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COTTAGES OF FOX LAKE	16, 18, 20, 22 LILAC AVE FOX LAKE, IL 60020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comment Facility Reported Incident: IL197472 - 295.6010 a) 2) IL197243 - 295.3000 a), 295.6010 a) 2) IL197080 - Unsubstantiated IL196785 - Substantiated, No violation written. IL196622 - 295.3000 a) Complaint Investigation: IL196376 295.2040 a) b) 1) A) B) 295.3000 a) b) 295.4010 a) 295.9000 a)	A 000		
A2040	Section 295.2040 Disaster Preparedness This Regulation is not met as evidenced by: Type 1 Violation 295.2040. Disaster Preparedness a) For the purpose of this Section, "disaster" means an occurrence, as a result of a natural force or mechanical failure such as water, wind or fire, or a lack of essential resources such as electrical power, that poses a threat to the safety and welfare of residents, personnel, and others present in the establishment. b) Each establishment shall: 1) Have a written plan for protection of all persons in the event of disasters, for keeping persons in place, for evacuating persons to areas of refuge, and for evacuating persons from the building when necessary. The plan shall address the physical and cognitive needs of residents and include special staff response, including the	A2040		

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procedures needed to ensure the safety of any resident. The plan shall be amended or revised whenever any resident with unusual needs is admitted. The plan shall also:

A) provide for the temporary relocation of residents for any disaster requiring relocation;

B) provide for the movement of residents to safe locations within the establishment in the event of a tornado warning or severe thunder storm warning issued by the National Weather Service;

These requirements were not met as evidence by:

Based on observation, interview and record review, the facility failed to assess their evacuation capabilities and develop an evacuaiton plan to account for residents needing a mechanical lift transfer for five residents (R5, R7, R8, R9, R10), in order to safely evacuate all residents out of Memory Care building 20 within 13 minutes in the event of an emergency evacuaiton. The facility also failed to enusre a staff member would be present in memory care buildong 18 during an emergency evacuation of memory care building 20. This failure has the substantial probability to cause severe harm or death to a resident or residents residing in the memory care buildings 18 and 20.

Findings include:

On 9/26/25 at 8:00 AM, E3 (Licensed Practical Nurse), stated from 10pm-6am, the facility has one caregiver per building and one nurse for all four buildings. The one nurse covers all four buildings.

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A2040	Continued From page 2 On 9/26/25 at 8:47 AM, E2 (Health and Wellness Director) confirmed that from 10pm-6am, the facility staffs one caregiver per building and one nurse to cover all four buildings. E3 confirmed all four building are independently free standing and are not connected to each other. Buildings 18 and 20 are enclosed inside a locked gate and separated from buildings 16 and 22. On 9/26/25 at 9:47 AM, during a walkthrough of memory care building 20, it was noted that there are 5 residents (R5, R7, R8, R9, and R10) that have mechanical lift slings under them while seated in their wheelchair. E4 (Caregiver) stated the reason they have the sling under them is because they are all mechanical lift transfers. E4 was asked how many staff members it takes and approximatley how long does the whole process of transfering a resident from their bed to a wheelchair using a mechanical lift take. E4 stated "We're required to have two staff for the (Mechanial Lift) transfers. For how long it takes, it depends on the resident. Some of the residents will help you and others don't. You have to do all the work for them. If they help you, maybe 5 mintues. If the resident doesn't help, it can take up to 10 mintues. It just depends on the resident, so I would say 5-10 minutes." The facility's hospice residents tracking sheet documents R5, R7, R8, R9 and R10 are on hospice and require a mechanical lift for transfers. R5, R7, R8, R9 and R10's service plan documents the residents transfer via the use of a mechanical lift. On 9/26/25 at 9:55 AM, E2 was asked how the	A2040		

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A2040	Continued From page 3	A2040		

facility evacuates the residents at night out of building 20, when there's only one caregiver assigned from 10pm-6am. E2 stated "The nurse and one of the caregivers from building 18 goes over to 20 to assist. That way we have three staff members to get everyone out." E2 was asked how many staff and how long the whole process of transferring a resident from their bed to a wheelchair using a mechanical lift takes. E2 stated "We require a two person transfer for all mechanical lifts. It usually takes between 5-10 minutes for each transfer." E2 confirmed there are five residents in building 20 that require a mechanical lift transfer and that getting all the residents out of building 20 within 13 minutes using three staff members was not feasible. E2 also confirmed that during night shift, when the staff member from buildng 18 leaves to assist building 20during an emergency, the residents in memory care building 18 will be left unattended. E2 confirmed that building 18 and 20 are memory care units.

On 9/26/25 E5 and E7 (Caregivers) both stated it's a facility requirement to use two staff memebers to safely transfer a residnt using a mechanical lift. They also stated it takes approximately 5 minutes to transfer a resident using a mechanical lift.

The facility's nursing/caregiver schedule dated July 20205 throug 9/25/25, documents that from 10pm-6am, one caregiver assigned to each building and one nurse assigned to all four buildings.

The facility's 'Memory Care Disclosure" policy documents "Staffing Patters: (Facility) Memory Care Neighborhood has always at least one awake staff person in charge on duty and as

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A2040	Continued From page 4 many employees as may be needed to properly safegaurd the health, safety and welfare of the residents. At minimum, the community will hae at least one Administrator, on-site Manager, or a responsible staff person twenty-four hours per day. Additionally, the staff level in the Memory Care Neighborhood varies from the Assited Living program in that it is determined by the unique needs of the residents in Memory Care at any given time."	A2040		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: Type 1 Violation 295.3000 Personnel Requirements, Qualifications and Training 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) b) The establishment shall have on duty at all times at least one direct care staff person who has obtained cardiopulmonary resuscitation (CPR) training specific to adults, which includes a demonstration of the individual's ability to perform CPR, and who has current certification in CPR. These requirements were not met as evidence by:	A3000		

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A3000	Continued From page 5 Based on observation, interview and record review, the facility failed to provide a sufficient number of staff to evacuate all residents out of memory care building 20 within 13 minutes in the event of a fire. The facility aslo failed to ensure that at least one CPR certified staff member was in the builidng and on duty at all times. The facility also failed to ensure staff were using a gait belt during a resident transfer for two resident (R2 and R5). These failures resulted in resident injury for R5 and bruising to R2 and has the substantial probability to cause severe harm or death to a resident or residents residing in buildings 16, 18, 20 and 22. Findings Include: 1) On 9/26/25 at 8:00 AM, E3 (Licensed Practical Nurse), stated from 10pm-6am, the facility has one caregiver per building and one nurse for all four buildings. The one nurse covers all four buildings. On 9/26/25 at 8:47 AM, E2 (Health and Wellness Director) confirmed that from 10pm-6am, the facility staffs one caregiver per building and one nurse to cover all four buildings. E3 confirmed all four building are independently free standing and are not connected to each other. Buildings 18 and 20 are enclosed inside a locked gate and separated from buildings 16 and 22. On 9/26/25 at 9:47 AM, during a walkthrough of building 20, it was noted that there are 5 residents (R5, R7, R8, R9, and R10) that have mechanical lift slings under them while seated in their wheelchair. E4 (Caregiver) stated the reason they have the sling under them is because those residents are all mechanical lift transfers. E4 was	A3000		

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A3000	Continued From page 6	A3000		

asked how many staff members it takes and approximatley how long does the whole process of transfering a resident from their bed to a wheelchair using a mechanical lift take. E4 stated "We're required to have two staff for the (Mechanial Lift) transfers. For how long it takes, it depends on the resident. Some of the residents will help you and others don't. You have to do all the work for them. If they help you, maybe 5 mintues. If the resident doesn't help, it can take up to 10 mintues. It just depends on the resident, so I would say 5-10 minutes."

The facility's hospice residents tracking sheet documents R5, R7, R8, R9 and R10 are mechanical lift transfers.

R5, R7, R8, R9 and R10's service plan documents the residents transfer via the use of a mechanical lift.

On 9/26/25 at 9:55 AM, E2 was asked how the facility evacuates the residents, at night, out of building 20, when there's only one caregiver assigned from 10pm-6am. E2 stated "The nurse and one of the caregivers from building 18 goes over to building 20 to assist. That way we have three staff members to get everyone out." E2 was asked how many staff and how long the whole process of transferring a resident from their bed to a wheelchair using a mechanical lift takes. E2 stated "We require a two person transfer for all mechanical lifts. It usually takes between 5-10 minutes for each transfer." E2 confirmed there are five residents in building 20 that require a mechanical lift transfer and that getting all the residents out of building 20 within 13 minutes using three staff members was not feasible. E2 also confirmed that during night shift, when the staff member from buildng 18 leaves to assist

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A3000	Continued From page 7	A3000		

building 20, there are no staff memebers left in building 18 to monitor the reisdents. E2 confirmed that building 18 and 20 are memory care units.

On 9/26/25 E5 and E7 (Caregivers) both stated it's a facility requirement to use two staff memebers to safely transfer a residnt using a mechanical lift. They also stated it takes approximatley 5 minutes to transfer a resident using a mechanical lift.

The facility's nursing/caregiver schedule dated July 20205 throug 9/25/25, documents that from 10pm-6am, one caregiver assigned to each building and one nurse assigned to all four buildings. CPR certifications for all staff memers working from 10pm-6am between this time was reviewed. Only the nurse CPR certification was verified.

On 9/26/25 at 3:30 PM, E2 confirmed the caregivers identified on the schedule did not have a CPR certification. E2 stated "We didn't think the caregivers needed to have their CPR card because the nurse did so we didn't make it mandatory. We didn't know each buildings would be considered as a separate establishment. I talked with (E1, Executive Director) and were looking into having someone come in and teach the BLS course to all the staff."

The facility's 'Memory Care Disclosure" policy documents "Staffing Patters: (Facility) Memory Care Neighborhood has always at least one awake staff person in charge on duty and as many employees as may be needed to properly safegaurd the health, safety and welfare of the residents. At minimum, the community will hae at least one Administrator, on-site Manager, or a responsible staff person twenty-four hours per

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A3000	Continued From page 8	A3000		

day. Additionally, the staff level in the Memory Care Neighborhood varies from the Assited Living program in that it is determined by the unique needs of the residents in Memory Care at any given time."

2) R2's accident/incident report dated 8/4/25 documents "At approximately 7:27pm, writer received a call from CG (caregiver) reporting resident had a fall. Upon entering resident's room, resident observed sitting on the bathroom floor near the toilet area. Per CG, as she was wheeling resident to the bathroom to assist resident with toileting, resident held on to the bathroom door attempted to stop the wheelchair, leaned herself forward and fell out of the wheelchair landed on to the floor on her knees then on to her left side. Per CG resident was not seen hitting her head. Head to toe assessment performed. No s./s (signs and symptoms) of head injuries observed at this time. ROM (Range of Motion) WNL (Within Normal Limits) remain within the resident's capability. Noted a small superficial abrasion to left knee; no other injuries noted at this time. Resident assisted to standing with two person assist. Writer and CG assisted resident with toileting. Resident resisted to care and frequently pushed caregiver from helping her with care. Writer and CG were able to manage to help resident with care. Resident brought to the living room area for close observation. POA, Hospice, ED, DON and MD all were notified. POA thanked this writer for letting her know. Resident observed sitting on the recliner comfortably; no verbalizing pain, or showing any s/s of pain or discomfort at this time. Care continues."

R2's accident/incident report dated 8/7/25 documents "Resident has bruising to bilateral inner upper extremities. Unknown origin.

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A3000	Continued From page 9	A3000		

Resident unable to tell Writer how bruising occurred due to dementia diagnosis. Writer lightly touched area, no facial grimacing or signs of discomfort noted. POA, HWD, MD, Hospice Nurse notified."

R2's follow up report for the 8/7/25 incident docuements "Educate staff on safe lifting techniques and use of gait belt for resident transfers. Inspect upper extremities weekly until healed."

On 9/27/25 at 2:12 PM, E3 stated that the brusies they discovered on 8/7/25 were from the 8/4/25 incident where the staff used their arms to pick R2 up off the floor. E2 was asked if a gait belt was used. E3 stated "No, staff are required to use a gait belt when getting a resident off the floor, but they didn't use one for this incident. I went through and educated the staff that a gait must be used."

3) R5's incident/accident report dated 9/5/25 documents "The writer was called by the care giver that the resident slide down while she was trying to assist him in the bathroom . The resident was met lying on the floor of his bathroom with his right hand bruised and hanging on the wall. He has a little cut to his head too. Wounds were cleaned and dressed . Vitals signs and ROM were all WNR IWithin Normal Range) , however he was medicated for pain , PRN (as needed) morphine was administered .The writer proceeded to notify hospice and they promised to send a nurse in an hours time. The ED, DON, POA and MD have all been notified."

On 9/5/25, at the time of the fall, R5's service plan documented "(R5) requires one-person minimal to moderate assistance with transfers.

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A3000	Continued From page 10 He is able to use grab bars to pull himself up, pivot, and complete transfers with support." On 9/6/25, the day after the fall, R5's service plan was updated requiring R5 to be tranfered via mechanical lift. On 9/27/25 at 2:37 PM, E2 was asked if R5 required the use of a gait belt for his transfers. E2 stated "Yes, that was right before he became a (mechanical lift). (R5) is on hospice and was having a decline in condition and needed more assistance with transfers. When I investigated the fall, I found that (R5) was transfered without the use of a gait belt. We just in-serviced the staff using a gait belt for transfers."	A3000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: General Violation 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. This requirement was not met as evidence by: Based on observation, interview and record review, the facility failed to include the use of a	A4010		

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A4010	Continued From page 11	A4010		

mechinal lift as part of the residents evacuation assistance in a residents service plan for five residents (R5, R7, R8, R9 and R10) reviewed for service plans.

Findings include:

On 9/26/25 at 9:47 AM, during a walkthrough of memory care building 20, it was noted that there are 5 residents (R5, R7, R8, R9, and R10) that have mechanical lift slings under them while seated in their wheelchair. E4 (Caregiver) stated the reason they have the sling under them is because they are all mechanical lift transfers.

R5, R7, R8, R9 and R10's serivce plans document under resident transfer, that the residents require the use of a two person mechanical lift for transfers.

The facility's Evacuation Policy documents "An Individual Evacuation Plan (IEP) is determined to be necessary when a resident is unable to navigate his/her own pathway to safety or area of refuge after being alerted of the need to evacuate ...The IEP will be added to the Individual Service Plan and be reviewed by the Administrator and/or Health Services Director no less than every quarter or when there is a significant change in the resident's condition."

R5's service plan documents "Evacuation Assistance: (R5) requires one-person assistance when exiting the premises, as he needs support with wheelchair mobility and safety during transfers." There is no mention of the two person assist for mechanical lift transfer as part of the emergency evacuation assistance.

R7's service plan documents "Evacuation

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A4010	Continued From page 12 Assistance: In an emergency situation, (R7) will require one-person assistance with maneuvering wheelchair out of premises." There is no mention of the two person assist for mechanical lift transfer as part of the emergency evacuation assistance. R8's service plan documents "Evacuation Assistance: In case of an emergency situation, (R8) is non-ambulatory, uses wheelchair and will require staff to escort her safely from premsis." There is no mention of the two person assist for mechanical lift transfer as part of the emergency evacuation assistance. R9's service plan documents "Evacuation Assistnace: In the case of an emergency evacuation, (R9) will require one-person assistance with all broda chair mobility needs." There is no mention of the two person assist for mechanical lift transfer as part of the emergency evacuation assistance. R10's serivice plan documents "Evacuation Assistance: In the case of an emergency, (R10) uses his wheelchair for mobility and will require one-person escort to safely exit the premises." There is no mention of the two person assist for mechanical lift transfer as part of the emergency evacuation assistance. On 9/27/25 at 4:30 PM, E2 stated "In the service plan it states which residents require (mechanical lift) assistance already. It would be known who needs assistance. Our drills also note how many evacuation assistance needs there are per (building). I don't believe it should be in a service plan."	A4010		

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A6010	Continued From page 13	A6010		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr	A6010		

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

295.6010. Abuse, Neglect, and Financial Exploitation Prevention and Reporting

a) When the establishment has a reasonable belief that a resident has been the victim of abuse, neglect, or financial exploitation, the establishment shall:

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.

This requirement was not met as evidence by:

Based on interview and record review, the facility failed to send a accident/incidnet final report to the state agency for two residents (R1 and R2) out of five resident reviewed for accidents/incidents.

Findings include:

1) R1's accident/incident report dated 8/31/25 documents "Writer notified by caregiver that resident has skin tear and bleeding to right hand, requesting nursing to assess. Per caregiver, resident was found with skin tear at exit door near her bedroom, drops of blood noted in resident's

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apartment floor. Writer observed resident sitting on couch in living room, tearful holding right hand. Large vertical irregular shaped skin tear about 6 inches or bigger noted to right posterior hand with bleeding. Pressure was applied, non-adherent pads applied and secured with Coban. Picture taken and sent to (MD) who requested that resident be taken to ER for eval and possible stiches. Spoke to POA, she is unable to take resident to ER, requesting resident to be taken via ambulance. 911 was called. Pt was transported to (Hospital) via ambulance at 1840."

R1's medical record documents R1 returned on 8/31 from the hospital. There is no documentation that a final report was sent to the state agency.

On 9/27/25 at 1:00 PM, E2 (Health and Wellness Director) stated "I didn't send a follow up report for (R1). I didn't know we had to."

2) R2's accident/incident report dated 8/4/25 documents "At approximately 7:27pm, writer received a call from CG (caregiver) reporting resident had a fall. Upon entering resident's room, resident observed sitting on the bathroom floor near the toilet area. Per CG, as she was wheeling resident to the bathroom to assist resident with toileting, resident held on to the bathroom door attempted to stop the wheelchair, leaned herself forward and fell out of the wheelchair landed on to the floor on her knees then on to her left side. Per CG resident was not seen hitting her head. Head to toe assessment performed. No s./s (signs and symptoms) of head injuries observed at this time. ROM (Range of Motion) WNL (Within Normal Limits) remain within the resident's capability. Noted a small superficial abrasion to left knee; no other injuries noted at this time. Resident assisted to standing

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A6010	Continued From page 15 with two person assist. Writer and CG assisted resident with toileting. Resident resisted to care and frequently pushed caregiver from helping her with care. Writer and CG were able to manage to help resident with care. Resident brought to the living room area for close observation. POA, Hospice, ED, DON and MD all were notified. POA thanked this writer for letting her know. Resident observed sitting on the recliner comfortably; no verbalizing pain, or showing any s/s of pain or discomfort at this time. Care continues." R2's accident/incident report dated 8/7/25 documents "Resident has bruising to bilateral inner upper extremities. Unknown origin. Resident unable to tell Writer how bruising occurred due to dementia diagnosis. Writer lightly touched area, no facial grimacing or signs of discomfort noted. POA, HWD, MD Potermin, Hospice Nurse Karam notified." R2's follow up report for the 8/7/25 incident docuements "Educate staff on safe lifting techniques and use of gait belt for resident transfers.Inspect upper extremities weekly until healed." The facility's final report was sent to the state agency on 9/2/25. On 9/27/25 at 2:12, E2 stated "Like I told you, I didn't know a final report was required. I didn't send one for (R2) until after I got back from vacation and saw the email from IDPH requesting a follow up report."	A6010		
A9000	Section 295.9000 Physical Plant	A9000		

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A9000	Continued From page 16	A9000		

This Regulation is not met as evidenced by:
Type 1 Violation

295.9000 Physical Plant

a) The establishment shall comply with the residential board and care occupancies chapter of the National Fire Protection Association's (NFPA) Life Safety Code (Life Safety Code) 101, Chapter 32 for new establishments and Chapter 33 for existing establishments.

This requirement was not met as evidence by:

Based on observation, interview and record review, the facility failed to assess their evacuation capabilities and provide sufficient staffing needed to evacuate all residents, including 5 residents requiring mechanical lift transfer (R5, R7, R8, R9, R10), out of memeory care building 20 within 13 minutes. This failure has the substantial probability to cause severe harm or death to a resident or residents residing in the memory care buildings 20.

Findings include:

On 9/26/25 at 8:00 AM, E3 (Licensed Practical Nurse), stated from 10pm-6am, the facility has one caregiver per building and one nurse for all four buildings. The one nurse covers all four buildings.

On 9/26/25 at 8:47 AM, E2 (Health and Wellness Director) confirmed that from 10pm-6am, the facility staffs one caregiver per building and one nurse to cover all four buildings. E3 confirmed all four building are independently free standing and are not connected to each other. Buildings 18 and 20 are enclosed inside a locked gate and

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A9000	Continued From page 17	A9000		

separated from buildings 16 and 22.

On 9/26/25 at 9:47 AM, during a walkthrough of memory care building 20, it was noted that there are 5 residents (R5, R7, R8, R9, and R10) that have mechanical lift slings under them while seated in their wheelchair. E4 (Caregiver) stated the reason they have the sling under them is because they are all mechanical lift transfers. E4 was asked how many staff members it takes and approximatley how long does the whole process of transfering a resident from their bed to a wheelchair using a mechanical lift take. E4 stated "We're required to have two staff for the (Mechanial Lift) transfers. For how long it takes, it depends on the resident. Some of the residents will help you and others don't. If they help you, maybe 5 mintues. If the resident doesn't help, it can take up to 10 mintues. It just depends on the resident, so I would say between 5-10 minutes to transfer a resident using the (Mechanical Lift)."

The facility's hospice residents tracking sheet documents R5, R7, R8, R9 and R10 are mechanical lift transfers.

R5, R7, R8, R9 and R10's service plan documents the residents transfer via the use of a mechanical lift.

On 9/26/25 at 9:55 AM, E2 was asked how the facility evacuates the residents at night out of building 20, when there's only one caregiver assigned from 10pm-6am. E2 stated "The nurse and one of the caregivers from building 18 goes over to 20 to assist. That way we have three staff members to get everyone out." E2 was asked how many staff and how long the whole process of transferring a resident from their bed to a wheelchair using a mechanical lift takes. E2

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stated "We require a two person transfer for all mechanical lifts. It usually takes between 5-10 minutes for each transfer." E2 confirmed there are five residents in building 20 that require a mechanical lift transfer and that getting all the residents out of building 20 within 13 minutes using three staff members was not feasible. E2 also confirmed that during night shift, when the staff member from buildng 18 leaves to assist building 20, there are no staff memebers left in building 18 to monitor the reisdents. E2 confirmed that building 18 and 20 are memory care units.

On 9/26/25 E5 and E7 (Caregivers) both stated it's a facility requirement to use two staff memebers to safely transfer a residnt using a mechanical lift. They also stated it takes approximatley 5 minutes to transfer a resident using a mechanical lift.

The facility's nursing/caregiver schedule dated July 20205 throug 9/25/25, documents that from 10pm-6am, one caregiver is assigned to each building and one nurse assigned to all four buildings.

The facility's 'Memory Care Disclosure" policy documents "Staffing Patters: (Facility) Memory Care Neighborhood has always at least one awake staff person in charge on duty and as many employees as may be needed to properly safegaurd the health, safety and welfare of the residents. At minimum, the community will hae at least one Administrator, on-site Manager, or a responsible staff person twenty-four hours per day. Additionally, the staff level in the Memory Care Neighborhood varies from the Assited Living program in that it is determined by the unique needs of the residents in Memory Care at any given time."

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