STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510540	A. BUILDING: _____ B. WING _____	07/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRED LIVING OF LAGRANGE	35 SHAWMUT AVENUE LA GRANGE, IL 60525

(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 Annual survey 295.4010 Service Plan a) B) 1) 2) d) e) g) 1) 2) 3) 295.4060 Alzheimer's and Dementia Programs a) i) 2) B) i) - v) Facility Reported Incident - IL201265/FRI 4.10.26 295.4010 a) B) 1) 2) d) e) g) 1) 2) 3) 295.6000 Resident Rights a) 13)	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: TYPE 1 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;	A4010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510540	A. BUILDING: _____ B. WING _____	07/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRED LIVING OF LAGRANGE	35 SHAWMUT AVENUE LA GRANGE, IL 60525

(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 2) The manager or manager's designee; and 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: 2) The amount, type, and frequency of health-related services needed by the resident; 3) Staff responsible for the provisions of the service plan; This requirement is not met as evidenced by: Based on record review and interview the establishment failed to: -review and revise the service plan to address unwitnessed falls for 2 out of 5 residents (R1, R4) reviewed for fall incidents; -address the presence and monitoring of a cardiac pacemaker for 2 of 5 residents (R1, R2) reviewed for cardiac conditoins; -develop interventions for monitoring pain for 1 out of 5 residents reviewed for pain. R4 fell and sustained several fractures as a result of a unwitnessed fall. This failure creates a substantial probability of severe harm to a resident or residents.	A4010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510540	A. BUILDING: _____ B. WING _____	07/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRED LIVING OF LAGRANGE	35 SHAWMUT AVENUE LA GRANGE, IL 60525

(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 Findings include: 1. R1 is a 97 year old resident who had diagnoses including unspecified Dementia without behavioral disturbance, Heart disease, Atrial Fibrillation, Pleural effusion and Generalized weakness, The list of diagnoses and radiology report shows R1 has a Cardiac pacemaker to left chest. Review of the service plan dated 5/24/26 does not include interventions to address the cardiac pacemaker to R1's left chest. There aren't any interventions to address cardiac monitoring or for signs and symptoms of chest discomfort or infection. 2. R2 is a 90 year old who has diagnoses including hypertension, congestive heart failure and a prosthetic heart valve. The progress note dated 4/25/26 shows the home health nurse came to complete an assessment. The right clavicle pacemaker site WNL (within normal limits). The service plan dated 6/23/26 does not include interventions to address the cardiac pacemaker to R1's left chest. There aren't any interventions to address cardiac monitoring or for signs and symptoms of chest discomfort or infection. 3. R4 is a 87 year old resident who has diagnoses including glaucoma, hypertension, hepatitis B, lung cancer, fracture , GERD (gastro esophageal reflux disease), anesthesia and hypoesthesia. The progress note dated 2/14/26 shows R4	A4010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510540	A. BUILDING: _____ B. WING _____	07/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRED LIVING OF LAGRANGE	35 SHAWMUT AVENUE LA GRANGE, IL 60525

(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 pushed her pendant for assistance. R4 noted on the floor in the bathroom in front of the toilet able to move upper extremities but complained of pain when nurse attempted to move lower extremities. R4 noted to have difficulty walking with a walker and a bump to her scalp. R4 said she hit her head. R4 was transported to a local hospital's emergency room for further evaluation. R4 was admitted to the hospital for multiple fractures related to fall. R4 was to rehab after hospital discharge. R4 was readmitted to the community on 3/5/26. The physician's order review shows orders for Acetaminophen 8 hour arthritis pain 650 mg, 1 tablet by mouth as needed and Acetaminophen 325mg by mouth every 4 hours as needed. The service plan dated 5/30/26 mentions fall potential, however was not revised with interventions to address the fall incident that occurred on 2/14/26. There are not interventions to address pain management.	A4010		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Type 2 Violation 295.4060 Alzheimer's and Dementia Programs a) In addition to this Section, Alzheimer and dementia programs shall comply with all of the other provisions of the Act. (Section 150(a) of the Act) i) Training requirements for individuals	A4060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510540	A. BUILDING: _____ B. WING _____	07/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRED LIVING OF LAGRANGE	35 SHAWMUT AVENUE LA GRANGE, IL 60525

(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
A4060	Continued From page 4 working in a special program: 2) Staff training: B) Direct care staff must receive 16 hours of on-the-job supervision and training within the first 16 hours of employment following orientation. Training must cover: i) encouraging independence in and providing assistance with the activities of daily living; ii) emergency and evacuation procedures specific to the dementia population; iii) techniques for creating an environment that minimizes challenging behaviors; iv) resident rights and choice for persons with dementia, working with families, caregiver stress; and v) techniques for successful communication. This requirement was not met as evidenced by: Based on record review and interview, the establishment failed to provide documentation that showed evidence of 7 out of 8 newly hired direct care employees (E4, E5, E6, E7, E8, E9, E10) received and completed the required 16 hours of dementia specific training after establishment orientation. This failure creates the substantial probability of harm to a resident or residents. Findings include:	A4060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510540	A. BUILDING: _____ B. WING _____	07/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRED LIVING OF LAGRANGE	35 SHAWMUT AVENUE LA GRANGE, IL 60525

(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
A4060	Continued From page 5 On 7/27/26 at 1:10pn, 8 personnel files were reviewed with E11 (business office manager) and showed the following: -E4 (LPN) hired 2/4/26; -E5 (CNA/certified nurse aide) hired 12/17/25; -E6 (care associate) hired 10/8/25; -E7 (care associate) hired 10/21/25; -E8 (CNA) hired 4/8/26; -E9 (care associate) hired 12/10/25; -E10 (care associate) hired 10/13/25. These 7 personnel files had a document titled Skills Check - Memory Care Programming. This document did not indicate that these 7 newly hired direct care employees received the required training on encouraging independence in and providing assistance with the activities of daily living, emergency and evacuation procedures specific to the dementia population, techniques for creating an environment that minimizes challenging behaviors, resident rights and choice for persons with dementia, working with families, caregiver stress; and techniques for successful communication. During the personnel file review, E11 acknowledged that specific dementia care training wasn't listed.	A4060		
A6000	Section 295.6000 Resident Rights	A6000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510540	A. BUILDING: _____ B. WING _____	07/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRED LIVING OF LAGRANGE	35 SHAWMUT AVENUE LA GRANGE, IL 60525

(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 6	A6000		

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 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.

This requirement was not met as evidenced by:

Based on record review and interview, the establishment failed to ensure correct technique and safety during a recliner to wheelchair transfer for 1 out of 3 residents (R1) reviewed who require transfer assistance and reviewed for falls. R1 sustained a closed head injury during this fall incident.

This failure creates a substantial probability of severe harm to a resident or residents.

Findings include:

R1 is a 97 year old resident who resides in assisted living. R1 has diagnoses including atrial fibrillation, pleural effusion and generalized weakness.

The progress notes dated 4/10/25 (7:30pm)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510540	A. BUILDING: _____ B. WING _____	07/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRED LIVING OF LAGRANGE	35 SHAWMUT AVENUE LA GRANGE, IL 60525

(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 7	A6000		

shows R1's private caregiver (Z1) reported transferring R1 from a recliner to a wheelchair when R1 fell forward during the transfer. Z1 called 911 and notified the nurse on duty (E2, LPN). R1 was transported to the emergency department for evaluation.

The incident report dated 4/10/26 shows in part that Z1 reported transferring R1 from a recliner to a wheelchair when R1 fell forward during the transfer. Z1 called 911 and notified E2 . R1 was transported to the emergency departmentt for evaluation and returned to the community at approximately 9:47pm with diagnoses of left hand pain, closed head injury and abrasion to the forehead. Root cause: Resident factors (sudden weakness) and improper transfer technique.

On 7/23/36 at 3:50pm, Z2 (private caregiver) stated, "R1 has 24 hour care. I've been R1's caregiver since the beginning, 2 years ago. I work 7am to 7pm. No, R1 can't get up by himself. R1is a fall risk. R1 is able to stand but not able to walk. The recliner goes all the way up to almost a standing position, R1 puts both hands on the wheelchair armrests and I give him verbal cues. R1 is a little hard of hearing. R1 gets PT (physical thereapy) and Speech therapy.The caregiver that was on when the incident happened wasn't a regular caregiver. Z1 had just started on the pm shift. I haven't seen that caregiver since the incident. Me and the other caregiver have been with R1 for a long time and we know how to help R1 transfer. We don't really get a shift to shift report."

On 7/23/26 at 3:50pm, R1 was noted seated in a recliner. R1 was friendly but hard of hearing and didn't recall the fall incident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510540	A. BUILDING: _____ B. WING _____	07/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRED LIVING OF LAGRANGE	35 SHAWMUT AVENUE LA GRANGE, IL 60525

(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 8 On 7/23/26 at 4:00pm E1 (executive director) stated, "I called the agency. I was informed that Z1 did not return to work after this incident. Z1 did not return the the community." On 7/28/26 E1 presented training dated 1/26/26 that Z1 received proper transfer techniques.	A6000		