STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510139	A. BUILDING: _____ B. WING _____	C 07/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER GLEN OF ST CHARLES	975 NORTH 5TH AVE SAINT CHARLES, IL 60174

(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 IL202150 295.2050a)b)c) 295.4010e)	A 000		
A2050	Section 295.2050 Incident and Accident Reporting This Regulation is not met as evidenced by: Type 2 Violation 295.2050a)b)c) Section 295.2050 Incident and Accident Reporting a) An establishment shall report to the Department any serious incident or accident. For the purposes of this Section, "serious" means any incident or accident that causes physical or emotional harm or injury to a resident. A change in an individual's (resident's) condition that is due to health or medical decline is not a reportable incident or accident. b) The report shall be made by contacting the Department of Public Health Division of Assisted Living via email at DPH.LTCAL@illinois.gov or as requested by the Department within 24 hours after the occurrence of the incident or accident. c) A copy of the report shall be maintained by the establishment for one year after the date of	A2050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510139	A. BUILDING: _____ B. WING _____	C 07/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER GLEN OF ST CHARLES	975 NORTH 5TH AVE SAINT CHARLES, IL 60174

(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
A2050	Continued From page 1 the incident or accident. These requirements were not met, as evidenced by: Based on interview and record review, the establishment failed to report a fall with injury and failed to report an injury of unknown origin within 24 hours for 1 of 3 residents (R1) reviewed for accidents and injuries in the sample of 3. This failure creates a substantial probability of harm to a resident or residents. The findings include: 1. On 7/8/26 at 12:43 PM, E4, Licensed Practical Nurse (LPN), said R1 was weak and had some liquid stool. As the resident assistant (RA) was cleaning up R1's bathroom, R1 fell. E4 said no one actually saw R1 fall, but E5, Maintenance Coordinator, heard the fall and contacted E4. E4 said she went to R1's room and he was on the floor right outside his doorway in the hall. E4 said she cannot remember all the details, so whatever she wrote in her note is what happened. E4 said they do neuro checks when a resident has a fall with a head injury and she would have called the family and sent the resident to the hospital, unless the family declined. E4 said she believes E2, Healthcare Coordinator/Registered Nurse (RN), was still in the building that day and was informed about R1's fall. E4 said R1 used a walker to ambulate. E4 said R1 was not able to tell how or why he fell; he was alert and oriented to person only, he was not able to make his needs known, and he didn't even know he had been incontinent of the liquid stool and needed to be cleaned up.	A2050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510139	A. BUILDING: _____ B. WING _____	C 07/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER GLEN OF ST CHARLES	975 NORTH 5TH AVE SAINT CHARLES, IL 60174

(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
A2050	Continued From page 2 On 7/8/26 at 11:05 AM, E3, Memory Care (RN) and Assistant Director of Nursing (ADON), said R1 fell on the evening shift on 5/14/26. The next morning, 5/15/26, R1 could not safely take his morning medications because he was so lethargic; she could not rouse him enough to take his medications. E3 said they were doing neuro checks because he hit his head on the PM shift fall on 5/14/26. On 7/8/26 at 1:34 PM, E2 said neither of R1's falls on 5/14/26 were reported to IDPH. R1's Progress Notes dated 5/14/26 at 6:42 PM show R1 was incontinent of stool, the RA took him to his room and as the RA was cleaning up the mess, R1 stood on his own, started walking out of his room and fell. E5 heard R1 fall and scream. Three staff members assisted R1 off the floor. A lump with hematoma was forming to the back on R1's head. Neuro checks were initiated. R1's emergency contact was notified but only wanted R1 monitored and would call back if he decided to send R1 to the hospital for an evaluation. R1's Service Plan dated 3/19/26 shows R1 has orders for Apixaban (a "blood thinner") to be given twice a day. The establishment's Incident & Accident Reporting Policy (effective/revised 10/1/22) shows an accident that has a significant negative effect on the health, safety or welfare of a resident shall be reported to the Department. 2. On 7/8/26 at 12:43 PM, E4 said R1 was having excruciating abdominal pain which wouldn't go	A2050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510139	A. BUILDING: _____ B. WING _____	C 07/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER GLEN OF ST CHARLES	975 NORTH 5TH AVE SAINT CHARLES, IL 60174

(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
A2050	Continued From page 3	A2050		

away, so she sent him to the hospital (on 5/19/26). E4 said the hospital found that R1 did have gallstones, but he also had spinal fracture. E4 said she doesn't know if R1's spinal fracture was old or new because he never had back pain.

On 7/8/26 at 10:15 AM, E2 said R1 had gallbladder issues. E2 said when R1 had gallbladder attacks, he would have uncontrollable crying and would vomit phlegm. E2 said R1 went to the Emergency Room (ER) [on 5/19/26]. E2 said they were working R1 up for gallbladder surgery when they saw a compression fracture on R1's vertebrae (T9). On 7/8/26 at 1:34 PM, E2 said R1's T9 fracture was considered an injury of unknown origin, and she knew about R1's T9 fracture within a day or two of hospitalization. E2 said she should have reported it to the state 5/20/26. E2 said any fracture needs to be reported to the state within 24 hours.

R1's Progress Notes dated 5/19/26 at 10:30 PM show R1 was yelling and sobbing with complaints of abdominal pain. Pain medication was given and a heat pack was applied with no relief. R1 was sent to the hospital as it could be his gallbladder. R1's Progress Notes dated 5/20/26 at 6:41 AM show R1 was admitted to the hospital with a T9 fracture. R1's Progress Notes dated 5/20/26 at 5:01 PM (documented by E2) show R1's abdominal CT scan revealed a T9 fracture.

R1's Internal Investigation shows a summary of findings for R1 from 5/19/26 to 5/28/26. The report shows it was reported to the state on 6/2/26 at 4:00 PM. R1's "5-19-26 Confirmation of final reportable" shows an initial report was not conducted.

The establishment's Abuse, Neglect, and Injuries

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510139	A. BUILDING: _____ B. WING _____	C 07/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER GLEN OF ST CHARLES	975 NORTH 5TH AVE SAINT CHARLES, IL 60174

(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
A2050	Continued From page 4 of Unknown Sources Policy (effective/revised 3/15/22) shows it is the policy of the community to report injuries of unknown sources as required by applicable law.	A2050		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 2 Violation Repeat Violation 295.4010e) Section 295.4010 Service Plan 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). These requirements were not met, as evidenced by: Based on interview and record review, the establishment failed to update a resident's service plan after two falls for 1 of 3 residents (R1) reviewed for accidents and injuries in the sample of 3. This failure creates a substantial probability of harm to a resident or residents. The findings include:	A4010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510139	A. BUILDING: _____ B. WING _____	C 07/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER GLEN OF ST CHARLES	975 NORTH 5TH AVE SAINT CHARLES, IL 60174

(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 5 On 7/8/26 at 11:05 AM, E3, Memory Care (RN) and Assistant Director of Nursing (ADON), said R1 scooted off his chair and sat on the floor at 3:45 PM (on 5/14/26) so it was technically not a fall, but a scoot. E3 said she knows it was not a fall by the way R1 was sitting and the way the footrest was angled, although it was not witnessed. E3 said the RA had checked on R1 ten minutes prior to finding him on the floor. E3 said R1 fell again on the evening shift on 5/14/26. The next morning, 5/15/26, R1 could not safely take his morning medications because he was so lethargic; she could not rouse him enough to take his medications. E3 said they were doing neuro checks because he hit his head on the PM shift fall on 5/14/26. On 7/8/26 at 12:43 PM, E4, Licensed Practical Nurse (LPN), said R1 was weak and had some liquid stool (on 5/14/26). As the resident assistant (RA) was cleaning up R1's bathroom, R1 fell. E4 said no one actually saw R1 fall, but E5, Maintenance Coordinator, heard the fall and contacted E4. E4 said she went to R1's room and he was on the floor right outside his doorway in the hall. E4 said she cannot remember all the details, so whatever she wrote in her note is what happened. E4 said they do neuro checks when a resident has a fall with a head injury and she would have called the family and sent the resident to the hospital, unless the family declined. E4 said she believes E2, Healthcare Coordinator/Registered Nurse (RN), was still in the building that day and was informed about R1's fall. E4 said R1 used a walker to ambulate. E4 said R1 was not able to tell how or why he fell; he was alert and oriented to person only, he was not able to make his needs known, and he didn't even know he had been incontinent of the liquid stool and needed to be cleaned up.	A4010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510139	A. BUILDING: _____ B. WING _____	C 07/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER GLEN OF ST CHARLES	975 NORTH 5TH AVE SAINT CHARLES, IL 60174

(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 6 On 7/8/26 at 1:34 PM, E2 said she does the service plans. E2 said service plans are done on admission, annually, and with a change of condition. R1's Progress Notes dated 5/14/26 at 3:31 PM show the RA found R1 on the floor in front of his recliner. R1's Progress Notes dated 5/14/26 at 6:42 PM show R1 was incontinent of stool, the RA took him to his room and as the RA was cleaning up the mess, R1 stood on his own, started walking out of his room and fell. E5 heard R1 fall and scream. Three staff members assisted R1 off the floor. A lump with hematoma was forming to the back on R1's head. Neuro checks were initiated. R1's emergency contact was notified but only wanted R1 monitored and would call back if he decided to send R1 to the hospital for an evaluation. R1's Progress Notes dated 5/19/26 at 10:30 PM show R1 was yelling and sobbing with complaints of abdominal pain. Pain medication was given and a heat pack was applied with no relief. R1 was sent to the hospital as it could be his gallbladder. R1's Progress Notes dated 5/25/26 at 2:58 PM show R1 returned from the hospital with a T9 vertebral fracture and will be on hospice. R1's Service Plan dated 3/19/26 shows R1 is a fall potential and requires staff to supervise transfers and ambulation and R1 should not be left in his apartment alone unless he is going to bed as he is not safe alone in his apartment. No updated fall interventions were added to R1's service plan after he fell twice on 5/14/26 until he returned from the hospital on hospice care due to a change in condition on 5/25/26.	A4010		