STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510019	A. BUILDING: _____ B. WING _____	C 04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS AT CENTENNIAL POINTE, THE	3430 HEDLEY ROAD SPRINGFIELD, IL 62712

(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 Complaint 2644458/IL201302 295.6010 Incident Report Investigation IL201444 295.1100 295.3000 295.4020 295.4060 295.5000 295.6000	A 000		
A1100	Section 295.1100 Alzheimer's and Related Dementias Special Car This Regulation is not met as evidenced by: Section 295.1100 Alzheimer's Disease and Related Dementias Special Care Disclosure Type 1 Violation An establishment that offers, advertises or markets to provide care for persons with Alzheimer's disease and related dementias through an Alzheimer's special care program shall disclose to the Department and to a potential or actual resident of the establishment the following information in writing: e) The establishment's minimum and maximum staffing ratios, specifying the general licensed health care provider to resident ratio and the trainee health care provider to resident ratio; Based on record review and interview the establishment failed to ensure it's Alzheimer's Disclosure was followed by not having a nurse scheduled to work in the establishment on 04-19-2026. This failure resulted in R4 being	A1100		

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A1100	Continued From page 1	A1100		

sent to the local emergency room on 04-19-2026 and creates a substantial probability of severe harm to residents.

Findings include:

This is a memory care establishment with eight residents in the building.

Establishment staffing schedules and the establishment's agency schedules were reviewed. The schedules do not contain documentation of a nurse working on 04-19-2026.

The establishment's Alzheimer's Disclosure form contains documentation that a licensed nurse will be scheduled to work at the establishment for at least 16 hours in a 24 hour period and that a licensed nurse will be available 24/7 to give medications outside of the normal administration times.

Resident April Medication Administration Records, (MAR,) were reviewed for all residents. Every resident's MAR is blank for medications not being administered on 04-19-2026.

All resident service plans were reviewed and contain documentation that all residents require medication administration. R4 and R7's service plans include documentation that the residents require insulin administration and blood glucose monitoring.

Resident records were reviewed for all eight residents in the building. R1's records include documentation that R1 is to receive cephalexin and ciprofloxacin twice a day. R4's records include documentation that R4 is to receive

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A1100	Continued From page 2	A1100		

insulin three times a day and that R4 receives sliding scale insulin. R4's progress notes also include documentation that R4 returned from the hospital on 04-22-2026. R7's records include documentation that R7 receives insulin twice a day.

On 04-16-2026 at approximately 9:45am, E1, Executive Director, states that he uses agency for staffing nurses, that he has a nurse in building from 8:00am to 8:00pm, that all nurses are agency nurses, and that E7, Registered Nurse, is the on-call nurse. E1 also states that he is busy trying to find permanent staff and training them so that he is not relying on agency staff so much.

On 04-23-2026, at approximately 11:15am, E5, Regional Nurse Consultant, states that three residents received medications on 04-19-2026 from family members. E5 states that R4 is diabetic and went to the hospital for insulin; that R4 was sent out on the 04-19-2026.

On 04-23-2026, at approximately 1:00pm, E4, Corporate Staff, states that he was not made aware of no nurse in the building on 04-19-2026 until Monday 04-20-2026, when he arrived at facility. E4 also states that he does not know why there was no nurse scheduled for that day. E4 states that he does not know how family members were able to get access to medications to give to residents.

On 04-23-2026, at approximately 1:00pm, E5 states that she was made aware of no nurse in the building on the evening of 4/19/26. E5 states she thinks that the agency nurse called in and could not be replaced.

On 04-23-2026, at approximately 1:15pm, E6,

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(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
A1100	Continued From page 3 Corporate Staff, states that she was returning from vacation on 04-19-2026 in the afternoon when she was notified by a family member's message of no nurse in the building. E6 states she does not know how family members got access to the medications. E6 states that E1 told her family was coming in to give the evening medications. E6 states that at 6:21pm on 04-19-2026, that she sent a message to E1 trying to find out more information on not having a nurse in the building and that E1 told her there was not a nurse, that he had spent all day looking for one to work. E6 states that she asked their Regional Director of Operation (RDO) about this as the RDO was covering for her while on vacation; and that the RDO did not know anything about the facility not having a nurse available. E6 states that the RDO had not had any conversations with E1 regarding staffing concerns. On 04-20-2026, at 2:38pm, Z1, complainant, states that she received a call from a family member who told her that there was no nurse in the building on 04-19-2026 and that residents did not receive their medications. On 04-20-2026, at 4:13pm, Z2, R1's family member, states that there was no nurse at the establishment all day on 04-19-2026 and that no medications were administered to the residents. Z2 states that the staff couldn't reach E1. Z2 states that after 1:00pm that day, that his sister went to the building and didn't see a nurse either. Z2 states that at about 4:00pm he was there and was told R1 had not had any medications at this time. Z2 states that there is a diabetic female resident who was having some medical issues and that staff called an ambulance for the resident. Z2 states that he told staff that he was	A1100		

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A1100	Continued From page 4 going to take R1 to the Emergency Room because R1 needed his medications. Z2 states that staff finally called E1 who gave them the code to the medication room door. Z2 states this call was made and he heard everything due to them being on speaker phone. Z2 states that the key to the medication cart was gotten by the staff and that they opened the medication cart. Z2 states that he gave R1 his 4:00pm medications. Z2 states that another gentleman was in visiting his wife and that the gentleman gave his wife her medications. Z2 also states that the medications are all in pill packs; except for R1's antibiotic that was packaged separately. Z2 states that he came back at 8:00pm to give R1 his night medications and there was still no nurse in the building at that time.	A1100		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: Section 295.3000 Personnel Requirements, Qualifications and Training Type 1 Violation a) The establishment shall have staff sufficient in number with qualifications, adequate skills, education and experience to meet the 24 hour scheduled and unscheduled needs of residents and who participate in ongoing training to serve the resident population. (Section 35(a)(3) of the Act) h) The establishment shall have sufficient personnel to provide the following for its current resident population:	A3000		

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A3000	Continued From page 5 1) All mandatory services; 2) Services established in each resident's service plan; 3) Service to meet the needs of each resident, including 24 hour scheduled and unscheduled needs, general supervision, and the ability to intervene in a crisis; Based on record review and interview the establishment failed to ensure staff were sufficient in number with qualifications, adequate skills, education and experience to meet the 24 hour scheduled and unscheduled needs of residents by not having a nurse scheduled to work in the establishment on 04-19-2026. This failure resulted in R4 being sent to the local emergency room on 04-19-2026 and creates a substantial probability of severe harm to residents. Findings include: This is a memory care establishment with eight residents in the building. Establishment staffing schedules and the establishment's agency schedules were reviewed. The schedules do not contain documentation of a nurse working on 04-19-2026. The establishment's Alzheimer's Disclosure form contains documentation that a licensed nurse will be scheduled to work at the establishment for at least 16 hours in a 24 hour period and that a licensed nurse will be available 24/7 to give medications outside of the normal administration times. Resident April Medication Administration	A3000		

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A3000	Continued From page 6 Records, (MAR,) were reviewed for all residents. Every resident's MAR is blank for medications not being administered on 04-19-2026. All resident service plans were reviewed and contain documentation that all residents require medication administration. R4 and R7's service plans include documentation that the residents require insulin administration and blood glucose monitoring. Resident records were reviewed for all eight residents in the building. R1's records include documentation that R1 is to receive cephalexin and ciprofloxacin twice a day. R4's records include documentation that R4 is to receive insulin three times a day and that R4 receives sliding scale insulin. R4's progress notes also include documentation that R4 returned from the hospital on 04-22-2026. R7's records include documentation that R7 receives insulin twice a day. On 04-16-2026 at approximately 9:45am, E1, Executive Director, states that he uses agency for staffing nurses, that he has a nurse in building from 8:00am to 8:00pm, that all nurses are agency nurses, and that E7, Registered Nurse, is the on-call nurse. E1 also states that he is busy trying to find permanent staff and training them so that he is not relying on agency staff so much. On 04-23-2026, at approximately 11:15am, E5, Regional Nurse Consultant, states that three residents received medications on 04-19-2026 from family members. E5 states that R4 is diabetic and went to the hospital for insulin; that R4 was sent out on the 04-19-2026. On 04-23-2026, at approximately 1:00pm, E4,	A3000		

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A3000	Continued From page 7	A3000		

Corporate Staff, states that he was not made aware of no nurse in the building on 04-19-2026 until Monday 04-20-2026, when he arrived at facility. E4 also states that he does not know why there was no nurse scheduled for that day. E4 states that he does not know how family members were able to get access to medications to give to residents.

On 04-23-2026, at approximately 1:00pm, E5 states that she was made aware of no nurse in the building on the evening of 4/19/26. E5 states she thinks that the agency nurse called in and could not be replaced.

On 04-23-2026, at approximately 1:15pm, E6, Corporate Staff, states that she was returning from vacation on 04-19-2026 in the afternoon when she was notified by a family member's message of no nurse in the building. E6 states she does not know how family members got access to the medications. E6 states that E1 told her family was coming in to give the evening medications. E6 states that at 6:21pm on 04-19-2026, that she sent a message to E1 trying to find out more information on not having a nurse in the building and that E1 told her there was not a nurse, that he had spent all day looking for one to work. E6 states that she asked their Regional Director of Operation (RDO) about this as the RDO was covering for her while on vacation; and that the RDO did not know anything about the facility not having a nurse available. E6 states that the RDO had not had any conversations with E1 regarding staffing concerns.

On 04-20-2026, at 2:38pm, Z1, complainant, states that she received a call from a family member who told her that there was no nurse in

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A3000	Continued From page 8 the building on 04-19-2026 and that residents did not receive their medications. On 04-20-2026, at 4:13pm, Z2, R1's family member, states that there was no nurse at the establishment all day on 04-19-2026 and that no medications were administered to the residents. Z2 states that the staff couldn't reach E1. Z2 states that after 1:00pm that day, that his sister went to the building and didn't see a nurse either. Z2 states that at about 4:00pm he was there and was told R1 had not had any medications at this time. Z2 states that there is a diabetic female resident who was having some medical issues and that staff called an ambulance for the resident. Z2 states that he told staff that he was going to take R1 to the Emergency Room because R1 needed his medications. Z2 states that staff finally called E1 who gave them the code to the medication room door. Z2 states this call was made and he heard everything due to them being on speaker phone. Z2 states that the key to the medication cart was gotten by the staff and that they opened the medication cart. Z2 states that he gave R1 his 4:00pm medications. Z2 states that another gentleman was in visiting his wife and that the gentleman gave his wife her medications. Z2 also states that the medications are all in pill packs; except for R1's antibiotic that was packaged separately. Z2 states that he came back at 8:00pm to give R1 his night medications and there was still no nurse in the building at that time.	A3000		
A4020	Section 295.4020 Mandatory Services This Regulation is not met as evidenced by:	A4020		

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A4020	Continued From page 9 Section 295.4020 Mandatory Services Type 1 Violation Each establishment shall provide or arrange for the following mandatory services: f) Assistance with activities of daily living as required by each resident. (Section 10 of the Act) Based on record review and interview the establishment failed to ensure residents received assistance with activities of daily living as required by each resident. This failure resulted in R4 being sent to the local emergency room on 04-19-2026 and creates a substantial probability of severe harm to residents. Findings include: This is a memory care establishment with eight residents in the building. Establishment staffing schedules and the establishment's agency schedules were reviewed. The schedules do not contain documentation of a nurse working on 04-19-2026. The establishment's Alzheimer's Disclosure form contains documentation that a licensed nurse will be scheduled to work at the establishment for at least 16 hours in a 24 hour period and that a licensed nurse will be available 24/7 to give medications outside of the normal administration times. Resident April Medication Administration Records, (MAR,) were reviewed for all residents. Every resident's MAR is blank for medications not being administered on 04-19-2026.	A4020		

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A4020	Continued From page 10 All resident service plans were reviewed and contain documentation that all residents require medication administration. R4 and R7's service plans include documentation that the residents require insulin administration and blood glucose monitoring. Resident records were reviewed for all eight residents in the building. R1's records include documentation that R1 is to receive cephalexin and ciprofloxacin twice a day. R4's records include documentation that R4 is to receive insulin three times a day and that R4 receives sliding scale insulin. R4's progress notes also include documentation that R4 returned from the hospital on 04-22-2026. R7's records include documentation that R7 receives insulin twice a day. On 04-16-2026 at approximately 9:45am, E1, Executive Director, states that he uses agency for staffing nurses, that he has a nurse in building from 8:00am to 8:00pm, that all nurses are agency nurses, and that E7, Registered Nurse, is the on-call nurse. E1 also states that he is busy trying to find permanent staff and training them so that he is not relying on agency staff so much. On 04-23-2026, at approximately 11:15am, E5, Regional Nurse Consultant, states that three residents received medications on 04-19-2026 from family members. E5 states that R4 is diabetic and went to the hospital for insulin; that R4 was sent out on the 04-19-2026. On 04-23-2026, at approximately 1:00pm, E4, Corporate Staff, states that he was not made aware of no nurse in the building on 04-19-2026 until Monday 04-20-2026, when he arrived at	A4020		

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A4020	Continued From page 11	A4020		

facility. E4 also states that he does not know why there was no nurse scheduled for that day. E4 states that he does not know how family members were able to get access to medications to give to residents.

On 04-23-2026, at approximately 1:00pm, E5 states that she was made aware of no nurse in the building on the evening of 4/19/26. E5 states she thinks that the agency nurse called in and could not be replaced.

On 04-23-2026, at approximately 1:15pm, E6, Corporate Staff, states that she was returning from vacation on 04-19-2026 in the afternoon when she was notified by a family member's message of no nurse in the building. E6 states she does not know how family members got access to the medications. E6 states that E1 told her family was coming in to give the evening medications. E6 states that at 6:21pm on 04-19-2026, that she sent a message to E1 trying to find out more information on not having a nurse in the building and that E1 told her there was not a nurse, that he had spent all day looking for one to work. E6 states that she asked their Regional Director of Operation (RDO) about this as the RDO was covering for her while on vacation; and that the RDO did not know anything about the facility not having a nurse available. E6 states that the RDO had not had any conversations with E1 regarding staffing concerns.

On 04-20-2026, at 2:38pm, Z1, complainant, states that she received a call from a family member who told her that there was no nurse in the building on 04-19-2026 and that residents did not receive their medications.

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A4020	Continued From page 12 On 04-20-2026, at 4:13pm, Z2, R1's family member, states that there was no nurse at the establishment all day on 04-19-2026 and that no medications were administered to the residents. Z2 states that the staff couldn't reach E1. Z2 states that after 1:00pm that day, that his sister went to the building and didn't see a nurse either. Z2 states that at about 4:00pm he was there and was told R1 had not had any medications at this time. Z2 states that there is a diabetic female resident who was having some medical issues and that staff called an ambulance for the resident. Z2 states that he told staff that he was going to take R1 to the Emergency Room because R1 needed his medications. Z2 states that staff finally called E1 who gave them the code to the medication room door. Z2 states this call was made and he heard everything due to them being on speaker phone. Z2 states that the key to the medication cart was gotten by the staff and that they opened the medication cart. Z2 states that he gave R1 his 4:00pm medications. Z2 states that another gentleman was in visiting his wife and that the gentleman gave his wife her medications. Z2 also states that the medications are all in pill packs; except for R1's antibiotic that was packaged separately. Z2 states that he came back at 8:00pm to give R1 his night medications and there was still no nurse in the building at that time.	A4020		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Section 295.4060 Alzheimer's and Dementia Programs	A4060		

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(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 13 Type 1 Violation 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) h) An establishment that offers to provide a special program for persons with Alzheimer's disease and related disorders shall: 6) Provide an appropriate number of staff for its resident population. The establishment shall provide staff sufficient in number, with qualifications, adequate skills, education, and experience to meet the 24-hour scheduled and unscheduled needs of the residents and who participate in ongoing training, to serve the resident population. At a minimum, at least one staff member shall be awake and on duty at all times; Based on record review and interview the establishment failed to ensure staff with qualifications, adequate skills, and education were scheduled to work to meet the 24-hour scheduled and unscheduled needs of residents. This failure resulted in R4 being sent to the local emergency room on 04-19-2026 and creates a substantial probability of severe harm to residents. Findings include: This is a memory care establishment with eight residents in the building. Establishment staffing schedules and the establishment's agency schedules were reviewed. The schedules do not contain documentation of a nurse working on	A4060		

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A4060	Continued From page 14 04-19-2026. The establishment's Alzheimer's Disclosure form contains documentation that a licensed nurse will be scheduled to work at the establishment for at least 16 hours in a 24 hour period and that a licensed nurse will be available 24/7 to give medications outside of the normal administration times. Resident April Medication Administration Records, (MAR,) were reviewed for all residents. Every resident's MAR is blank for medications not being administered on 04-19-2026. All resident service plans were reviewed and contain documentation that all residents require medication administration. R4 and R7's service plans include documentation that the residents require insulin administration and blood glucose monitoring. Resident records were reviewed for all eight residents in the building. R1's records include documentation that R1 is to receive cephalexin and ciprofloxacin twice a day. R4's records include documentation that R4 is to receive insulin three times a day and that R4 receives sliding scale insulin. R4's progress notes also include documentation that R4 returned from the hospital on 04-22-2026. R7's records include documentation that R7 receives insulin twice a day. On 04-16-2026 at approximately 9:45am, E1, Executive Director, states that he uses agency for staffing nurses, that he has a nurse in building from 8:00am to 8:00pm, that all nurses are agency nurses, and that E7, Registered Nurse, is the on-call nurse. E1 also states that he is busy	A4060		

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A4060	Continued From page 15 trying to find permanent staff and training them so that he is not relying on agency staff so much. On 04-23-2026, at approximately 11:15am, E5, Regional Nurse Consultant, states that three residents received medications on 04-19-2026 from family members. E5 states that R4 is diabetic and went to the hospital for insulin; that R4 was sent out on the 04-19-2026. On 04-23-2026, at approximately 1:00pm, E4, Corporate Staff, states that he was not made aware of no nurse in the building on 04-19-2026 until Monday 04-20-2026, when he arrived at facility. E4 also states that he does not know why there was no nurse scheduled for that day. E4 states that he does not know how family members were able to get access to medications to give to residents. On 04-23-2026, at approximately 1:00pm, E5 states that she was made aware of no nurse in the building on the evening of 4/19/26. E5 states she thinks that the agency nurse called in and could not be replaced. On 04-23-2026, at approximately 1:15pm, E6, Corporate Staff, states that she was returning from vacation on 04-19-2026 in the afternoon when she was notified by a family member's message of no nurse in the building. E6 states she does not know how family members got access to the medications. E6 states that E1 told her family was coming in to give the evening medications. E6 states that at 6:21pm on 04-19-2026, that she sent a message to E1 trying to find out more information on not having a nurse in the building and that E1 told her there was not a nurse, that he had spent all day looking for one to work. E6 states that she asked their	A4060		

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A4060	Continued From page 16 Regional Director of Operation (RDO) about this as the RDO was covering for her while on vacation; and that the RDO did not know anything about the facility not having a nurse available. E6 states that the RDO had not had any conversations with E1 regarding staffing concerns. On 04-20-2026, at 2:38pm, Z1, complainant, states that she received a call from a family member who told her that there was no nurse in the building on 04-19-2026 and that residents did not receive their medications. On 04-20-2026, at 4:13pm, Z2, R1's family member, states that there was no nurse at the establishment all day on 04-19-2026 and that no medications were administered to the residents. Z2 states that the staff couldn't reach E1. Z2 states that after 1:00pm that day, that his sister went to the building and didn't see a nurse either. Z2 states that at about 4:00pm he was there and was told R1 had not had any medications at this time. Z2 states that there is a diabetic female resident who was having some medical issues and that staff called an ambulance for the resident. Z2 states that he told staff that he was going to take R1 to the Emergency Room because R1 needed his medications. Z2 states that staff finally called E1 who gave them the code to the medication room door. Z2 states this call was made and he heard everything due to them being on speaker phone. Z2 states that the key to the medication cart was gotten by the staff and that they opened the medication cart. Z2 states that he gave R1 his 4:00pm medications. Z2 states that another gentleman was in visiting his wife and that the gentleman gave his wife her medications. Z2 also states that the medications are all in pill packs; except for R1's antibiotic that	A4060		

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A4060	Continued From page 17 was packaged separately. Z2 states that he came back at 8:00pm to give R1 his night medications and there was still no nurse in the building at that time.	A4060		
A5000	Section 295.5000 Medication Reminders, Supervision of Self Med This Regulation is not met as evidenced by: Section 295.5000 Medication Reminders, Supervision of Self-Medication, Medication Administration and Storage Type 1 Violation d) Medication administration refers to a licensed health care professional employed by an establishment engaging in administering routine insulin and vitamin B-12 injections, oral medications, topical treatments, eye and ear drops, or nitroglycerin patches. Non-licensed staff may not administer any medication. (Section 70 of the Act) h) Any medication stored by the establishment shall meet the following requirements: 1) Medication shall be stored in a locked container, cabinet, or area that is inaccessible to residents; 2) Medication shall not be left unattended by an employee; Based on record review, observation, and interview the establishment failed to ensure residents were administered their scheduled medications on 04-19-2026. The establishment failed to ensure resident medications were stored in a locked container, inaccessible to residents,	A5000		

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A5000	Continued From page 18	A5000		

and not left unattended by an employee. These failures resulted in R4 being sent to the local emergency room on 04-19-2026, R4 and R7 not receiving their scheduled insulin being administered by a licensed nurse, and creates a substantial probability of severe harm to residents.

Findings include:

This is a memory care establishment with eight residents in the building.

Establishment staffing schedules and the establishment's agency schedules were reviewed. The schedules do not contain documentation of a nurse working on 04-19-2026.

The establishment's Alzheimer's Disclosure form contains documentation that a licensed nurse will be scheduled to work at the establishment for at least 16 hours in a 24 hour period and that a licensed nurse will be available 24/7 to give medications outside of the normal administration times.

Resident April Medication Administration Records, (MAR,) were reviewed for all residents. Every resident's MAR is blank for medications not being administered on 04-19-2026.

All resident service plans were reviewed and contain documentation that all residents require medication administration. R4 and R7's service plans include documentation that the residents require insulin administration and blood glucose monitoring.

Resident records were reviewed for all eight

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A5000	Continued From page 19	A5000		

residents in the building. R1's records include documentation that R1 is to receive cephalexin and ciprofloxacin twice a day. R4's records include documentation that R4 is to receive insulin three times a day and that R4 receives sliding scale insulin. R4's progress notes also include documentation that R4 returned from the hospital on 04-22-2026. R7's records include documentation that R7 receives insulin twice a day.

On 04-16-2026, at approximately 1:15pm, the medication room door was observed to be open and no staff were observed in the room. The medication cart was observed to be unlocked, with the top drawer slightly open.

On 04-16-2026, at approximately 9:45am, E1, Executive Director, states that he uses agency for staffing nurses, that he has a nurse in building from 8:00am to 8:00pm, that all nurses are agency nurses, and that E7, Registered Nurse, is the on-call nurse. E1 also states that he is busy trying to find permanent staff and training them so that he is not relying on agency staff so much. At approximately 1:20pm E1 was notified of the medication room door and medication cart observations. E1 stated he would talk with the nurses.

On 04-23-2026, at approximately 11:15am, E5, Regional Nurse Consultant, states that three residents received medications on 04-19-2026 from family members. E5 states that R4 is diabetic and went to the hospital for insulin; that R4 was sent out on the 04-19-2026.

On 04-23-2026, at approximately 1:00pm, E4, Corporate Staff, states that he was not made aware of no nurse in the building on 04-19-2026

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A5000	Continued From page 20	A5000		

until Monday 04-20-2026, when he arrived at facility. E4 also states that he does not know why there was no nurse scheduled for that day. E4 states that he does not know how family members were able to get access to medications to give to residents.

On 04-23-2026, at approximately 1:00pm, E5 states that she was made aware of no nurse in the building on the evening of 4/19/26. E5 states she thinks that the agency nurse called in and could not be replaced.

On 04-23-2026, at approximately 1:15pm, E6, Corporate Staff, states that she was returning from vacation on 04-19-2026 in the afternoon when she was notified by a family member's message of no nurse in the building. E6 states she does not know how family members got access to the medications. E6 states that E1 told her family was coming in to give the evening medications. E6 states that at 6:21pm on 04-19-2026, that she sent a message to E1 trying to find out more information on not having a nurse in the building and that E1 told her there was not a nurse, that he had spent all day looking for one to work. E6 states that she asked their Regional Director of Operation (RDO) about this as the RDO was covering for her while on vacation; and that the RDO did not know anything about the facility not having a nurse available. E6 states that the RDO had not had any conversations with E1 regarding staffing concerns.

On 04-20-2026, at 2:38pm, Z1, complainant, states that she received a call from a family member who told her that there was no nurse in the building on 04-19-2026 and that residents did not receive their medications.

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A5000	Continued From page 21 On 04-20-2026, at 4:13pm, Z2, R1's family member, states that there was no nurse at the establishment all day on 04-19-2026 and that no medications were administered to the residents. Z2 states that the staff couldn't reach E1. Z2 states that after 1:00pm that day, that his sister went to the building and didn't see a nurse either. Z2 states that at about 4:00pm he was there and was told R1 had not had any medications at this time. Z2 states that there is a diabetic female resident who was having some medical issues and that staff called an ambulance for the resident. Z2 states that he told staff that he was going to take R1 to the Emergency Room because R1 needed his medications. Z2 states that staff finally called E1 who gave them the code to the medication room door. Z2 states this call was made and he heard everything due to them being on speaker phone. Z2 states that the key to the medication cart was gotten by the staff and that they opened the medication cart. Z2 states that he gave R1 his 4:00pm medications. Z2 states that another gentleman was in visiting his wife and that the gentleman gave his wife her medications. Z2 also states that the medications are all in pill packs; except for R1's antibiotic that was packaged separately. Z2 states that he came back at 8:00pm to give R1 his night medications and there was still no nurse in the building at that time.	A5000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Section 295.6000 Resident Rights	A6000		

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A6000	Continued From page 22 Type 1 Violation 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: 5) The right to receive the services specified in the service plan, to review and renegotiate the service plan at any time; and to be informed of the cost of the changes; 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; Based on record review and interview the establishment failed to ensure residents received medication administration by a licensed nurse on 04-19-2026. This failure resulted in R4 and R7 not receiving their scheduled insulin administration, R4 being sent to the local emergency room on 04-19-2026, and creates a substantial probability of severe harm to residents. Findings include: This is a memory care establishment with eight residents in the building. Establishment staffing schedules and the establishment's agency schedules were reviewed. The schedules do not contain documentation of a nurse working on 04-19-2026. The establishment's Alzheimer's Disclosure form contains documentation that a licensed nurse will be scheduled to work at the establishment for at	A6000		

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A6000	Continued From page 23	A6000		

least 16 hours in a 24 hour period and that a licensed nurse will be available 24/7 to give medications outside of the normal administration times.

Resident April Medication Administration Records, (MAR,) were reviewed for all residents. Every resident's MAR is blank for medications not being administered on 04-19-2026.

All resident service plans were reviewed and contain documentation that all residents require medication administration. R4 and R7's service plans include documentation that the residents require insulin administration and blood glucose monitoring.

Resident records were reviewed for all eight residents in the building. R1's records include documentation that R1 is to receive cephalexin and ciprofloxacin twice a day. R4's records include documentation that R4 is to receive insulin three times a day and that R4 receives sliding scale insulin. R4's progress notes also include documentation that R4 returned from the hospital on 04-22-2026. R7's records include documentation that R7 receives insulin twice a day.

On 04-16-2026, at approximately 9:45am, E1, Executive Director, states that he uses agency for staffing nurses, that he has a nurse in building from 8:00am to 8:00pm, that all nurses are agency nurses, and that E7, Registered Nurse, is the on-call nurse. E1 also states that he is busy trying to find permanent staff and training them so that he is not relying on agency staff so much.

On 04-23-2026, at approximately 11:15am, E5, Regional Nurse Consultant, states that three

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A6000	Continued From page 24	A6000		

residents received medications on 04-19-2026 from family members. E5 states that R4 is diabetic and went to the hospital for insulin; that R4 was sent out on the 04-19-2026.

On 04-23-2026, at approximately 1:00pm, E4, Corporate Staff, states that he was not made aware of no nurse in the building on 04-19-2026 until Monday 04-20-2026, when he arrived at facility. E4 also states that he does not know why there was no nurse scheduled for that day. E4 states that he does not know how family members were able to get access to medications to give to residents.

On 04-23-2026, at approximately 1:00pm, E5 states that she was made aware of no nurse in the building on the evening of 4/19/26. E5 states she thinks that the agency nurse called in and could not be replaced.

On 04-23-2026, at approximately 1:15pm, E6, Corporate Staff, states that she was returning from vacation on 04-19-2026 in the afternoon when she was notified by a family member's message of no nurse in the building. E6 states she does not know how family members got access to the medications. E6 states that E1 told her family was coming in to give the evening medications. E6 states that at 6:21pm on 04-19-2026, that she sent a message to E1 trying to find out more information on not having a nurse in the building and that E1 told her there was not a nurse, that he had spent all day looking for one to work. E6 states that she asked their Regional Director of Operation (RDO) about this as the RDO was covering for her while on vacation; and that the RDO did not know anything about the facility not having a nurse available. E6 states that the RDO had not had any

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A6000	Continued From page 25 conversations with E1 regarding staffing concerns. On 04-20-2026, at 2:38pm, Z1, complainant, states that she received a call from a family member who told her that there was no nurse in the building on 04-19-2026 and that residents did not receive their medications. On 04-20-2026, at 4:13pm, Z2, R1's family member, states that there was no nurse at the establishment all day on 04-19-2026 and that no medications were administered to the residents. Z2 states that the staff couldn't reach E1. Z2 states that after 1:00pm that day, that his sister went to the building and didn't see a nurse either. Z2 states that at about 4:00pm he was there and was told R1 had not had any medications at this time. Z2 states that there is a diabetic female resident who was having some medical issues and that staff called an ambulance for the resident. Z2 states that he told staff that he was going to take R1 to the Emergency Room because R1 needed his medications. Z2 states that staff finally called E1 who gave them the code to the medication room door. Z2 states this call was made and he heard everything due to them being on speaker phone. Z2 states that the key to the medication cart was gotten by the staff and that they opened the medication cart. Z2 states that he gave R1 his 4:00pm medications. Z2 states that another gentleman was in visiting his wife and that the gentleman gave his wife her medications. Z2 also states that the medications are all in pill packs; except for R1's antibiotic that was packaged separately. Z2 states that he came back at 8:00pm to give R1 his night medications and there was still no nurse in the building at that time.	A6000		

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A6010	Continued From page 26	A6010		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr	A6010		

This Regulation is not met as evidenced by:
Section 295.6010 Abuse, Neglect, and Financial Exploitation Prevention and Reporting

Violation

a) When the establishment has a reasonable belief that a resident has been the victim of abuse, neglect, or financial exploitation, the establishment shall:
1) Notify the Department within 24 hours after receiving the allegation, by contacting the Assisted Living Complaint Registry by telephone, fax, or other electronic means. The establishment shall document this report and maintain documentation on the premises for 12 months after the date of the report.
2) Investigate and develop a written report within 14 days after the initial report. The establishment shall send the written report to the Department within 24 hours after it is completed and shall maintain a copy of the written report on the premises for 12 months after the date of the report.

The establishment failed to ensure the Department was notified within 24 hours after receiving an allegation of abuse and failed to send a written investigation report to the Department of the allegation of abuse. This failure creates a substantial probability of harm to a resident or residents.

Findings include:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510019	A. BUILDING: _____ B. WING _____	C 04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS AT CENTENNIAL POINTE, THE	3430 HEDLEY ROAD SPRINGFIELD, IL 62712

(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
A6010	Continued From page 27 The establishment's "Reporting Abuse to Community Management" policy contains documentation that all alleged cases should be reported to the state licensing agency. The establishment's "Abuse Investigation" policy contains documentation that if a suspected incident of resident abuse is reported, that the administrator or designed will conduct an investigation. Further documentation includes that in Illinois the Department will be notified within 24 hours after receiving the allegations and that an investigation report will be sent to the Department within 14 days of the initial report. The establishment's 04-07-2026 investigation report contains documentation that E6 (Regional Director of Operations) was notified on 04-07-2026 of an allegation of abuse of R1. The allegation was that R1 had been pushed by E2 (Personal Care Attendant.) The report contains documentation that video footage was reviewed, and confirms that R1 was seated at a dining room table with a walker positioned beside R1. Video footage confirms that R1 lost R1's balance and fell while reaching for the table. Video footage also confirms that E2 was present in the dining room at the time R1 fell and that E2 was not close to R1 when the fall occurred. Documentation also includes that R1 was assisted to a chair and assessed by a nurse. The report contains documentation that an initial investigation was done and determination was made within one hour that abuse did not occur, "so it was not reported to IDPH..." R1's 04-07-2026 progress notes include documentation that R1 had a fall in the dining room; that R1 was seen standing up from the	A6010		

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A6010	Continued From page 28	A6010		

table and began to walk tripping on R1's walker then falling to the floor. The progress notes also include documentation that R1 was assessed and evaluated for injuries. Documentation includes that R1 was observed to have bruising to the left upper back near the shoulder blade and a small abrasion to the left knee. Further documentation includes that R1 was able to move all extremities with no limitations, and that R1 has no signs or symptoms of pain or discomfort noted.

E1 (Executive Director) was interviewed on 04-16-2026 during the investigation. E1 states that R1 did not have a fall when no staff were around, that staff (E2) went in to assist R1 in getting up from floor. E1 states that R1's daughter came in following the fall and started claiming that staff pushed R1. E1 states that the Ombudsman came in some time later that day but did not alert anyone or himself of being in the building. E1 also states that he cannot get in to view video footage of R1's fall, but that regional staff were able to view the video footage of R1's fall. E1 states that footage shows no staff near R1 when fall occurred. E1 was asked if the abuse allegation was investigated and reported to Department. E1 states that they did everything they should have done, that they sent the staff home (E2) for two days, that R1's family was notified, and that Corporate viewed the video footage. E1 states it was informal, and he will ask Corporate/Regional staff if the Department was notified.

E2 (Personal Care Attendant) was interviewed and states that the day R1 fell, that R1 was sitting in the dining room at a table where R1 usually sits. E2 states that he was moving chairs to the side of the room for cleanup, E2 states that he had his back turned to R1 when R1 fell, that he

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A6010	Continued From page 29 heard the crash and turned around noticing R1 on floor. E2 states that he assisted R1 up and that R1's daughter came in at that time assuming that E2 pushed R1. E2 states that he didn't push R1, that he was across the room. E2 states that he was sent home for a few days. E2 also states that he and the agency staff working completed statements and gave them to management. E2 states that the nurse working when R1 fell had just given resident medications and left to go next door to Assisted Living building when R1 fell. E2 states that they called her and she was back to assess R1 about 10 minutes after leaving the building. On 04-23-2026, at approximately 11:30am, E4 (Corporate Staff) states that he is not sure if the Deptartment was notified of R1's allegations of abuse. E4 states he does not think it was, as abuse did not occur.	A6010		