STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510508	A. BUILDING: _____ B. WING _____	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAN GABRIEL MEMORY CARE	813 LARS HOFFMAN CROSSING GODFREY, IL 62035

(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 Licensure Survey entered on 05/05/26 and exited on 05/06/26. 295.4000 b) 295.4010 d) e) g) 1) A) C) 2) 3) h) 295.6000 a) 1) 13)	A 000		
A4000	Section 295.4000 Physician/s Assessment This Regulation is not met as evidenced by: Type 2 Violation Section 295.4000 Physician's Assessment b) At least annually, once a resident has moved into the establishment, a comprehensive assessment shall be completed by a physician. Based on interview and record review, the establishment failed to ensure a Physician's Assessment was completed annually by a physician for two of two residents (R1 and R2) reviewed for Physician's Assessments in the sample of two. This failure creates a substantial probability of harm to a resident or residents. Findings include: 1. R1's medical record documents R1's most current Physician's Assessment was completed on 04/01/22 by Z1 (Family Nurse Practitioner). On 05/06/26 at 11:20 AM, E1 (Manager) stated R1 has not had a Physician's Assessment completed by a physician within the past year.	A4000		

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A4000	Continued From page 1 2. R2's current Physician's Assessment (dated 07/03/25) was signed and completed by Z2 (Physician's Assistant). On 05/06/26 at 11:25 AM, E1 (Manager) verified that R2's current Physician's Assessment was not completed and signed by a Physician.	A4000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 1 Violation Section 295.4010 Service Plan d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act) e) The service plan shall be reviewed and revised if necessary immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000). g) Service plans shall address: 1) The level of service the resident is receiving, including: A) assistance with activities of daily living;	A4010		

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A4010	Continued From page 2 C) special accommodations for the resident; 2) The amount, type, and frequency of health-related services needed by the resident; 3) Staff responsible for the provisions of the service plan; h) The service plan shall include all support services provided or arranged for by the establishment. Based on interview and record review, the establishment failed to revise a Service Plan to reflect resident falls for two of two residents (R1 and R2) reviewed for falls in the sample of two. This failure creates a substantial probability of severe harm to a resident or residents. Findings include: 1. R1's Fall Investigation (dated 03/27/26) documents R1 was found on the floor in her living room after an unwitnessed fall and sustained a skin tear to her left elbow. R1's current Service Plan has no mention of R1's 03/27/26 fall, or any fall prevention intervention that was implemented following R1's fall. On 05/06/26 at 11:15 AM, E1 (Manager) verified R1's Service Plan was not revised following her 03/27/26 fall and stated no new fall prevention intervention was implemented at that time. 2. The establishment's Incident Report Binder (dated 01/01/26 - 05/05/26) was reviewed and documents R2 fell at the establishment on 02/20/26, 03/07/26, 03/31/26, and 04/23/26. All of	A4010		

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A4010	Continued From page 3 these Incident Reports document that R2 fell unassisted while he was in his bathroom. R2's Service Plan has no mention of R2's falls on 03/07/26, 03/31/26, and 04/23/26 and does not document any fall prevention interventions following these falls. On 05/05/26 at 11:30 AM, E1 (Manager) verified that no fall prevention interventions were implemented following R2's falls on 03/07/26, 03/31/26, and 04/23/26, and therefore, R2's Service Plan was not revised to reflect these falls.	A4010		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 1 Violation Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 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; 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform	A6000		

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A6000	Continued From page 4 labor; Based on interview and record review, the facility neglected to implement fall prevention interventions to prevent further falls for two of two residents (R1 and R2) reviewed for falls in the sample of two. This failure creates a substantial probability of severe harm to a resident or residents. Findings include: 1. R1's Fall Investigation (dated 03/27/26) documents R1 was found on the floor in her living room after an unwitnessed fall and sustained a skin tear to her elbow. R1's current Service Plan has no mention of R1's 03/27/26 fall, or any fall prevention intervention that was implemented following R1's fall. On 05/06/26 at 11:15 AM, E1 (Manager) verified R1's Service Plan was not revised following her 03/27/26 fall and stated no new fall prevention intervention was implemented at that time. 2. R2's Incident Report (dated 03/07/26) documents the following: R2 was found by staff on the floor in his bathroom; R2 stated to staff that he was trying to use the bathroom and lost his balance. This Incident Report does not document that a new fall prevention intervention was implemented following R2's 03/07/26 fall. R2's Incident Report (dated 03//31/26) documents the following: R2 was found on the floor of his bathroom by staff after he had fallen. This same report does not document a fall prevention intervention was implemented after R2's 03/31/26 fall.	A6000		

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A6000	Continued From page 5 R2's Incident Report (dated 04/23/26) documents the following: A caregiver discovered R2 on the floor in his bathroom, and R2 stated that he lost his balance while using the restroom which caused him to fall. This Incident Report does not document a new fall prevention intervention was implemented following R2's 04/23/26. R2's current Service Plan (dated 02/19/26) has no mention of R2's falls on 03/07/26, 03/31/26, and 04/23/26, and does not document any fall prevention interventions following these falls. On 05/06/26 at 11:30 AM, E1 (Manager) stated no fall prevention interventions were implemented following R2's falls on 03/07/26, 03/31/26, and 04/23/26, and therefore, R2's Service Plan was not revised to reflect these falls. E1 stated, "We have been using agency nurses, and they may not have known to update the Service Plan."	A6000		