STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510496	A. BUILDING: _____ B. WING _____	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OVERLOOK VILLAGE ASSISTED	941 6TH STREET MOLINE, IL 61265

(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: 295.2040a)d)e)g)h) 295.2060a)b)1)2) 295.3020a)1)2)3)4)5)6) 295.3030a)b) 295.3040	A 000		
A2040	Section 295.2040 Disaster Preparedness This Regulation is not met as evidenced by: Type 1 Violation Section 295.2040 Disaster Preparedness 295.2040a)d)e)g)h) 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. d) The establishment shall conduct a tornado drill on each shift during February of each year for employees. e) Drills shall include residents, establishment personnel, and other persons in the establishment. 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 evacuation or who have special health problems shall not be required to participate in the drill;	A2040		

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A2040	Continued From page 1	A2040		

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 regulation is NOT MET as evidenced by:

Based on interview and record review, the establishment failed to ensure residents participated in disasters drills and were identified, failed to consistently evaluate drills, and failed to ensure evacuation times took no longer than 13 minutes. This failure has the substantial probability to affect all residents in the establishment. This failure creates a substantial probability of severe harm or death to a resident or residents.

The findings include:

On 06/03/2026, reviewed disaster drill logs provided by E2 (Executive Director) with the following findings:
Fire drill log dated 05/26/2026 "10:01" (first shift) documented eighteen staff members participated, and "151" residents were evacuated. No resident names or resident roster was provided of residents who were evacuated. Seven residents who refused were listed by name and two residents were listed by name for "nurses pass". Time required for evacuation was documented as "16". Log documented "crowded at [Independent Living] elevator. Action: utilize the two [Assisted Living] elevators" under "if evacuation time took longer than thirteen minutes".

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A2040	Continued From page 2 Fire drill log dated 04/30/2026 at "06:15" (no shift indicated) documented four staff members participated and indicated no residents were evacuated. No resident names or resident roster was provided. Fire drill log dated 03/30/2026 at 02:40 PM (second shift) documented six staff members participated and indicated no residents were evacuated. No resident names or resident roster was provided. Fire drill log dated 02/27/2026 at "08:15" (first shift) documented nine staff members participated and indicated no residents were evacuated. No resident names or resident roster was provided. Fire drill log dated 01/29/2026 at 06:15 AM (third shift) documented six staff members participated and did not indicate whether residents were evacuated. No resident names or resident roster was provided. Time required for evacuation was documented as "20". Log documented "went over all procedures with staff" under "if evacuation time took longer than thirteen minutes". Fire drill log dated 01/08/2026 (no time or shift indicated) documented five staff members participated and indicated no residents were evacuated. No resident names or resident roster was provided. Time required for evacuation was documented as "20". No documentation was noted under "if evacuation time took longer than thirteen minutes". Fire drill log dated 10/10/2025 at 06:10 AM (third shift) documented six staff members participated, indicated no residents were evacuated, then	A2040		

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A2040	Continued From page 3	A2040		

documented "22" residents were evacuated. No resident names or resident roster was provided. No evaluation was documented.

Fire drill log dated 10/09/2025 (no time indicated; first shift) documented eight staff members participated and indicated "20" residents were evacuated. No resident names or resident roster was provided.

Fire drill log dated 08/14/2025 at 05:30 PM (second shift) documented seven staff members participated and indicated no residents were evacuated. No resident names or resident roster was provided. Log documented under observations/comments, "alarm went off for kitchen and we treated it like a drill ..." then documented under evacuation time, "did not evacuate any residents as we knew the reason for the smoke in the kitchen was that they were cleaning the grill and the power went out".

Fire drill log dated 05/15/2025 at 05:30 PM (second shift) documented five staff members participated and indicated no residents were evacuated. No resident names or resident roster was provided. Log documented "did not evacuate" under "time required for evacuation", then documented "residents at dinner. did not evacuate" under evacuation time.

Fire drill log dated 05/12/2025 at 11:00 AM (first shift) documented eight staff members participated and indicated no residents were evacuated. No resident names or resident roster was provided. No evaluation was documented. Log documented "did not evacuate" under "time required for evacuation".

Fire drill log dated 04/09/2025 at 05:30 AM (third

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A2040	Continued From page 4	A2040		

shift) documented six staff members participated and indicated no residents were evacuated. No resident names or resident roster was provided. No documentation was noted under "time required for evacuation".

Tornado drill report dated 03/26/2026 at 10:30 AM (first shift) documented ten staff members and "19" residents participated. No resident names or resident roster was provided. Time required for evacuation was documented as "15".

**No other tornado drill logs/report provided for 2026 on 06/03/26.

On 06/02/2026 at 02:37 PM, E2 (Executive Director) said "only one tornado drill per year is required".

On 06/03/2026, E2 provided the following tornado drill logs:

Tornado drill report dated 02/27/2026 at "03:00" (second shift) documented eight staff members participated and "various residents participated". No resident names or resident roster was provided. Time required for evacuation was documented as "16".

Tornado drill report dated 02/26/2026 at "10:46" (third shift) documented six staff members participated and "various residents participated". No resident names or resident roster was provided. Time required for evacuation was documented as "18".

On 06/03/2026 at 12:15 PM, when asked when the community's last life safety code survey was, E1 (Operations Director) said she believed it was in 2023.

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A2040	Continued From page 5 On 06/03/2026 at 3:55 PM, E2 said she is aware that evacuation times should be thirteen minutes or less per life safety/fire codes, then indicated residents should participate in disaster drills and be identified by name. E2 added that residents do have the right to refuse. At 3:58 PM, E2 said the disaster drill logs should include time, date, and shift then indicated she is now aware that three tornado drills should be conducted annually in February on each shift. E2 added that the previous maintenance director "wasn't staying on top of drills". At 4:11 PM, E2 said, "moving forward we will include a resident roster and indicate which residents need assistance". Per (Life Safety) statement of findings dated 07/20/2023 for survey date of 02/09/2023, report documented, " ...there were no records provided to demonstrate the facility meets a slow evacuation capability. The facility did not provide documented timed evacuation drills ... within the required timeframe (13 minutes) with all residents attending except those that are unable due to illness in accordance with the NFPA 101A, 2000 edition sections 32.3.1.2.3 and 3.3.56 ...drills shall provide residents with experience in egressing through all exits ...example drill records shall include timeframe to evacuate, residents and staff attending, narrative of drill ...	A2040		
A2060	Section 295.2060 Quality Improvement Program This Regulation is not met as evidenced by: Type 2 Violation Section 295.2060 Quality Improvement Program	A2060		

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A2060	Continued From page 6 295.2060a)b)1)2) a) The establishment shall establish an effective quality improvement program that encompasses oversight and monitoring, resident satisfaction, and ongoing quality improvement and implementation of any plan that addresses improved quality services. The quality improvement process implemented by the establishment must benchmark performance, be customer centered, be data driven, and focus on resident satisfaction. (Section 30(a) of the Act) For the purpose of this Section, "benchmark" means creating points of reference from which measurements can be made. b) A system shall be in place to facilitate the detection of issues and problems, to expedite the implementation of action, and to resolve problems. 1) Data analysis shall be used to identify and implement changes that will improve performance or reduce the risk of additional events. 2) The establishment shall maintain documentation that shows that data analysis has occurred and that actions, as appropriate, have been implemented to address identified issues and to resolve problems, as well as any follow-up actions taken by the establishment. This regulation is NOT MET as evidenced by: Based on interview and record review, the establishment failed to provide documentation of an effective quality assurance committee or program is in place to detect and resolve any issues or problems. This failure has the substantial probability to affect all residents in the establishment. This failure creates a substantial probability of harm to a resident or residents.	A2060		

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A2060	Continued From page 7 The findings include: On 06/02/2026, requested Quality Improvement plan that includes satisfaction survey documents. Community provided the following document: Quality Assurance & Performance Improvement (undated) policy: Operational Standard: The Quality Assurance and Performance Improvement process will be the focus in all DSL communities to assist in achieving the organizational Mission, Vision, and Values while upholding and maintain industry standards, best practices, policies, procedures, budget adherence, and regulatory requirements. Purpose: Ensure quality excellence for team members, residents and families. Procedure: Communities are to utilize the QAPI (Quality Assurance Performance Improvement) process when reviewing data/information and implementing improvements. QAPI reviews will be completed by the Executive Directors, Department Managers, and team members on a weekly basis utilizing standard forms provided. Site visits will be completed by Home Office and/or Regional Directors quarterly and as needed. Follow up documents from the site visit are to be utilized in the development of performance improvement at the community. The existence, results, and process of a QAPI process cannot be used as evidence in any civil or criminal court proceeding. The result of the QAPI process cannot be the sole basis for citing a violation or regulatory insufficiency. On 06/03/2026 at 3:40 PM, surveyor discussed survey concerns with E2 (Executive Director) and	A2060		

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A2060	Continued From page 8 again requested documentation of the community's Quality Improvement Program. When asked if the community's QI program benchmarks performance, is customer centered, data driven and focuses on resident satisfaction, E2 said "yes" then added that regional directors come in and are a part of this process then send a report after each visit. E2 indicated she would provide documentation of these previous reports. On 06/03/2026 at 05:00 PM, E3 (Director of Nursing) provided a blank "Regional Nurse Manager Site Visit" form(s). No other documents were provided to show the community was meeting the requirement. On 06/04/2026 at 04:21 PM, E2 said "I know [E3-Director of Nursing] gave you quality improvement documents before you left yesterday". No other Quality Improvement Program documents were provided to surveyor other than those mentioned above during the course of survey.	A2060		
A3020	Section 295.3020 Employee Orientation and Ongoing Training This Regulation is not met as evidenced by: Type 2 Violation Section 295.3020 Employee Orientation and Ongoing Training 295.3020a)1)2)3)4)5)6)	A3020		

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A3020	Continued From page 9 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, 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. This regulation is NOT MET as evidenced by: Based on interview and record review, the establishment failed to ensure a new employee completed all the required trainings within ten days of hire per the requirement. This failure has the substantial probability to affect all residents in the establishment. This failure creates a substantial probability of harm to a resident or residents. The findings include: Community provided a staff roster dated 05/27/2026 on 06/02/2026. On 06/03/2026, staff requirements review was conducted on nine staff members with following findings: E8's (Licensed Practical Nurse) employee file and staff roster showed a hire date of 01/09/2026. Review of E8's training logs provided by community during survey showed abuse training was not completed until 05/09/2026 which is past	A3020		

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A3020	Continued From page 10 the ten-day timeframe per the requirement. On 06/03/2026 at 04:21 PM, E2 (Executive Director) said she is aware that new employees are required to complete ten and thirty day trainings within these timeframes per the requirement. E2 indicated she would provide onboarding training documents as these specific training courses are within their onboarding process. On 06/04/2026, E2 provided training documentation for E8 that included resident rights and HIPPA (confidentiality) but did not show that E8's abuse training was completed within ten days of hire.	A3020		
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 295.3030a)b) 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.	A3030		

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A3030	Continued From page 11 This regulation is NOT MET as evidenced by: Based on interview and record review, the establishment failed to ensure a new employee received an initial health evaluation not more than thirty days prior to and no later than thirty days after the employee's initial employment per the requirement. This failure has the substantial probability to affect all residents in the establishment. This failure creates a substantial probability of harm to a resident or residents. The findings include: Community provided a staff roster dated 05/27/2026 on 06/02/2026. On 06/03/2026, staff requirements review was conducted on nine staff members with following findings: E5's (Assistant Director of Nursing) employee file and staff roster showed a hire date of 02/12/2026. Training checklist within file documented her date of hire as 04/20/2026. E5's personnel file did not include an initial health evaluation. On 06/03/2026 at 9:45 AM, E2 (Executive Director) said E5 was hired on 02/12/2024 at the community but then went to work at a sister community in 2025 and became their Director of Nursing. E5 was not happy there and was rehired at current community on 02/12/2026 as ADON but she did not start working until 04/20/2026. E2 added that E5 would require all the new employee requirements including tuberculosis screen, physical, trainings, etc.	A3030		

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A3040	Continued From page 12	A3040		
A3040	Section 295.3040 Health Care Worker Background Check This Regulation is not met as evidenced by: Type 1 Violation Section 295.3040 Health Care Worker Background Check An establishment shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code. (Source: Amended at 36 Ill. Reg. 13632, effective August 16, 2012) This regulation is NOT MET as evidenced by: Based on interview and record review, the establishment failed to provide Illinois Department of Public Health (IDPH) healthcare worker background check documentation, including national sex offender and department of corrections, to show these checks were conducted through IDPH websites prior to date of hire. This failure has the substantial probability to affect all residents in the establishment. This failure creates a substantial probability of severe harm to a resident or residents. The findings include: Community provided a staff roster dated 05/27/2026 on 06/02/2026. On 06/03/2026, staff requirements review was conducted on nine staff members with following findings: Personnel files were reviewed with no IDPH	A3040		

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A3040	Continued From page 13 healthcare worker background check documentation, including national sex offender and department of corrections, found for E6 (Dishwasher), E9 (Certified Nursing Assistant), E10 (Housekeeping), E11 (Dietary Server), E12 (Maintenance) and E13 (Caregiver). The staff authorization forms were signed by each employee prior to their dates of hire, allowing the background checks to be completed. Background check documentation from a private, outside source not affiliated with IDPH were noted in all files except for E12. On 06/03/2026 at 04:21 PM, E2 (Executive Director) said background checks should be done prior to hire, and she will provide the correct background check documentation. On 06/04/2026 at 01:48 PM and 02:07 PM, E2 provided background documentation that was previously reviewed on 06/03/2026. E2 did not provide any results from an IDPH healthcare worker background check, national sex offender, or department of corrections for E6, E9, E10-E13 during course of survey.	A3040		