STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510400	A. BUILDING: _____ B. WING _____	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSHIRE MORTON GROVE	8415 WAUKEGAN ROAD MORTON GROVE, IL 60053

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comment Annual Survey & Investigation IL00201866 Conducted Annual Violations: 295.2040e)f)g)h) 295.3020a)1-6)b)1-6) 295.3030a)b)e)1)2) 295.4000a)b) 295.4010g)1)A)B)C)2)5)h) 295.4050 IL00201866 No Violations	A 000		
A2040	Section 295.2040 Disaster Preparedness This Regulation is not met as evidenced by: Type 1 Violation Section 295.2040 Disaster Preparedness e) Drills shall include residents, establishment personnel, and other persons in the establishment. f) Drills shall include making a general announcement throughout the establishment that a drill is being conducted or sounding an emergency alarm. Drills may be announced in advance to residents. g) Drills shall involve the actual evacuation of residents to an assembly point as specified in the emergency plan and shall provide residents with experience using various means of escape. If an establishment has an evacuation capability classification of impractical, those residents who cannot meaningfully assist in their own	A2040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510400	A. BUILDING: _____ B. WING _____	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSHIRE MORTON GROVE	8415 WAUKEGAN ROAD MORTON GROVE, IL 60053

(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
A2040	Continued From page 1 evacuation or who have special health problems shall not be required to participate in the drill; however, other requirements of the Life Safety Code will apply. h) A written evaluation of each drill shall be submitted to the establishment manager and shall be maintained for one year from the date of the drill. The evaluation shall include the date and time of the drill, names of employees participating in the drill, and identification of any residents who received assistance for evacuation. This requirement was not met, as evidenced by: Based on record review and interview, the establishment failed to identify residents and visitors who participated in the drills. The establishment also failed to actually evacuate residents to an assembly point and provide residents with experience using various means of escape. These failures create a substantial probability of severe harm to residents. Findings include: During record review on 6/15/2026 at 1:27 PM it was found that the establishment fire drills did not identify any residents. The drills also state that residents were in their rooms with their doors closed. During record review on 6/15/2026 at 1:40 PM the establishment's most recent life safety inspection cited them for a similar violation. The Life Safety Statement of Findings stated the establishments drill documentation failed to include "B. Evacuation drill record demonstrating all residents attended and those residents that did not attend due to illness. Evacuations Drills	A2040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510400	A. BUILDING: _____ B. WING _____	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSHIRE MORTON GROVE	8415 WAUKEGAN ROAD MORTON GROVE, IL 60053

(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
A2040	Continued From page 2 Records demonstrating all residents attended unless the resident were unable based on allowable exceptions of the Licensure code lister below. A list of room numbers indicating the resident attended, or the room is vacant, or resident is out of the building, a hospice patient meeting the requirements of Section 2905.2000(f), or the resident is quadriplegic or paraplegic, or individuals with neuro-muscular diseases, such as muscular dystrophy and multiple sclerosis, or other chronic diseases and conditions meeting the requirements of Section 2905.20009g). or a temporary illness that would prevent the resident from self-evacuation." During an interview with E3 (Maintenance Director) on 6/15/2026 at 12:51 PM he stated, "Here are all the drills."	A2040		
A3020	Section 295.3020 Employee Orientation and Ongoing Training This Regulation is not met as evidenced by: Type 3 Violation Section 295.3020 Employee Orientation and Ongoing Training a) Each new employee shall complete orientation within 10 days after the starting date of employment that includes: 1) The establishment's philosophy and goals; 2) Promotion of resident dignity, independence, self-determination, privacy,	A3020		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510400	A. BUILDING: _____ B. WING _____	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSHIRE MORTON GROVE	8415 WAUKEGAN ROAD MORTON GROVE, IL 60053

(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
A3020	Continued From page 3 choice, and resident rights; 3) Confidentiality of resident records and resident information; 4) Hygiene and infection control; 5) Abuse and neglect prevention and reporting requirements; and 6) Disaster procedures. b) Each employee shall also complete orientation within 30 days after the starting date of employment that includes: 1) Orientation to the characteristics and needs of the establishment's residents; 2) The significance and location of resident service plans; 3) Internal establishment requirements and the establishment's policies and procedures; 4) The employee's job responsibilities and limitations; 5) CPR and emergency procedures for medical events, if applicable; and 6) Training in assistance with activities of daily living appropriate to the job. These requirements were not met, as evidenced by: Based on interview and record review, the establishment failed to ensure that employees had orientation within the required time frames	A3020		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510400	A. BUILDING: _____ B. WING _____	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSHIRE MORTON GROVE	8415 WAUKEGAN ROAD MORTON GROVE, IL 60053

(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
A3020	Continued From page 4	A3020		

with the required components. These failures involve 6 of 6 employees reviewed for these requirements (E6, E7, E8, E9, E10, & E11).

Findings include:

During an interview with E4 (Nurse Consultant) on 6/15/2026 at 1:10 PM they stated, "A lot of these employees here started 1st at the other building but they pick up shifts over here, so the start date listed on that list is the date they started picking up shifts here."

An interview with Z1 (ADON of LTC building next door) on 6/16/2026 at 11:55 AM went as follows:

Z1: "[E7] and [E10] don't have any history of positive skin tests. So we just do the yearly questionnaire. Upon hire to my side they were negative."

Surveyor: "From their start date in the assisted living building have they had any TB testing?"

Z1: "Since they have been working with us for so many years we just do the questionnaire."

During record review on 6/16/2026 at 10:04 AM it was found that E6 (LPN) started with the long term care facility next door to the establishment on 10/10/2023. E6 started with the Assisted Living establishment on 4/20/2026. No employee orientation was found for E6 during their employment with the assisted living establishment.

During record review on 6/16/2026 at 10:15 AM it was found that E7 (LPN) started with the long term care facility next door to the establishment on 1/23/2026. E7 started with the Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510400	A. BUILDING: _____ B. WING _____	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSHIRE MORTON GROVE	8415 WAUKEGAN ROAD MORTON GROVE, IL 60053

(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
A3020	Continued From page 5	A3020		

establishment on 4/28/2026. No employee orientation was found for E7 during their employment with the assisted living establishment.

During record review on 6/16/2026 at 10:25 AM it was found that E8 (CNA) started with the long term care facility next door to the establishment on 1/13/2025. E8 started with the Assisted Living establishment on 1/7/2026. E8's employee orientation was conducted on 12/07/2025. This is approximately 1 year before their employment with the assisted living establishment.

During record review on 6/16/2026 at 10:35 AM it was found that E9 (CNA) started with the long term care facility next door to the establishment on 6/10/2025. E9 started with the Assisted Living establishment on 12/1/2025. E9's employee orientation was conducted on 9/22/2025. This is approximately 3 months before their employment with the assisted living establishment.

During record review on 6/16/2026 at 10:40 AM it was found that E10 (CNA) started with the long term care facility next door to the establishment on 1/13/2027. E10 started with the Assisted Living establishment on 4/21/2025. There was no orientation for E10 that was during their employment with the assisted living establishment.

During record review on 6/16/2026 at 10:50 AM it was found that E11 (CNA) started with the long term care facility next door to the establishment on 12/23/2025. E11 started with the Assisted Living establishment on 4/27/2026. E11's orientation was conducted on 2/20/2026. This is approximately 2 months before they were hired to the assisted living establishment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510400	A. BUILDING: _____ B. WING _____	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSHIRE MORTON GROVE	8415 WAUKEGAN ROAD MORTON GROVE, IL 60053

(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
A3030	Section 295.3030 Initial Health Eval for Dir Care and FS empl This Regulation is not met as evidenced by: Type 2 Violation Section 295.3030 Initial Health Evaluation for Direct Care and Food Service Employees a) Each direct care and food service employee shall have an initial health evaluation, which shall be used to ensure that employees are not placed in positions that would pose undue risk of infection to themselves, other employees, residents, or visitors. b) The initial health evaluation shall be conducted not more than 30 days prior to and no later than 30 days after the employee's initial employment in the establishment. e) Each employee shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696). The test must meet one of the following time frames: 1) The test must be completed no more than 90 days prior to the date of initial employment in the establishment; or 2) The test must be commenced no more than ten days after the date of initial employment in the establishment. These requirements were not met, as evidenced by: Based on interview and record review, the establishment failed to ensure direct care	A3030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510400	A. BUILDING: _____ B. WING _____	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSHIRE MORTON GROVE	8415 WAUKEGAN ROAD MORTON GROVE, IL 60053

(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
A3030	Continued From page 7	A3030		

employees had an initial health evaluation and TB testing within the required time frames. These failures involve 6 of 6 employees reviewed for these requirements (E6, E7, E8, E9, E10, & E11). These failures create a substantial probability of harm to residents.

Findings include:

During an interview with E4 (Nurse Consultant) on 6/15/2026 at 1:10 PM they stated, "A lot of these employees here started 1st at the other building but they pick up shifts over here, so the start date listed on that list is the date they started picking up shifts here."

An interview with Z1 (ADON of LTC building next door) on 6/16/2026 at 11:55 AM went as follows:

Z1: "[E7] and [E10] don't have any history of positive skin tests. So we just do the yearly questionnaire. Upon hire to my side they were negative."

Surveyor: "From their start date in the assisted living building have they had any TB testing?"

Z1: "Since they have been working with us for so many years we just do the questionnaire."

During record review on 6/16/2026 at 10:04 AM it was found that E6 (LPN) started with the long term care facility next door to the establishment on 10/10/2023. E6 started with the Assisted Living establishment on 4/20/2026. E6's TB testing was done on 10/6/2023. This is approximately 2.5 years before their employment within the assisted living establishment. This is outside of the required time frame. E6's initial health evaluation was completed on 10/6/2023. This is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510400	A. BUILDING: _____ B. WING _____	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSHIRE MORTON GROVE	8415 WAUKEGAN ROAD MORTON GROVE, IL 60053

(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
A3030	Continued From page 8	A3030		

approximately 2.5 years before their employment within the assisted living establishment.

During record review on 6/16/2026 at 10:15 AM it was found that E7 (LPN) started with the long term care facility next door to the establishment on 1/23/2026. E7 started with the Assisted Living establishment on 4/28/2026. E7 had a chest x-ray completed on 3/5/2017. This is approximately 10 years before their employment with the assisted living establishment. E7 had an initial health evaluation completed on 11/13/2014. This is approximately 12 years before their employment with the assisted living establishment

During record review on 6/16/2026 at 10:25 AM it was found that E8 (CNA) started with the long term care facility next door to the establishment on 1/13/2025. E8 started with the Assisted Living establishment on 1/7/2026. E8's TB testing was done on 1/14/2025. This is approximately 1 year before their employment within the assisted living establishment. This is outside of the required time frame. There was no initial health evaluation for E8 within their employment for the assisted living establishment.

During record review on 6/16/2026 at 10:35 AM it was found that E9 (CNA) started with the long term care facility next door to the establishment on 6/10/2025. E9 started with the Assisted Living establishment on 12/1/2025. There was no TB testing found for E9 during their employment with the assisted living establishment. E9's initial health evaluation was conducted on 6/6/2025. This is approximately 6 months before their employment with the assisted living establishment. This is outside of the required time frames.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510400	A. BUILDING: _____ B. WING _____	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSHIRE MORTON GROVE	8415 WAUKEGAN ROAD MORTON GROVE, IL 60053

(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
A3030	Continued From page 9 During record review on 6/16/2026 at 10:40 AM it was found that E10 (CNA) started with the long term care facility next door to the establishment on 1/13/2027. E10 started with the Assisted Living establishment on 4/21/2025. There was no TB testing found for E10 during their employment with the assisted living establishment. E10's initial health evaluation was conducted on 1/4/2017. This is approximately 8 years before their employment with the assisted living establishment. This is outside of the required time frame. During record review on 6/16/2026 at 10:50 AM it was found that E11 (CNA) started with the long term care facility next door to the establishment on 12/23/2025. E11 started with the Assisted Living establishment on 4/27/2026. E11's TB testing was done on 12/23/2025. This is approximately 4 months before their employment within the assisted living establishment. This is outside of the required time frame. E11's initial health evaluation was completed on 12/23/2025. This is approximately 4 months before their employment within the assisted living establishment.	A3030		
A4000	Section 295.4000 Physician/s Assessment This Regulation is not met as evidenced by: Type 3 Violation Section 295.4000 Physician's Assessment a) No more than 120 days prior to admission of a resident to any establishment, a comprehensive assessment that includes an	A4000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510400	A. BUILDING: _____ B. WING _____	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSHIRE MORTON GROVE	8415 WAUKEGAN ROAD MORTON GROVE, IL 60053

(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
A4000	Continued From page 10 evaluation of the prospective resident's physical, cognitive, and psychosocial condition shall be completed by a physician. The physician's assessment shall include documentation of the presence or the absence of tuberculosis infection in accordance with the Control of Tuberculosis Code. At the time of admission, the physician's assessment must reflect the resident's current condition. b) At least annually, once a resident has moved into the establishment, a comprehensive assessment shall be completed by a physician. This requirement was not met, as evidenced by: Based on record review and interview, the establishment failed to ensure that physician assessments were completed by a physician. This failure involves 3 of 5 residents reviewed for this requirement (R1, R2, & R3). Findings include: During record review on 6/16/2026 at 12:15 PM it was found that R2's physician assessment, dated 1/16/2026 was completed and signed by Z2 (APN). During record review on 6/16/2026 at 12:41 PM it was found that R3's physician assessment, dated 3/19/2026, was completed and signed by Z2. During record review on 6/16/2026 at 1:25 PM it was found that R1's physician assessment, dated 2/5/2026, was completed and signed by Z2. An interview with E2 (Assistant Administrator) on 6/16/2026 at 1:42 PM went as follows: Surveyor: "Are you aware that a physician's	A4000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510400	A. BUILDING: _____ B. WING _____	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSHIRE MORTON GROVE	8415 WAUKEGAN ROAD MORTON GROVE, IL 60053

(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
A4000	Continued From page 11 assessment must be completed and signed by a physician, not a nurse practitioner?" E2: "Okay. I honestly was not aware but that is good to know."	A4000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 2 Violation Section 295.4010 Service Plan g) Service plans shall address: 1) The level of service the resident is receiving, including: A) assistance with activities of daily living; B) dietary needs, if the establishment provides therapeutic diets; and C) special accommodations for the resident; 2) The amount, type, and frequency of health-related services needed by the resident; 5) Whether the resident requires medication reminders, supervision of self-administered medication, or medication administration. h) The service plan shall include all support services provided or arranged for by the establishment.	A4010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510400	A. BUILDING: _____ B. WING _____	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSHIRE MORTON GROVE	8415 WAUKEGAN ROAD MORTON GROVE, IL 60053

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4010	Continued From page 12 These requirements were not met, as evidenced by: Based on record review and interview, the establishment failed to ensure resident service plans addressed all required components. This failure involves 2 of 3 residents reviewed for this requirement (R1 & R3). This failure creates a substantial probability of harm to residents. Findings include: During record review on 6/16/2026 at 11:30 AM R1's service plan, dated 6/21/2025 did not address oral hygiene, transferring, ambulation, or eating. During record review on 6/16/2026 at 12:43 PM R3's service plan, dated 3/15/2026, did not address toileting or eating. The bathing and mobility sections were left blank. An interview with E12 (RN) on 6/16/2026 at 1:30 PM went as follows: E12: "[R1] was a 1 person assist or standby for transferring. He ambulated by wheelchair. His wife would push it but he would also push it himself. He was able to brush his own teeth. He had a soft diet. We would set it up for him and then he would feed himself. He was able to make his needs known. He was not on hospice. I feel he was appropriate for care here." Surveyor: "Does [R3] need assistance showering?" E12: "He needs set up and assistance due to his hypotension."	A4010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510400	A. BUILDING: _____ B. WING _____	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSHIRE MORTON GROVE	8415 WAUKEGAN ROAD MORTON GROVE, IL 60053

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4010	Continued From page 13 Surveyor: "How does he ambulate?" E12: "He ambulates with a walker. He can toilet himself. He feeds himself."	A4010		
A4050	Seciton 295.4050 Tuberculin Skin Test Procedures This Regulation is not met as evidenced by: Type 2 Violation Section 295.4050 Tuberculin Skin Test Procedures Tuberculin skin tests for employees and residents shall be conducted in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696). Section 696.140 Screening for Latent Tuberculosis Infection (LTBI) and Active Tuberculosis (TB) Disease A TB screening test shall be used when screening persons for latent TB infection (LTBI). Persons who have signs and symptoms of active TB disease or a positive TB screening test result shall complete a diagnostic evaluation for active TB disease in accordance with the Centers for Disease Control and Prevention (CDC) guidelines, Targeted Tuberculin Testing and Treatment of Latent Tuberculosis Infection and Guidelines for Health-Care Settings. a) Screening for Latent TB Infection 2) Workers and clients at health care settings and other residential settings serving high-risk groups shall be screened in accordance with this subsection (a)(2) and the following CDC	A4050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510400	A. BUILDING: _____ B. WING _____	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSHIRE MORTON GROVE	8415 WAUKEGAN ROAD MORTON GROVE, IL 60053

(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
A4050	Continued From page 14 guidelines: Targeted Tuberculin Testing and Treatment of Latent Tuberculosis Infection; Guidelines for Health-Care Settings; Prevention and Control of Tuberculosis in Correctional and Detention Facilities: Recommendations from CDC. C) All clients in non-acute care residential health care settings serving high-risk groups shall obtain an entry TB screening according to the healthcare facility written protocol. Routine periodic screening shall be determined by completing a Department approved a risk assessment tool performed in cooperation with the local TB control authority. The TB Risk Assessment Form is available on the Department's website at https://dph.illinois.gov/content/dam/soi/en/web/idph/files/forms/tuberculosis-risk-assessment.pdf. This requirement was not met, as evidenced by: Based on record review and interview, the establishment failed to act in accordance with the Control of Tuberculosis Code by failing to follow its own policy by failing to test a resident for TB within 7 days after admission. This failure involves 1 resident (R2). This failure creates a substantial probability of harm to residents. Findings include: During record review on 6/15/2026 at 11:10 AM it was found that the establishment's TB policy states that residents must be tested for TB within 7 days of admission. During record review on 6/16/2026 it was found that R2's date of admission was 1/16/2026. R2 did not have TB testing until 2/2/2026. This is	A4050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510400	A. BUILDING: _____ B. WING _____	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSHIRE MORTON GROVE	8415 WAUKEGAN ROAD MORTON GROVE, IL 60053

(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
A4050	Continued From page 15 past the 7 days after admission time requirement. An interview with E1 (Executive Director/ Director of Nursing) on 6/16/2026 at 2:24 PM went as follows: Surveyor: "[R2]'s move in date is 1/16/2026. Why was her TB testing not started until 2/2/2026?" E1: "They kept refusing. That is why it is late."	A4050		