenced by:
Type 3 Violation

Section 295.4000 Physician's Assessment

a) No more than 120 days prior to admission of a resident to any establishment, a comprehensive assessment that includes an evaluation of the prospective resident's physical, cognitive, and psychosocial condition shall be completed by a physician. The physician's assessment shall include documentation of the presence or the absence of tuberculosis infection in accordance with the Control of Tuberculosis Code. At the time of admission, the physician's assessment must reflect the resident's current condition.

This requirement was not met as evidenced by:

Based on interview and record review the establishment failed to ensure physician assessment was completed prior to move in. This deficient practice affected one (R2) of ten residents reviewed for this requirement.

Findings include:

R2's nursing note indicated R2's actual physical move into the community was on 2/2/26.

R2's document titled "Physician Certification" was signed by physician on 2/4/26.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	6022161	A. BUILDING: _____ B. WING _____	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENDALE SIX CORNERS	4715 WEST IRVING PARK RD CHICAGO, IL 60641

(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
A4000	Continued From page 6 On 4/23/26 at 2:09pm, E2 (Associate Executive Director) said Physician Certification is done prior to moving in.	A4000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 1 Violation Section 295.4010 Service Plan 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: C) special accommodations for the resident; 2) The amount, type, and frequency of health-related services needed by the resident;	A4010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	6022161	A. BUILDING: _____ B. WING _____	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENDALE SIX CORNERS	4715 WEST IRVING PARK RD CHICAGO, IL 60641

(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 7 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. These requirements are not met as evidenced by: Based on observation, interview and record review, the establishment failed to revise service plan to include interventions, reflecting current needs for residents who require specific care such as dialysis (R1), wound (R1), multiple falls (R2, R7, R10), catheter (R3, R7), hospice (R8), and use of insulin (R4). This involves seven of ten residents reviewed for service plan. This deficient practice has the probability of affecting consistency of care, prevention of wound deterioration, infection control and safety of residents. This failure creates the substantial probability of severe harm to a resident or residents. Findings include: R1 According to R1's documents, R1 is 88 years old who moved to the community on 12/23/23. R1's diagnoses include but are not limited to Cerebral Infarction due to unspecified occlusion or stenosis of anterior cerebral artery, Acute Kidney Failure and Type II Diabetes Mellitus. On 4/21/26 at 2:30pm, R1 was observed seated on recliner. R1 was alert, oriented x3. R1 was interviewed. R1 indicated presence of wound on the back and complained of pain. R1 said, wound dressing was last changed on Friday (4/17/26). R1 said, she has been asking for dressing to be	A4010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	6022161	A. BUILDING: _____ B. WING _____	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENDALE SIX CORNERS	4715 WEST IRVING PARK RD CHICAGO, IL 60641

(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 8	A4010		

changed since she has moved her bowels 3x since Friday. R1 said no one has been to see or check on the wound since Friday. R1 is dependent on staff for toileting needs. R1 is also dependent on caregiver to assist and turn R1 while on chair and bed. R1 said, she has been in the same position since dialysis started at 10:00am. Dialysis ended about 2:00pm. R1 said, "I cannot turn on my own". R1 is on dialysis 4x per week. Dialysis is done in R1's apartment. E16 (Assistant Director of Health Services) said they do not have supplies for wound dressing change. There have been changes on the wound team and E16 need to contact R1's daughter to get information about it. E16 confirmed R1 cannot turn on her own and requires staff to assist. At 2:50pm, E18 (Care Manager) came to R1's apartment. E18 transferred R1 to the wheelchair and brought R1 to the bathroom. R1 was able to stand up using the grab bar. R1 hoisted self-up to standing position. E16 took off the undated dressing on R1's sacral area. The dressing had brown particles on the outside. The inside of the dressing that comes in contact with the skin was also covered with brown colored particles. E16 confirmed brown particles were feces. E16 removed the wound dressing and left it as is. At 3:10pm, E16 was able to get wound kit. E16 was observed cleaning R1's wound with woven gauze wet with saline. After cleaning the wound, E16 covered it with Hydro cellular Foam dressing silicone adhesive with border sacral gentle adhesive. R1's wound was pinkish, moist approximately 1-inch x1/2 inch.

R1's wound notes dated 4/17/26, were completed by Z4 (Nurse Practitioner). Wound notes indicated:
Wound Type: Pressure Ulcer. Wound Status: Not healed. Wound Condition: Chronic. Baseline size:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	6022161	A. BUILDING: _____ B. WING _____	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENDALE SIX CORNERS	4715 WEST IRVING PARK RD CHICAGO, IL 60641

(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 9 Length (cm): 3.5. Width(cm): 2.4. Depth: 0.2cm. Area (cm sq): 8.4 ...Wound thickness: Partial Thickness. Pressure Ulcer Stage 2. Color Pink. Treatment Plan: Dressing should be changed every other day paying careful attention to any clinical signs of infection ...management of wound every other day: Medi honey, collagen cover with adhesive border foam. Careful attention was used to make sure the dressing was secured but not compressed ...offload, turn and reposition every two hours. New Orders: Clean wound with wound cleanser or warm water and mild soap. Apply Medi honey, calcium alginate, and cover with adhesive border foam dressing. Change dressing every other day. On 4/23/26 at 3:33pm, Z4 (Nurse Practitioner) confirmed, seeing R1 on 4/17/26. Z4 confirmed R1's pressure wound is at stage 2. Z4 said scars were observed near wound site, wound was recurrent. Z4 was asked of the potential effect of a dressing soiled with feces on wound. Z4 said, possible contamination of the wound, leading to infection. Z4 also said recommended wound treatment were to offload every two hours and dressing change every other day. R1's service plan dated 12/18/25, had no revised interventions for wound care including measures to promote wound healing or prevent further skin breakdown. It indicated "Wound care 3 times a week from (name of wound provider). Skin Integrity: Offer frequent changes position changes to avoid skin breakdown and support mobility and transfers. Frequency: 1 time per day, every day. Other wound treatment, and preventative measures recommended by wound team were not integrated on R1's service plan. It did not indicate measures to maintain clean wound dressing to prevent possible infection.	A4010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	6022161	A. BUILDING: _____ B. WING _____	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENDALE SIX CORNERS	4715 WEST IRVING PARK RD CHICAGO, IL 60641

(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 10 According to 2/4/26 home health notes, " ...upon assessment, the assessment, the patient's sacral/coccyx area was noted with hypopigmented scar tissue, maceration/redness, adherent crusting, no drainage, odor, or tenderness noted. No rash or open wound noted either On 4/22/26 at 10:23am, E13 (Licensed Practical Nurse) said she has not seen R1's wound and they do not do wound treatment. E13 said, if the dressing is soiled then nurse will change the dressing. R1's service plan had no interventions in place for a resident undergoing dialysis, including but not limited to care for the port/access. R1's service plan documented:" Need- Extensive Nursing Services. Action: (R1) receives dialysis 4 days a week Monday- Tuesday- Thursday- Friday." No other interventions in place including but not limited to care of port/access. R1 indicated access is located on chest. R2 According to R2's documents, R2 is 70 years old. R2 moved to the community on 2/2/26. R2's diagnosis includes but are not limited to Progressive Supranuclear Ophthalmoplegia, Repeated Falls, Insomnia, Parkinson's Disease, Overactive Bladder, Asthma, Frequency of Micturition. On 4/22/26 at 9:59am, R2 was observed in the communal area, seated on a wheelchair. At 1:53pm, R2 was observed with a seatbelt (attached to wheelchair) fastened around waist. R2's Service Plan dated 2/4/26 documented:	A4010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	6022161	A. BUILDING: _____ B. WING _____	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENDALE SIX CORNERS	4715 WEST IRVING PARK RD CHICAGO, IL 60641

(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 11 Need: Mobility/Ambulation Action: Dependent on staff members for all mobility/ambulation needs or requires hands on assistance on routine basis. Need: Transferring Action: Dependent on staff members for all mobility/ambulation needs or requires hands assistance with transfer or hands on assistance. Need: Fall Potential Action: (R2) has a diagnosis of Progressive Supranuclear Palsy (PSP). Due to involuntary movements, impaired impulse control, and decreased safety awareness associated with this condition, she is unable to consistently recognize or avoid unsafe situations, placing her high risk for falls. Interventions/ Plan of Care: -(R2) requires continuous supervision during waking hours and must not be left alone. -(R2) will be awakened and showered on the NOC shift, then immediately brought to the nurse for ongoing monitoring for safety. (R2) will only be left alone when sleeping in bed. -While sleeping (R2) will receive safety checks every 30 minutes per fall- prevention protocol. -Care Staff will provide frequent redirection and cueing as needed. -Staff will encourage participation in activities aligned with (R1's) interest to promote engagement, reduce anxiety, and provide positive distraction. - Any changes in behavior, mobility, or fall risk will be promptly reported to the nurse and documented. R2's Service plan did not reflect review and revisions of fall interventions. R2 notes indicated several falls since move in: -2/3/26 6:53pm- per family observed on the floor near bathroom in apartment, swelling noted to left	A4010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	6022161	A. BUILDING: _____ B. WING _____	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENDALE SIX CORNERS	4715 WEST IRVING PARK RD CHICAGO, IL 60641

(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 12	A4010		

jaw.
- 2/7/27 4:22pm, being toileted, staff turned around to get supply, resident observed on the floor.
-2/9/26 7:10pm-noted on the floor in resident's room...bruise noted on the left elbow, superficial scratch near shoulder.
-2/18/26 2:30am- observed on the floor with back to bed... no injury.
-3/20/26 7:15am- unwitnessed fall inside apartment sitting on fall mat.
- 4/4/26 5:15am: resident was found on the floor in apartment.

On 4/22/26 at 1:53pm, Z3 (Family Member) was concerned about R2's fall incidents. Z3 said a camera was installed in R2's room. On 4/17/26, R2 can be seen in the camera falling, and hitting head on the dresser. The next day a bruise was observed by Z3 above R2's eye. Z3 was asked if Z3 was aware of the seatbelt on R2's wheelchair. Z3 said "yes". While inside R2's apartment, fall mat, R2's bed is in low position, and a camera by the wall were observed.
Use of seatbelt, fall mat were not discussed on R2's service plan.

On 4/23/26 at 4:04pm, E17 (Licensed Practical Nurse) said, R2 is not retaining instructions not to get out of bed due to cognitive decline.

R3
According to R3's documents, R3 is 85 years old. R3's diagnoses include but are not limited to Benign Prostatic Hyperplasia with lower urinary tract symptoms. Unspecified Dementia, unspecified severity, Other secondary Parkinsonism. R3 moved to the community on 9/2/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	6022161	A. BUILDING: _____ B. WING _____	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENDALE SIX CORNERS	4715 WEST IRVING PARK RD CHICAGO, IL 60641

(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 13 On 4/23/26 at 3:12pm, E19 (Caregiver) was observed emptying R3's catheter bag. R3 has suprapubic catheter. On 4/23/26 at 11:47am, E16 (Assistant Director of Health Services) confirmed R3 has suprapubic catheter. R3's Service plan did not document interventions for care of a resident with suprapubic catheter. R3's Electronic Health Record reviewed documented multiple history of Urinary Tract Infections, including proteus mirabilis infection on 10/1/25. R4 Per R4's Electronic Health Record (EHR) R4's diagnoses include but are not limited to Type 1 Diabetes Mellitus, and Progressive Supranuclear Ophthalmoplegia. R4 moved to the community on 2/26/26. On 4/22/26 at 10:41am, R4 was with a private caregiver inside the room. R4 said she has insulins indicated for diabetes. R4 said there was a time R4 must go to the hospital due to high blood sugar. R4 EHR indicated on 3/26/26, R4's blood glucose reading went up to 444mg/dl. Per R4's Physician Order Summary, R4 has sliding scale Novolog 4x daily. R4's blood sugar readings were mostly in the 200's and 300's. R4's Service plan dated 2/27/26 did not include interventions for a resident who has high blood sugar and takes insulin. R7 R7 is 82 years old. R7's diagnoses included but are not limited to Dementia, and Essential	A4010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	6022161	A. BUILDING: _____ B. WING _____	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENDALE SIX CORNERS	4715 WEST IRVING PARK RD CHICAGO, IL 60641

(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 14	A4010		

Hypertension. R7's SLUMS (St Louis University Mental State Examination) score dated 3/13/26 was 6 (Dementia)

On 4/22/26 at 10:12am, R7 was observed in the apartment with E10 (Caregiver). R7 has urinary catheter. R7 uses high back wheelchair, and requires staff assistance for mobility

R7's EHR documented:
3/23/26 11:28PM- unwitnessed fall in bedroom, shaking sent to hospital.
3/22/26 11:40am- observed during rounds, attempting to self-transfer observed sliding down to floor.
R7's service plan dated 3/26/26, no interventions in place for care of catheter. Service plan was also not revised to include fall interventions.

R8
R8 was transferred from the Assisted Living to the memory care on 2/11/26. R8's diagnoses include but are not limited to Progressive Supranuclear Ophthalmoplegia. R8 was admitted to hospice care on 2/24/26, with a diagnosis of Malignant Neoplasm of Vulva. R8's SLUMS score dated 4/1/26 was 2 (Dementia).
R8's Service plan dated 2/12/26 was not revised to include/integrate hospice plan of care.

R10
R10 is 82 years old. R10's diagnoses include but are not limited to Dementia. On 4/22/26 at 11:12am, R10 was observed and interviewed in the apartment. R10 was pleasant but unable to provide appropriate answer to questions. R10's wheelchair was beside bed.

R10's Service plan dated 10/20/25 did not indicate revisions to fall interventions. R10 had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	6022161	A. BUILDING: _____ B. WING _____	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENDALE SIX CORNERS	4715 WEST IRVING PARK RD CHICAGO, IL 60641

(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 15 several falls. 10/1/25 8:10am fall, bleeding to the left side of head 10/8/25 2:10pm- found on the floor. No injury 10/12/25 3:23pm- found on the floor, slid off the bed 12/5/26 7:11pm- resident was seen from the hallway, lost balance and fell 12/12/25 3:55pm- found on the floor during rounds 12/15/26 1:15pm- stand up after eating lunch lose balance. 1/3/26 1:24pm- fell from wheelchair in the dining room, repositioning self. 1/29/26 6:01am- wants to reach wheelchair to go to the bathroom lost balance and fall. 2/17/26 5:56pm: bump on the right side of the forehead, small cut with small amount of blood observed. "I fell" 4/14/26 4:37pm- witnessed fall, tried to stand up without assistance, fell on floor skin tear to right elbow 4/21/26 4:00pm- dining room, attempted to stand up, slipped down out of wheelchair.	A4010		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 1 Violation Section 295.6000 Resident Rights 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	A6000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	6022161	A. BUILDING: _____ B. WING _____	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENDALE SIX CORNERS	4715 WEST IRVING PARK RD CHICAGO, IL 60641

(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
A6000	Continued From page 16 establishment, nor shall a resident forfeit any of the following rights: 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; These requirements are not met as evidenced by: Based on observation, interview and record review, the establishment failed to: -Follow the current recommendation for wound treatment, and preventative measures to prevent skin breakdown, and promote wound healing. -Failed to provide emergency supplies to provide wound treatment. This deficient practice affected one (R1) of two residents who are at high risk for developing wounds. This failure creates the substantial probability of severe harm to a resident or residents. Findings include: According to R1's documents, R1 is 88 years old who moved to the community on 12/23/23. R1's diagnoses include but are not limited to Cerebral Infarction due to unspecified occlusion or stenosis of anterior cerebral artery, Acute Kidney Failure and Type II Diabetes Mellitus. On 4/21/26 at 2:30pm, R1 was observed seated on recliner. R1 was alert, oriented x3. R1 was interviewed. R1 indicated presence of wound on the back and complained of pain. R1 said, wound dressing was last changed on Friday (4/17/26). R1 said, she has been asking for dressing to be changed since she has moved her bowels 3x since Friday. R1 said no one has been to see or check on the wound since Friday. R1 is	A6000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	6022161	A. BUILDING: _____ B. WING _____	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENDALE SIX CORNERS	4715 WEST IRVING PARK RD CHICAGO, IL 60641

(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
A6000	Continued From page 17	A6000		

dependent on staff for toileting needs. R1 is also dependent on caregivers to assist and turn R1 while on chair or bed. R1 said, she has been in the same position since dialysis started at 10:00am. Dialysis ended at about 2:00pm. R1 said, "I cannot turn on my own". Dialysis is done in R1's apartment. E16 (Assistant Director of Health Services) said they do not have supplies for wound dressing change. E16 said there have been changes on the wound team and E16 needed to contact R1's daughter to get information about it. E16 confirmed R1 cannot turn on her own and requires staff to assist. At 2:50pm, E18 (Care Manager) came to R1's apartment. E18 transferred R1 to the wheelchair and brought R1 to the bathroom. R1 was able to stand up using the grab bar. R1 hoisted self-up to standing position. E16 took off the undated dressing on R1's sacral area. The dressing had brown particles on the outside. The inside of the dressing that comes in contact with the skin was also covered with brown colored particles. E16 confirmed brown particles were feces. E16 removed the wound dressing and left it as is. At 3:10pm, E16 was able to get wound kit. E16 was observed cleaning R1's wound with woven gauze wet with saline. After cleaning the wound, E16 covered it with Hydro cellular Foam dressing silicone adhesive with border sacral gentle adhesive. R1's wound was pinkish, moist approximately 1-inch x1/2 inch.

R1's wound notes dated 4/17/26, completed by Z4 (Nurse Practitioner), were later provided for review. Wound notes indicated:

Wound Type: Pressure Ulcer. Wound Status: Not healed. Wound Condition: Chronic. Baseline size: Length (cm): 3.5. Width(cm): 2.4. Depth: 0.2cm. Area (cm sq): 8.4 ...Wound thickness: Partial

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	6022161	A. BUILDING: _____ B. WING _____	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENDALE SIX CORNERS	4715 WEST IRVING PARK RD CHICAGO, IL 60641

(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
A6000	Continued From page 18 Thickness. Pressure Ulcer Stage 2. Color Pink. Treatment Plan: Dressing should be changed every other day paying careful attention to any clinical signs of infection ...management of wound every other day: Medi honey, collagen cover with adhesive border foam. Careful attention was used to make sure the dressing was secured but not compressed ...offload, turn and reposition every two hours. New Orders: Clean wound with wound cleanser or warm water and mild soap. Apply Medi honey, calcium alginate, and cover with adhesive border foam dressing. Change dressing every other day. On 4/23/26 at 3:33pm, Z4 (Nurse Practitioner) confirmed assessing R1 on 4/17/26. Z4 confirmed R1's pressure wound is at stage 2. Z4 said scars were observed near wound site, it is a recurring wound. Z4 was asked the potential effect of a dressing soiled with feces on the wound. Z4 said, possible contamination of the wound, leading to infection. Z4 also said recommended wound treatment were to offload every two hours and dressing change every other day. R1's service plan dated 12/18/25, had no revised interventions for wound care including measures to promote wound healing or prevent further skin breakdown. It indicated "Wound care 3 times a week from (name of wound provider). Skin Integrity: Offer frequent changes position changes to avoid skin breakdown and support mobility and transfers. Frequency: 1 time per day, every day. Other wound treatment, and preventative measures recommended by wound team were not integrated on R1's service plan. It did not indicate measures to maintain clean	A6000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	6022161	A. BUILDING: _____ B. WING _____	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENDALE SIX CORNERS	4715 WEST IRVING PARK RD CHICAGO, IL 60641

(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
A6000	Continued From page 19 wound dressing to prevent possible infection. No plan documented when dressing gets soiled. According to previous home health dealing with R1's wound dated 2/12/26 (no wound notes later than this date submitted for review) " ...upon assessment, the patient's sacral/coccyx area was noted with hypopigmented scar tissue, maceration/redness, adherent crusting, no drainage, odor, or tenderness noted. No rash or open wound noted either ..." On 4/22/26 at 10:23am, E13 (Licensed Practical Nurse) said she has not seen R1's wound and they do not do wound treatment. E13 said, if the dressing is soiled the establishment nurse will change the dressing. During the initial stage of survey, and identification of resident sample, Surveyor requested for list of residents with wounds. On the list provided, R1 was not on the list. E16 also denied R1 had wound at that time.	A6000		