STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL5106155	A. BUILDING: _____ B. WING _____	C 07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIGO AT ELMHURST (THE)	123 WEST BRUSH HILL ROAD ELMHURST, IL 60126

(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 Survey Conducted # IL202128 - Substantiated VIOLATIONS: 295.2000 a) c) 3) 5) 12) 295.6000 a) 1) 13)	A 000		
A2000	Section 295.2000 Residency Requirements This Regulation is not met as evidenced by: Type 1 Violation Section 295.2000 Residency Requirements a) No individual shall be accepted for residency or remain in residence if the establishment cannot provide or secure appropriate services, if the individual requires a level of service or type of service for which the establishment is not licensed or which the establishment does not provide, or if the establishment does not have the staff appropriate in numbers and with appropriate skill to provide such services. (Section 75(a) of the Act) c) A person shall not be accepted for residency if: 3) The person requires total assistance with 2 or more activities of daily living; 5) The person requires more than minimal assistance in moving to a safe area in an emergency. For the purpose of this Section, minimal assistance means that the resident is	A2000		

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A2000	Continued From page 1 able to respond, with or without assistance, in an emergency to protect themselves, given the staffing and construction of the building; 12) The person requires treatment of stage 3 or stage 4 decubitus ulcers or exfoliative dermatitis; This requirement is not met as evidenced by: Based on record review and interviews, the facility failed to ensure residents are appropriate to live in an assisted living or shared housing environment. This applies to 1 of 3 residents (R1) reviewed for residency requirements in the sample of 3. This failure creates a substantial probability of severe harm to a resident or residents. Findings include: R1's face-sheet showed R1 was admitted on 4/6/26 with diagnoses to include Dementia, Diabetes Mellitus, Alzheimer's Disease and Benign Prostatic Hyperplasia. R1's service plan dated 6/8/26 showed R1 required extensive assist for bathing, dressing, toileting, transfer, ambulation and emergency evacuation. R1's Home Health Progress notes dated 05/27/2026 document R1's pressure injury as a stage 4. R1's Progress notes on 6/1/26 at 3:26 PM showed R1 had a documented Stage III pressure	A2000		

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A2000	Continued From page 2 injury located at the intergluteal cleft. On 6/29/26 at 1:12 PM E3 (LPN-Licensed Practical Nurse) stated since admission, R1 always used wheelchair to ambulate. E3 stated she never saw him walking. He needed extensive assist for all ADLs (activities of daily life) since admission. On 6/29/26 at 1:25 PM E2 (HCC-Healthcare coordinator) stated during the time that R1's wound was getting worse, R1 needed total assist for all ADLs. On 6/29/26 at 1:25 PM, E2 stated the referral to home health was made. But the home health did not start treatment because they were waiting on face-to-face assessment from the physician. E2 stated E2 was on bereavement leave during this time. E2 stated there was no one else as RN (Registered Nurse) to assess the wound. So, no one knew the wound was getting worse.	A2000		
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:	A6000		

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A6000	Continued From page 3 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 labor; This requirement is not met as evidenced by: Based on interviews and record reviews, establishment failed to provide prompt care for resident with wound progression from stage 1 to stage 3 for 1 of 3 residents (R1) reviewed for neglect in a sample of 3. This failure creates a substantial probability of severe harm to a resident or residents. Findings include: R1's face-sheet showed R1 was admitted on 4/6/26 with diagnoses to include Dementia, Diabetes Mellitus, Alzheimer's Disease and Benign Prostatic Hyperplasia. R1's service plan dated 6/8/26 showed R1 required extensive assist for bathing, dressing, toileting, transfer, ambulation and emergency evacuation. R1's progress notes on 4/28/26 at 3:20 PM showed R1 developed a stage 1 ulcer on his sacrum. R1's Progress notes on 4/29/26 at 11:38 AM showed R1's primary physician referred him for wound care home health.	A6000		

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A6000	Continued From page 4	A6000		

R1's Progress notes on 5/22/26 at 4:20 PM showed the wound care nurse from Home Health arrived at the facility but did not evaluate the patient pending physician signature on the order form for insurance verification and treatment authorization.

R1's Progress notes on 5/25/26 at 3:28 PM showed home health nurse started treatment on the wound with the Santyl and calcium alginate. Home health nurse would visit the resident on Mondays, Wednesdays and Fridays for treatment.

The above progress notes showed there was a gap of almost a month between the physician's referral and the actual treatment to begin.

R1's Progress notes on 6/1/26 at 8:19 AM showed the wound was malodorous and redness noted around wound bed. R1's Physician ordered to send R1 to the hospital for wound debridement and intravenous antibiotics.

R1's Progress notes on 6/1/26 at 3:26 PM showed R1 had a documented Stage III pressure injury located at the intergluteal cleft.

R1's Progress notes dated 6/5/26 at 9:58 PM showed R1 returned to the establishment after wound debridement. Home Health nurse to continue visits 3 days a week for wound treatment and the establishment nurse to change the dressings as needed.

R1's Progress notes on 6/24/26 at 10:18 PM showed R1 was re-hospitalized for decreased responsiveness & lethargy.

On 6/29/26 at 1:12 PM, E3 (LPN-Licensed

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A6000	Continued From page 5 Practical Nurse) stated on admission R1 had no wound and that the current wound was facility acquired. E3 stated she never saw R1 walking and that he was always on his wheelchair. On 6/29/26 at 1:25 PM, E2 (HCC-Healthcare coordinator) stated the referral to home health was made. But the home health did not start treatment because they were waiting on face-to-face assessment from the physician. E2 stated she was on bereavement leave during this time. E2 stated there was no one else as RN (Registered Nurse) to assess the wound. So, no one knew the wound was getting worse.	A6000		