STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	6022161	A. BUILDING: _____ B. WING _____	C 05/10/2026

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CLARENDALE SIX CORNERS	4715 WEST IRVING PARK RD CHICAGO, IL 60641

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A 000	Initial Comment Facility reported incident: dated: 5-4-2026/IL00201671. 295.4010 a)c)d)e) 295.6000 a)1)	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. c) The service plan shall be signed and dated by all individuals involved in its development. d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act) e) The service plan shall be reviewed and revised if necessary immediately after a significant change in the resident's physical,	A4010		

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A4010	Continued From page 1	A4010		

cognitive, or functional condition (see Section 295.4000).

This requirement was not met as evidenced by

Based on interview and record review. The facility failed to ensure service plans were updated following falls for three of three sampled residents reviewed for accidents (R1, R2, and R3). Specifically, the facility failed to document individualized post-fall interventions, reassessments, and/or updates to the residents' service plans after each resident experienced a fall.
This failure creates the substantial probability of severe harm to a resident or residents.

Findings include:

1. R1 is an 85-year-old female with diagnoses including, but not limited to, dementia and presence of a cardiac pacemaker. R1 moved into the facility on 1/15/2026.

On 5/9/2026 at 9:45 AM, R1 was observed eating breakfast and appeared clean and well groomed. Light yellow discoloration was observed bilaterally on the face adjacent to the nose. Record review showed R1 sustained a fall on 5/3/2026, R1 was transferred to a local hospital.

On 5/9/2026 at 11:45 AM, E5 (Licensed Practical Nurse) said, R1 fell from her bed in her room on 5/3/2026 about 12:15 AM, sustained facial injuries with bleeding, and was transferred via 911 to a local hospital where she was admitted with a diagnosis of subarachnoid hemorrhage. E5 said the service plan was not updated following the fall. Review of the service plan failed to identify any newly implemented interventions related to

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A4010	Continued From page 2	A4010		

the fall event for 5/3/2026. Further review of R1's progress notes revealed R1 also sustained a fall on 5/1/2026 resulting in a skin tear to the right elbow requiring home health treatment. Review of the service plan failed to identify any new interventions or documentation updates following this fall event.

On 5/9/2026 at 12:00 PM, E3 (Assistant Director of Health Services/ADON) said R1 returned from the hospital with orders for a neurology appointment and interventions including a hospital bed, enablers, fall mats, and maintaining the bed in a low position. E3 also said I am unsure whether those interventions were documented on the service plan prior to or after the 5/3/2026 fall, the service plan interventions do not indicate the day where implemented.

On 5/9/2026 at 1:00 PM, E2 (Director of Nursing) said R1's fall assessment was completed on 1/15/2026 scored the resident at high risk for falls, no additional fall reassessment or change in condition assessment was completed after the falls because the resident already scored at the highest risk level, it would be irrelevant to do another one because the risk will not be any higher than what it was.

2. R2 is a 90-year-old female with a diagnosis of dementia. Review of R2's service plan, signed on 4/2/2026, identified the problem of: fall potential with the intervention for staff to monitor for changes in condition. Review of progress notes revealed R2 sustained a fall on 5/7/2026 at 2:38 PM from her bed and complained of neck pain. R2 was transferred emergently to a local hospital for evaluation and returned to the facility at 7:00 PM with negative findings. Review of the service plan failed to identify any new interventions or

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A4010	Continued From page 3	A4010		

updates following the fall event.

On 5/9/2026 at 1:00 PM, E2 said R2's assessment was completed on 4/2/2026, it identifies R2 as high risk for falls, and no reassessment was completed after the fall. E2 said there would be no change to interventions due to the resident already scoring high risk for falls.

3. R3 is a 79-year-old male with diagnoses including, but not limited to, dementia, diabetes, and hypertension. R3's service plan was signed on 4/15/2026, identified as fall potential with the intervention for staff to monitor or changes in condition. Review of progress notes read R3 sustained a fall on 5/3/2026 with no apparent injuries and hospice was notified. Review of the service plan failed to identify any new interventions or updates following the fall event.

On 5/9/2026 at 1:00 PM, E2 stated R3's fall assessment completed on 4/9/2026 identified the resident as high risk for falls and no additional reassessment was completed after the fall.

On 5/9/2026 at 1:50 PM, E4 (Director of Memory Care) said, staff update service plans when new information is obtained; however, the electronic medical record system does not display dates for added interventions unless a new issue is created. E4 acknowledged the importance of dating interventions to identify when new interventions are implemented and when are discontinued, at this time we cannot tell you when the interventions were implemented.

On 5/9/2026 at 2:00PM, E2 said the electronic medical record system does not allow printing of implementation dates on service plans and no

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A4010	Continued From page 4 additional documentation regarding implementation dates could be provided at this time. E1(executive Director) presented policy titled: Service Plans and dated: 3-2025. Reads in part: All residents receiving assisted living services should have a service plan in place. Service plans are based on the outcomes of initial and subsequent assessments, reassessments, monitoring, and individual review of the resident's needs and preference. Resident service plans should have elements of personalization that create an individualized care experience for them. Service plans should be revised, if needed, based in residents' assessments and monitoring to include but not limited to falls, weight loss, change in health condition. Service plans and any revisions or updates will be entered into the residents' record, including notice of change in fees when applicable.	A4010		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 2 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:	A6000		

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A6000	Continued From page 5 1) The right to live in an environment that promotes and supports each resident's dignity, individuality, independence, self-determination, privacy, and choice and to be treated with consideration and respect; This requirement was not met as evidenced by: Based on interview and record review, the facility failed to ensure the resident's primary medical provider was notified of abnormal urinalysis and urine culture results for one resident (R1). This failure affected one resident and has the potential to delay medical evaluation and treatment for all residents. This failure creates the substantial probability of harm to a resident or residents. Findings include: R1 is an 85-year-old female with diagnoses including, but not limited to, dementia and the presence of a cardiac pacemaker. R1 was admitted to the facility on 1/15/2026. On 5/9/2026 at 12:00 PM, E3 (Assistant Director of Health Services) said, on 4/30/2026 the facility received an order from R1's physician to obtain a urinalysis due to behaviors including yelling and screaming, the urine specimen was collected and that preliminary results were received on 5/1/2026 at 2:11 PM, with final results received on 5/5/2026 at 12:53 PM. The urine culture was positive for E. coli greater than 100,000 colonies. E3 said there is no documentation indicating the physician or nurse practitioner had been notified of either the preliminary or final results. E3 further said the expectation was for nursing staff to notify the provider of abnormal results and obtain further recommendations/ orders.	A6000		

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A6000	Continued From page 6 On 5/9/2026 at 1:00 PM, E2 (Director of Nursing) said the facility was not responsible for notifying the medical provider of laboratory results, the laboratory and ordering physician are responsible for reviewing results, we (facility) do not have a policy regarding follow-up of laboratory results. Attempts to contact R1's medical provider were unsuccessful. The facility failed to provide a policy regarding notification and follow-up of abnormal laboratory results.	A6000		