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A 000	Initial Comment Facility Reported Incident Investigation: Facility Reported Incident of May, 07, 2026/IL201883 - 295.4010a)3)c), 295.4060a)c)f), 295.2050a)b)c) Facility Reported Incident of May, 24, 2026/IL202179 - 295.4010a)3)c), 295.4060a)c)f), 295.2050a)b)c)	A 000		
A2050	Section 295.2050 Incident and Accident Reporting This Regulation is not met as evidenced by: TYPE 2 VIOLATION 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 the incident or accident. These REQUIREMENTS were not met as evidence by:	A2050		

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A2050	Continued From page 1 Based on interview and record review, the establishment failed to report an incident of unknown injury to Illinois Department of Public Health (IDPH) within 24 hours of the incident/accident for one (R1) of five residents reviewed for reporting.This failure creates a substantial probability of harm to a resident or residents. Findings include: R2 is an 84-year-old female, with move in date of 03/02/2026 with diagnosis that include Dementia in other diseases classified elsewhere, unspecified severity, with behavioral disturbance, Vitamin D deficiency, Hyperlipidemia, unspecified, Atherosclerosis of aorta, Unspecified dementia, unspecified severity, with psychotic disturbance, Major depressive disorder, recurrent, Fall on same level, unspecified, initial encounter, Interstitial cystitis (chronic) without hematuria, Weakness, Pain in other specified joint R2 currently resides in facility. Initial facility reported incident submitted to IDPH on 5/26/2026 by E2, Health Service Director documents in part: Incident/Accident Date 5/24/2026 Accident/Incident Time 3:10pm R2 is alert and oriented to self, ambulates with contact guard assist, has private caregiver 24/7. On 5/24/2026 the private caregiver reported to the nurse about a bruise that he noticed to the resident's right buttock and right thigh. No recent falls reported. Investigation on-going. Final report to follow. E18, Private Caregiver text notes document in part on 5/21/2026 PM shift 8:30pm change her	A2050		

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pull ups, and private caregiver sees her bruises. So caregiver started to read notes and ask about the bruises and no fall reported. 6:00am just work up ...went to pee. grooming, and change her clothes and pull ups ...and report the bruises to the nurse. When E19, Private Caregiver arrives, we took a picture and reported it to E17 and send the picture to her

Nurses Progress note dated 5/24/2026 at 8:17pm by E5 Incident documents in part 05/24/2026 Incident The private caregiver reported in the dining room today at approximately 11:30 AM that the resident (R2) has bruising on the right buttock and right thigh areas of unknown origin. This writer assessed the resident at approximately 3:10 PM. Skin assessment was completed, observed old healing purplish bruising with yellow discoloration along the edges on the right buttock, coccyx/tailbone area, right lateral thigh extending down to the right lower leg, and purplish bruise on the right calf. The resident was asked to lift and bend the right leg to assess for pain, the resident responded by shaking her head side to side, indicating no pain. No facial grimacing noted. The resident was able to ambulate without difficulty, and no limping was noted. Approximate measurement of bruised areas are as follows: right buttock:14 cm x 17 cm; right lateral thigh: 9 cm x 12.5 cm; right calf: 26 cm x17 cm. All the responsible parties were notified. Per HSD, an investigation will be conducted. Investigation was started immediately, initial incident report was faxed to IDPH.

On 6/12/2026 at 4:30pm E6, LPN stated in part she is familiar with R2, but she was not here when bruises were found. E6 stated resident skin is assessed two times per week during shower days and when caregiver brings it to our attention

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then we assess at that time. Facility told family she had to have a caregiver so the day she moved in she had a private caregiver assigned to her. The facility staff is supposed to still provide care to the residents. Private caregiver has to let us know what is going on and if they need help, we need to assist and check on R2 every 2 hours. The private and facility caregiver will tell us about any concern. R2 was a fall risk reason why they assigned her a 1:1. E6 has not seen behavior since she moved in. R2 tends to walk around, she is hand to hand or stand by. She cannot follow directions and rambles words. E6 stated nurses complete an incident report and says what happened but E2 does reporting to the state.

On 6/13/2026 at 9:44am E4, Licensed Practical Nurse stated in part I am familiar with R2. R2 has a 24-hour caregiver, and we assist with the shower and other than that everything is taken care of by the personal caregiver. The nurses give her medication and that is it. The personal caregiver does everything for her. E2 showed me the bruises. E4 stated, she had no idea how R2 got the bruises. R2 has not had any recent falls. Nobody told me she had bruises. E4 stated she worked on 5/21/2026 and she did not get report of any bruises. E2 asked me if somebody reported to me that R2 had bruises. E2 showed me all the bruises she had. The caregiver is supposed to report any bruises to us, and we check and call the family, the doctor and let E2 know.

On 6/13/2026 at 10:30am E5, LPN stated she is familiar with R2, and she was her nurse the day the bruises were found and one of the private caregivers reported it to me. The private caregiver stated he noticed bruise on resident,

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and E5 asked when he noticed, and he said he reported it to another nurse but E5 does not remember the day that he reported. E5 stated she checked the bruising and saw some old bruising on right lower leg on the back area tailbone and side of the thigh right and back of right leg could see bruising. E5 do not remember seeing bruising on her before. On shower days we are supposed to look at her skin, E5 does not know her shower days. E5 stated she told E2, and the name of the private caregiver. E5 told E2 that day and E1 was aware that day. E5 stated she takes care of R2 when she works. E5 asked the caregiver how she was that morning and he stated he notice bruises and he said on the back and thigh area and after med pass E5 went to check he resident and asked the caregiver if he dressed the resident and he said when he received the resident she was dressed and E5 saw the bruising was down the lower leg and tailbone. She does remember asking the facility caregivers if they saw any bruising. The caregiver said the resident was already dressed up. E5 did not know if they dressed her early.

On 6/13/2026 at 1:24pm E1 stated, R2 showers are completed by private caregivers and facility caregivers. Caregivers do not always tell us when they render care. There has been some miscommunication with this care group. When we found the bruising, the private caregiver called our nurse to come look at it. The bruising looked rashy and labs were drawn. Private caregivers typically report to E17, Care Coordinator for Home Health and our nurse and E17 communicates with E2. E17 did not report any bruise for R2. They should have reported to the facility and told their supervisor. E1 stated incident reports within 24-hour report to the state. If it is the weekend E2 is not here we try to do it

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as soon as possible, immediately. E2 sends in the reportable. E1 further stated we follow the regulation for reporting.

On 6/14/2026 at 7:50am E2, Health Services Director/LPN stated in part he puts in reportable and if he is not around E1 will send report to the state. Staff do not put in reportable. If it is reportable E2 gets information about what happened and have internal incident report that the nurse on duty fills out. Regarding R2 we do not know how she got bruises. Private caregivers should report anything to the nurse. They reported when there were big bruises on the buttock, the thigh and the right leg. There was no report of a fall so do not know how it happened. The nurse should do an immediate assessment, but E2 thinks the nurse forgot to do it and when she came back the next day, she did an assessment and saw the big bruises. The day nurse was E5, and night nurse was E20, LPN when it was reported by the private caregiver to E5. She passed on the report of the bruise to E20, and she should have followed up. The nurse is supposed to assess the resident at the time the bruise was reported. No one knows how the bruise got there. Someone should know how she got the bruise. The private caregivers sent group chat to includes manager and said when reported to the nurse. E2 did not speak with each private caregiver but the manager (E17) did the investigation with each private caregiver and just gave me the report and no one knows how R2 got the bruise.

Facility policy

On 6/14/2026 at 4:47pm per E1 email we follow the IDPH guidelines. IDPH Administrative Code-Incident & Accident Reporting-section

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A2050	Continued From page 6 295.2050	A2050		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: TYPE 1 VIOLATION 295.4010 Service Plan a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the Act) The establishment shall respect and accept the resident's choices regarding the service plan. 3) A registered nurse, if the resident is receiving nursing services or medication administration, or is unable to direct self-care. c) The service plan shall be signed and dated by all individuals involved in its development. This REQUIREMENT was not met as evidenced by: Based on observation, interview and record review, the establishment failed to follow a resident's service plan to keep two (R1, R2) of five residents in a safe supervised environment while residing in the facility and failed to ensure two (R4, R6) of four residents were transported	A4010		

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via wheelchair in a safe manner. These failures resulted in R1 sustaining a fall and transported to local hospital and diagnosed with brain herniation and hematoma and R2 sustaining unknown bruising to right side of waist and down leg. These failures have the potential to affect all 66 residents residing at the facility. This failure creates a substantial probability of severe harm to a resident or residents.

Findings include:

R1 was an 81-year-old female, with move in date of 12/31/2025 with diagnosis that include acute respiratory failure with hypoxia, Acute bronchitis, unspecified, Atherosclerotic heart disease of native coronary artery without angina pectoris, Contusion of other part of head, subsequent encounter, Essential (primary) hypertension, Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, Other abnormalities of gait and mobility, Muscle weakness (generalized), Hyperlipidemia, unspecified, Anxiety disorder, unspecified

R1 was transferred to hospital on 5/7/2026 and did not return to facility.

Initial facility reported incident submitted to IDPH on by E2, Health Service Director documents in part: Incident/Accident Date 5/07/2026 Accident/Incident Time 2:00pm The resident can propel self-using standard wheelchair requires stand by assist with transfers, AOX 1-2. The resident was observed lying supine on the bathroom floor. Upon assessment, bump was felt on the back of the head. 911 called. Description of Action Taken by establishment as Result of Incident/Accident: 911 was called, the resident

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was taken to local hospital emergency department for evaluation. The resident admitted. Diagnosis brain herniation and hematoma

R1's service plan dated 2/15/2026 documents in part: Need: Transferring: ADL Services Area: Transferring Goal: Resident will maintain and/or maximize current level of functioning with transferring Action: Gait belt, Transferring: Partial Assist Care staff to provide transfer assistance from wheelchair to the toilet and vice versa. Care staff to use gait belt for transfers.
12. Need: Toileting Goal: Resident will maintain and/or maximize current level of functioning with toileting Action: R2 is continent of bladder and required partial assistance to use the bathroom.

Registered Nurse signature and date omitted from R1's care plan

R1 05/07/2026 02:52:27 PM Incident note by E4 documents in part, the resident had unwitnessed fall, resident was observed lying supine in the bathroom floor. Upon assessment, a big bump was felt at the back of the head. 911 was called. and sent the resident to local hospital for further evaluation

R1 05/07/2026 09:24:19 PM Nursing note by E4 documents in part, Resident got admitted to local hospital Dx brain herniation and hematoma

R1 05/08/2026 10:06:39 PM Incident note by E2 documents in part, The resident was observed lying supine in the bathroom floor. Upon assessment, a big bump was felt at the back of the head. 911 was called.

R1 05/08/2026 02:33:07 PM Family Communication note by E2 documents in part,

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received a call from the POA reporting that the resident is going to be admitted to hospice in-house at the hospital. The POA reported that the doctor gave the resident at least 24 hours to live. The POA was requested to notify the community of the residents' passing should it occur within 24 hours. The ED was notified of the residents' status. Incident report was sent to IDPH.

On 6/12/2026 at 2:16pm E3, Caregiver stated, she was familiar with R1, and she was her caregiver on 5/7/2026. E3 stated honestly, she was not in the building but when she returned from her break, she heard a noise/squeak or someone calling for help, and she went into R1's room and she was on the floor. E3 called for help and E2 came running and he told me not to yell down the hall and E3 called E4, and she came to assess her and notice the bump on her head. There was no blood, but you could feel around the bump. R1 said she tried to go to the bathroom, and she slipped. The wheelchair was in front of her when E3 opened the door, off to the wall and resident was laying close to door, feet towards the door. E4 said to put pressure on the wound. I put pressure on the wound, and the paramedics were called immediately and R1 said she just wanted to go to bed and she said, "Oh my head hurts". She had a colostomy; E3 was not sure why she was going to bathroom. She was escorted to and from meals and kept her with me and she would do activities. E3 stated she would physically pick her up. When E3 took care of her E3 took her to the bathroom. Some days she had strength and some days she did not. E3 believes she was a high fall risk and E3 was not sure if R1 had pendant on. E3 stated she remembers them saying the alert system went off to alert staff that something happened to her. It happened between

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A4010	Continued From page 10 1:00pm -1:30pm. R1 was alert and talking and had lunch. R1was able to participate in activities. When we tried to get her up, she said, "Oh my head hurts". She had a roommate. E3 never saw R1 walk by herself. The nurse will let us know or our coordinator will update up about service plan changes. Nurse comes in to do skin check on shower day. R3 pretty much stays in her chair. Every time we check her she is soaked and wet. She drinks a lot and always complains that her wrist hurts, her back hurts. She does not want to go into the bathroom. She wears an overnight pad and wears slippers with her big socks. She gets wet several times a day. R3, knows when she needs to go to the bathroom. Always complain of pain. Left wrist is usually swollen. E3 stated she pushes residents in wheelchairs, and some have footrest, and some do not. We will tell them to lift their feet and if they can, we will push them; if they cannot lift feet, we use footrest. On 6/12/2026 at 5:13pm E15, Caregiver stated she was familiar with R1 and was working on the day R2 fell. E15 did not know R1 fell until the paramedics came because E15 was with her residents. E15 stated she is not sure who was in the Bistro, she does not know if anyone was in there. E15 further stated she is not saying no one was in there but she cannot remember if anyone was. E15 stated she was not in the bistro. R1 fell while in her room. E15 did not know she fell until she walked past her room and saw paramedics there and did not know how serious it was. Caregivers let us know when they are going on break. E15 asks the nurse if the nurse says ok and they ask who is in the bistro. E15 lets both caregivers know when she is going on break. If the other caregiver is not there, we must let at least one caregiver and nurse know we are leaving. Both caregivers are responsible for the	A4010		

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other caregivers' residents, which is why we have to let them know we are going on break and keep an eye on residents. E15 could not recall if E3 told her. E15 did not hear her, but she definitely was not aware that she was on break and only one caregiver can go on break at a time. E15 did not know if E16 was on break she could have been on break or taking her residents to bathroom. E15 stated she thinks she heard that E16 was on break sitting in her car. E15 stated she takes her breaks late. But E15 knows two of us are not supposed to be on break at the same time. We must punch out if we are leaving outside the building. E15 had no idea who was in the bistro, E15 was taking residents to the bathroom, and she cannot remember if anyone else was in there. When one caregiver has to step out of the bistro someone has to be there. R1 was a fall risk, and we never saw her walk and when she gets up always have to help her. She could not get up by herself she would have to wheel herself and at times she had trouble getting herself up. E15 does not think she would try to walk by herself. She was alert and would crack jokes and able to let us know she had to go to the bathroom and did not have accidents.

On 6/13/2026 at 9:44am E4, LPN stated she is familiar with R1, and she was the nurse the day R1 fell on 5/7/2026. E4 stated she received a call from E3 caregiver that R1 fell. E4 found R1 laying back on her back yelling, E4 checked everything and found a big bump on the back of her head and E4 called 911 and sent her out to the ER (Emergency Room). R1 said she fell trying to go to the bathroom. R1 had a wheelchair and sometimes would call for help and sometimes she would not. She was dressed and wearing shoes and we found her by the bathroom door. E4 stated she did not hear the electronic room

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monitor go off. R1 goes to her room after she eats, she likes to be in her room. The caregiver was on her break and when she was coming back, she saw her on the floor. The caregivers are supposed to be in the activity area; they are supposed to watch her. E3 told me she was going on break. The caregivers communicate with each other too. E4 did not ask E3 if she told other caregivers she was going on break. E4 stated she was busy charting, and she did not know if other caregivers were in bistro. E3 did not tell me where R1 was prior to her leaving for break. Usually she says, but E4 does not remember if she told me. R1 was able to talk but said her head hurt. R1 would help with transferring but we don't trust her all the time. E4 found out R1 fell because E3 told me, E4 did not hear the room alarm go off. E4 does not know how long R1 was on the floor. Residents are to be supervised when in the Bistro. The caregivers should know when residents leave the Bistro. We try to keep the residents in the common areas but sometimes they insist they want to be in their room, especially R1. E4 documented how she found her and completed the facility incident report. E4 asked the other caregivers if anyone saw her and nobody saw R1 leaving the bistro.

On 6/15/2026 at 1:33pm E16, Caregiver stated, she had R1 right in the beginning when she first started working at facility. Normally R1 is in her room. E16 remembers hearing about R1 from the nurse. E16 remembered hearing the ambulance come but she did not know what resident. E16 thinks she was on break at the time of the fall. E16 thinks she told E6 the nurse she was going on break. When we take our 30-minute break we let the nurse know and the other two caregivers are not allowed to go at the same time. When you return, we have to let the

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nurse know you are back. The caregivers see them come back. E16 did not remember E3 being on break and did not know she was on break at the same time as E16. E16 does not remember F3 telling caregivers she was going on break.

R2 is an 84-year-old female, with move in date of 03/02/2026 with diagnosis that include Dementia in other diseases classified elsewhere, unspecified severity, with behavioral disturbance, Vitamin D deficiency, Hyperlipidemia, unspecified, Atherosclerosis of aorta, Unspecified dementia, unspecified severity, with psychotic disturbance, Major depressive disorder, recurrent, Fall on same level, unspecified, initial encounter, Interstitial cystitis (chronic) without hematuria, Weakness, Pain in other specified joint

R2 currently resides at facility.

Initial facility reported incident submitted to IDPH on 5/26/2026 by E2, Health Service Director documents in part: Incident/Accident Date 5/24/2026 Accident/Incident Time 3:10pm R2 is alert and oriented to self, ambulates with contact guard assist, has private caregiver 24/7. On 5/24/2026 the private caregiver reported to the nurse about a bruise that he noticed to the resident's right buttock and right thigh. No recent falls reported. Investigation on-going. Final report to follow.
Final facility reported incident submitted to IDPH documents in part, conclusion based on the information gathered, the bruise remains of unknown origin. The investigation found no evidence of abuse, neglect, or fall contributing to the injury. The bruise appears to be an isolated finding with no identified cause at this time.

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A4010	Continued From page 14 R2 service plan dated 3/6/2026 documents in part, Need Neurocognitive Goal Resident will maintain and/or maximize current level of functioning with orientation Action Orientation: Moderate Impairment R2 has current or history of occasional disorientation to place, time or situation even in familiar surroundings and requires supervision and oversight for safety 04. Mobility/Ambulation Resident will maintain and/or maximize current level of functioning with mobility/ambulation Mobility/Ambulation: Extensive Assist R2 has unsteady gait and impaired balance Currently R2 requires assistance with all ambulation with contact guard assistance. R2 is currently receiving one on one care for safety. 05. Escorts Resident will maintain and/or maximize current level of functioning with escorts Escorts: Extensive Assist R2 is currently receiving one on one care for safety. R2 requires escort to all ambulation using standard wheelchair and contact guard assistance at all times. Safety and Risk Resident will be monitored for safety in their environment. Spot Checks R2 will receive spot checks round the clock. Registered Nurse signature and date omitted from R2's care plan R2 progress note dated 5/24/2026 at 8:17pm by E5 Incident documents in part 05/24/2026 Incident The private caregiver reported in the dining room today at approximately 11:30 AM that the resident (R2) has bruising on the right buttock and right thigh areas of unknown origin. This writer assessed the resident at approximately 3:10 PM. Skin assessment was completed,	A4010		

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A4010	Continued From page 15 observed old healing purplish bruising with yellow discoloration along the edges on the right buttock, coccyx/tailbone area, right lateral thigh extending down to the right lower leg, and purplish bruise on the right calf. The resident was asked to lift and bend the right leg to assess for pain, the resident responded by shaking her head side to side, indicating no pain. No facial grimacing noted. The resident was able to ambulate without difficulty, and no limping was noted. Approximate measurement of bruised areas are as follows: right buttock:14 cm x 17 cm; right lateral thigh: 9 cm x 12.5 cm; right calf: 26 cm x17 cm. All the responsible parties were notified. Nursing note E21, LPN, 05/25/2026 11:15:50 PM Writer and caregiver E22 explained to one on one that the resident's door cannot be barricaded and that the nurses and caregivers should have access at all times. Writer also explained that the residents' safety is very important and if they are observed sleeping it will be reported to upper management. Care and monitoring ongoing. Nursing note E20, LPN at 05/25/2026 05:43:52 documents in part Alert Charting - Other- bruising on right buttock/tailbone/right lateral thigh/ right lower extremity. Resident sleeping with no c/o pain and discomfort to right buttock, tail bone, right lateral thigh, right lower extremity, will continue to monitor. On 6/12/2026 at 1:27pm E13, R2's Private Caregiver stated he takes care of R2 all the time and her private caregivers are always with her, we never leave her. When we go to lunch, we have to have another caregiver with her or the nurse. E13 stated wherever she goes we go with her. She had not bumped into anything, and he did not see the bruises when it first happened.	A4010		

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She had a bruise that went down her leg. It was like a rash and patches. R2 will cooperate but you have to constantly redirect her and walk with her. We do all of her care, but we do not give her showers, The facility staff will give her showers twice a week. R2 was dressed, groomed, wearing shoes and sitting on couch. R2 fidgety and babbles words but unable to follow direction or answer questions.

On 6/12/2026 at 4:30pm E6, LPN stated, I am familiar with R2 but was not here when bruises were found. Resident skin is assessed two times per week during shower days and when caregiver brings to our attention then we assess at that time. Facility told family she had to have a caregiver so the day she moved in they assigned her a private caregiver. R2 has private caregivers but our staff still have to provide care for her. Every 2-hour checks, private caregiver has to let us know what is going on and if they need help. We need to assist and check on her every 2 hours. The caregiver will tell us about any concern. R2 was a fall risk reason why they assigned her a 1:1. R2 tends to walk around she is hand to hand or stand by. She cannot follow directions and rambles words.

On 6/12/2026 at 5:13pm E15, Caregiver stated she was familiar with R2. She has a caregiver but E15 was not aware on shower days we were supposed to shower her, and she has never done that when she had her. E15 stated E2 told me today we are supposed to shower her, and they are just the private caretaker. When E15 was her caregiver, she did not do anything. E15 thought the caregiver did everything for her. E15 only watched her if caregiver had to go to the bathroom. We check on our residents every 2 hours, which is as often as we would change

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them. E15 did not check on R2 every 2 hours because she thought the caregivers took care of her. E15 thought it was their job to take care of her. The 1:1 caregiver tells the nurse if anything happened to R2 but E15 has never seen any bruises on her, but she is always dressed.

On 6/13/2026 at 9:44am E4, LPN stated she is familiar with R2. R2 has a 24-hour caregiver, and we assist with the shower and everything else is taken care of by the personal caregiver. The nurses give her medication and that is it. The personal caregiver does everything for her. E2 showed me the bruises, and E4 told E2 she had no idea how she got the bruises. R2 had not had any recent falls. Nobody told me she had bruises. E4 worked on 5/21/2026 and she did not get report of any bruises. E2 asked me if somebody reported to me that R2 had bruises. E2 showed me all the bruises she had. The caregiver is supposed to report any bruises to us, and we check and call the family, the doctor and let E2 know.

On 6/13/2026 at 10:30am E5, LPN stated she is familiar with R2. She was her nurse the day the bruises were found and one of the private caregivers reported it to her. The private caregiver stated he noticed bruises on resident, and E5 asked when he noticed it, and he reported it to another nurse but E5 does not remember the day that he reported. E5 check the bruising and saw some old bruising on right lower leg on the back area tailbone and side of the thigh right and back of right leg could see bruising. E5 do not remember seeing bruising on her before. On shower days we are supposed to look at her skin, E5 does not know her shower days. E5 told E2 and the name of the private caregiver. E5 stated she told E2 that day and E1 was aware that day.

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E5 takes care of R2 when she works. Any skin issues E5 will ask the caregiver about skin issues. E5 asked the caregiver how she was that morning, and he stated he noticed bruises and he said on the back and thigh area. After med pass E5 went to check R2 and asked the caregiver if he dressed the resident and he said when he receive the resident she was dressed. E5 saw the bruising was down the lower leg and tailbone. E5 stated she does remember asking the facility caregivers if they saw any bruising. The caregiver said R2 was already dressed up. E5 does not know if they dress her early.

On 6/13/2026 at 1:24pm E1 stated, R2 showers are completed by caregivers and facility caregivers. Caregivers do not always tell us when they render care. There has been some miscommunication with this care group. If a resident refuses shower, we typically reschedule shower that day or next day. R2 was pm showers and now changed to am showers. When we found the bruising, the private caregiver called our nurse to come look at it. The bruising looked rashy and labs were drawn. Possible R2 could have bumped into something because she has an unsteady gait. R2 has had a caregiver almost from the beginning. In this case the private caregiver dresses her and does all ADL care. E1 stated she can't really answer why facility caregivers do not see her skin. We have a service plan for her. Typically, we work with private care teams, and we work together. The service plan should still be followed. Clearly a miscommunication between them and caregivers. Private caregivers typically report to E17 (Care Coordinator for Home Health) and our nurse and E17 will communicate with E2. E17 did not report any bruising for R2. They should have reported to the facility and told their supervisor. R2 has no

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body awareness. E2 and E1 did investigation. We spoke to private caregivers. She does use a wheelchair at times, but the caregivers put her in the chair, this was one of the theories. Bruising did not appear to be any type of blunt trauma. We did not suspect any abuse of that kind. Behind the closed door would not know if R2 bumped into something, it would have to be reported for us to know. The service plan is to be enacted even with a private caregiver, but with the private caregiver doing tasks, we are at a little bit of a disadvantage. The same private caregivers for the most part. The private caregivers seem to be very caring. No concern with any of the caregivers and visible in the community. They walk her around. We could not substantiate any cause because we never found out why. There were concerns about whether there were any underlying issues due to bruise. In March incident with caregiver that fell asleep while caring for R2. Private caregiver admitted he closed his eyes for a minute, and she fell. We were told he just closed his eyes, and she fell. I have encouraged her POA to put camera in her room. We have communicated with the family but communication with home health has not been very good. The facility is still responsible for R2's care.

R4 is 79-year-old female, with move in date of 8/30/2026 with diagnosis that include Dementia, Lung Cancer, COPD, Primary Hypertension, Acquired Hypothyroidism, UTI, Uncomplicated, Type 2 Diabetes Mellitus Without Complications, Vitamin D Deficiency, Dementia, Unspecified Dementia Severity
R4 currently resides at facility.

R4's service plan dated 10/4/2025 documents in part, Need: Mobility/Ambulation Goal: Resident will maintain and/or maximize current level of

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functioning with mobility/ambulation Action: Mobility/Ambulation Transferring Extensive Assist R4 required hands on assistance with mobility using a standard wheelchair for all ambulation with caregiver assistance

05 Need Escorts Goal: Resident will maintain and/or maximize current level of functioning with escorts Action: Escorts: Full Assist Care staff to provide escort to all ambulation using standard wheelchair

Registered Nurse signature and date omitted from R4's care plan

On 6/12/2026 at 12:06pm during tour of facility observed R4 dressed, groomed and wearing shoes being pulled (backwards) in wheelchair by E9, Caregiver down the hall without leg/footrest. E9 stated you have to pull her backwards because she puts her legs and feet down. We pull her because we can hurt her legs if she puts her legs down. E9 stated she tried to pull her alongside her. E9 further stated when footrests are put on R4 will try and pull them off or try to walk on them. Sometimes she can help us. R4 can walk but she is a high fall risk. She uses the walker for short distances. R4 will stand up if she needs to go to the bathroom. She is not very verbal, she repeats the same thing, no conversation just babbles. She cannot follow directions. If she answers a question is not reliable, always yes. R4 is alert but unable to answer simple questions.

R6 is an 87-year-old female, with move in date of 8/12/2021with diagnosis that include Alzheimer's Disease, unspecified, Dementia in other disease classified elsewhere, unspecified severity without behavioral disturbance, psychotic disturbance,

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mood disturbance and anxiety, Muscle weakness, Depression, unspecified, Acute kidney failure, unspecified, Anxiety disorder, Essential Hypertension, Dysphagia, oral phase, Syncope and collapse
R6 currently resides at facility.

On 6/13/2026 at 11:56 am during dining observation, observed E14, Caregiver pushing R6 in wheelchair without footrest to dining room. E14 stated R6 uses a walker and wheelchair and R6 can move feet herself. Sometimes R6 says she needs help. E14 stated that when pushing residents in wheelchairs we should use footrest.

On 6/12/2026 at 12:53pm E11, Clinical and Rehab Director stated in part, he educates staff all the time on PT and OT and lets caregivers know how to transfer a resident. When transferring someone in a wheelchair they need to have footrest on due to safety, so residents do not drag their feet and get injured. Sometimes we can encourage residents to propel themselves. If a resident can use wheelchair and propel self, staff follow behind. All residents should have footrest for their wheelchair. Wheelchairs should not be pulled and staff walking backwards down the hall, wheelchairs should be pushed.

On 6/14/2026 at 7:50am E2, Health Services Director/LPN stated in part, supposed to have leg rest and if resident can propel, we do not have leg rests on. Only those that do not propel themselves have to have leg rest. If they have the strength to hold their leg up. If pushing from dining room to their room they should have leg rest on. Should always push forward. The wheelchair is designed to push forward and not backwards. There should be at least one caregiver in the Bistro and the 300-dining room

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watching the residents because high fall risk residents try to stand up, want to use bathroom. The caregiver is to call for assistant if that caregiver needs to take a resident to the bathroom. Breaktime sign out for the caregivers is with the nurse or will walkie and let nurse know they are going to take break, and nurse will write it down on the sheet. The caregiver on the floor is responsible for that caregivers' residents. If group one goes on break group 2 and 3 should answer the calls. They should go one at a time. The nurse will walkie to the group that the caregiver is going on break. When the caregiver returns page the nurse they are back. E2 stated he remembers when R1 fell. We have electronic alert that notified us that there was a fall in R1's room. E2 paged could someone go to R1 after a few minutes another alert for R1 occurred, so no one went on first alert, so E2 went out and that is when E3 returned from break. E3 went to the room and saw R1 on the floor. E2 called the nurse to do assessment and after that she called 911 because there was a bump on the back of the head. E2 did not go there, but the nurse did the assessment and R1 usually can communicate, E2 did not know at that time what R1 was able to say what happened. E3 was R1's care giver. The wheelchair was in the bathroom and R1 was outside of the door walking and the 2nd picture with 1/2 body inside the bathroom and other part of body outside the door with her feet pointing towards the door. R1 can go in and out of her room and can propel in wheelchair and knows how to walk with walker inside room. E2 thinks she was fully dressed in shoes. For R1 they do not stop her because she can go around the building on her own. R1 was alert and oriented x2. The caregivers that were in that section and there should be one in the Bistro. Whoever was not on break should be there

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watching the resident. Service plan revised when there is a fall and generates a new care plan and activated and get signature. The old ISP is there but a new ISP is generated so the updated on says incomplete with update fall incident. E2 reviews and when he activates, he requests for electronic signature from POA. E2 revises service plans and signs service plans. We used to have an RN sign off on it, now the NP who comes every Wednesday, she signs off on all ISPs. R2 has Private Caregivers 24/7 with her every hour. If they want to take break will notify the nurse and the nurse tells the caregiver to watch the resident or if the nurse is in the care station the nurse stays with the resident. The private caregiver takes R2 to the nurse or caregiver outside the room. We do not provide 1:1. The nurse still administers the meds, and the facility caregivers still check on R2 every 2 hours and just implemented that they must chart on the resident what the resident is doing. We give the resident showers, and the nurse will check her skin. Incontinence care is done by private caregivers. The community caregiver just lays eyes on her and charts in computer what she is doing at the time of inspection. Regarding R2 we do not know how she got bruises. She takes trazadone every night which is increased bleeding risk. Did PTT/INR after incident and was within normal range. We discovered caregivers were not giving her showers and if she refused, they should notify the nurse so it can be documents. We switched showers to the day because we have more staff to do the showers. Private caregivers should report anything to the nurse. They reported when there were big bruises on the buttock, the thigh and the right leg. There was no report of a fall so do not know how it happened. The nurse should do an immediate assessment but E2 thinks the nurse forgot to do it and when she came back the

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A4010	Continued From page 24	A4010		

next day, she did an assessment and saw the big bruises. E5 passed on the report of the bruise. E20 should have followed up. The nurse is supposed to assess the resident at the time the bruise was reported. No one knows how the bruise got there. Someone should know how she got the bruise. The private caregivers sent group chat to includes manager and said when reported to the nurse. E2 stated he did not speak with each private caregiver, but the manager (E17) did the investigation with each private caregiver and just gave me the report, and no one knows how R2 got the bruise. Incontinence care done should be able to see and no one reported until large and visible. They should have seen it. Initial report to nurse was 5/22/26 reported to the nurse and E2 received report on 5/24/26 from E5. Facility caregivers did not see because showers were not being done. R2 was unable to say what happened. The private caregivers should know how she got the bruises. No caregivers reported any incident and there was no report of a fall. There were 4-5 different private caregivers at that time.

Facility policy

On 6/14/2026 at 4:47pm per E1 email we follow the IDPH guidelines. IDPH Administrative Code-Incident & Accident Reporting-section 295.4010

Planning And Monitoring Services updated documents in part, PURPOSE: Residents' service needs, and requirements are identified, planned, implemented, monitored, and reassessed on an on-going basis in accordance with the pre-move-in, move-in and resident's stay procedures. Service needs and requirements are coordinated with other entities, such as hospice,

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A4010	Continued From page 25 on an ongoing and as needed basis. PROCEDURE: 1. Background information is collected on each resident during the pre-move-in phase in order to: o Identify and plan for the resident's service needs, requirements and preferences. Develop the Resident's Service Plan 2. Additional information is gathered during move-in to supplement the initial Service Plan 4. The community team is responsible for ensuring that the service plan/care plan is properly implemented through day to day activity and engagement with the resident.	A4010		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: TYPE 1 VIOLATION 295.4060 Alzheimer's and Dementia Programs a) In addition to this Section, Alzheimer and dementia programs shall comply with all of the other provisions of the Act. (Section 150(a) of the Act) c) No persons shall be accepted for residency or remain in residence if the person's mental or physical condition has so deteriorated to render residency in such a program to be detrimental to the health, welfare or safety of the person or of other residents of the establishment. The assessment must be approved by the resident's physician and shall occur prior to acceptance for residency, annually, and at such time that a change in the resident's condition is identified by a family member, staff of the establishment, or the resident's physician.	A4060		

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A4060	Continued From page 26 (Section 150(c) of the Act) f) No person shall be accepted for residency or remain in residence if the person meets the criteria provided in subsections (b) through (g) of Section 75 of the Act. (Section 150(e) of the Act) These requirements are not met as evidenced by: Based on observation, interview and record review, the establishment failed to terminate residency of an individual who was having increasing behaviors of verbal aggression, agitation, and inappropriate behaviors towards residents and staff. This applies to one of five (R5) residents reviewed for residency requirements in the sample of 5. This failure creates a substantial probability of severe harm or death to a resident or residents. Findings include: R5 is a 63-year-old male, with move in date of 02/28/2026with diagnosis that include Vascular Dementia, Moderate, with Other Behavioral Disturbance, Type 2 Diabetes Mellitus without Complications, Gastro-Esophageal Reflux Disease without Esophagitis, Hyperlipidemia, Unspecified, Depression, Unspecified R5 currently resides in memory care establishment. On 6/12/2026 at 5:13pm E15, Caregiver stated in part she was familiar with R5. R3 was upset because one resident R5 went into her room. She says R5 messed up her hand. E15 did see R5 in her room but he goes in rooms a lot, so we started locking doors because of that. R5 can be aggressive and eats off of other residents' plates and if you intervene, he turns ugly. He goes into other residents' room. We do not know if dementia or psych. R5 has already grabbed me	A4060		

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by the arm R5 went into R3's room yesterday and E15 had to get E2 to come get R5. R5 grabbed my wrist. He goes into other resident rooms and takes their food and their stuff.

On 6/13/2026 at 9:44am E4, LPN stated in part she is familiar with R5 He is really confused and walks around. He gets agitated and can sometimes be aggressive when you tell him not to touch things and when you try to move him, he gets agitated. He goes into other residents' rooms and will take other residents' stuff. When redirected with food things and stuff he will get aggressive. E4 has not heard he has hit or touched anyone. He eats good and if he sees anything he will grab it. He walks all around. We monitor and redirect him and try to make him sit but he does not stay. He was found in other residents' room. As much as we can we try to watch him at least every 2 hours. Nobody follows him around. Sometimes other residents complain about him and tell us he is in my room, and we then go get him out. He has a roommate, but E4 does not know if he has taken his roommates stuff but sometime R5 sleeps in his roommates' bed. He is not supposed to lay down in his roommate's bed. The roommate will try to guide him and help him get up and put him in his bed. E4 stated E2 knows about him, but E4 is not sure E1 knows he is like that. We try our best to check on him often. E4 tries, it is very hard to keep an eye on him. He does not have a 1:1 caregiver.

On 6/13/2026 at 10:30am E5, LPN stated in part she is familiar with R5. He is really confused alert x1 and likes to go into residents' room and wanders around and picks up food from other residents even if you try to redirect him and goes from one to another residents plates. There are

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times he can be aggressive towards staff and other residents. I think one of the residents' report R5 had altercation with another resident. R5 provoked the altercation because R5 took that residents stuff. Other residents do not understand R5s mental issues. Everyone watches R5. We usually lock the rooms to keep him out and if we catch him we have to redirect him. He gets agitated but has not been aggressive with me. He has been aggressive with caregivers. R5 will hit and hits the staff and has hit other residents. We separate them and report to E2 and if he has a PRN we will give when agitated and aggressive and cannot be redirected. We notify the psyche NP and MD. In my opinion R5 is not appropriate to be in memory care. We try to watch him especially when he is walking and encourage him to sit in the Bistro. We lock the rooms so R5 does not go in rooms. Some residents say he takes stuff and takes their food even if he has food on his plate he just picks up their food and other residents get mad.

On 6/13/2026 at 11:56 am during dining observation, E14, Caregiver stated R5 likes to go to other residents' room and lay down in that resident's bed. R5 can be aggressive and will say don't touch me and tries to pull away. E14 stated she has not seen R5 being physically aggressive just verbally aggressive. R5 will take other residents' stuff, and he should not do that. We now have keys to lock resident doors to keep R5 from going into other residents' rooms. We have so many residents we cannot always watch R5. R5 needs a private caregiver. We try to keep R5 in the bistro and activity room because there is always a caregiver in there.

On 6/13/2026 at 12:16pm R5 dressed, groomed, and wearing shoes escorted to dining room by E3

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and placed at table across from R7 who was eating her lunch. R5 started to take R7's food. R7 stated to R5 stop taking my food and tapped his hands while saying stop taking my food. R5 continued to try and take R7's food. E3 left R5 at table to go and get R5's lunch. R5 was saying something but unable to understand what he was saying. E13 intervened to stop R5 from taking R7's food and called for someone to get R5 some food. E3 returned with food for R5 and sat down to feed R5. R5 calmed down and sat down to eat. other residents. E3 stated R5 wanders so she had to find him to bring to lunch. R5 can answer simple questions. During meal observation, R5 became agitated and annoyed and spilled his drink. R5 stated he was hungry and tried to feed self but E3 reminded R5 that she was feeding him. During this observation, R5 needed constant redirecting and reminders. R5 then began spitting his food out. There were three other caregivers feeding other residents. R5 continued to be hard to redirect. R5 continued to spit out food. E3 attempting to ask R5 not to spit out food.

On 6/13/2026 at 1:24pm E1 stated, she is familiar with R5. R5 is doing much better. He has behaviors he wanders and will eat someone cookies and check resident doorknobs. If a door is open, he will go in it. E1 has not seen him being aggressive or physically aggressive. He does not have a sitter. He went to behavioral health due to his behaviors after he came here. E2 assessed him and felt he met the regulation. R5 is on different meds than when he got here. He met the regs to be here. We do a lot of training with staff. He does engage in programing and physical activities. He is advanced in his disease process. He wanders and goes into other residents' rooms, and they try to redirect him and keep him in programing as possible. R5

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wanders into other rooms. If R5 is in their group, try to make sure he is at activities. More frequent checks and a lot of redirections. He is not always super social. Sometimes he does not make sense and other days he does. R5 needs a lot of redirecting. E1 thinks he still meets the regulation requirement. He has declined but he is aging in place. He does have behaviors we have to deal with at times.

On 6/14/2026 at 7:50am E2, Health Services Director/LPN stated, R5 when assessed fine and answering questions but did not get any right. When he moved in hard to redirect and refused care and swat/hit caregivers when they tried to assist. R5 was sent for med adjustment to behavioral health hospital. When he returned meds adjusted and fine since then, but still refusal but when he hears his wife's name he responds. He has not had any behavior since he returned from behavioral health facility. When E2 was doing initial assessment prior to moving in he raised his arms and clenched his teeth but did not swing his arm was about to jump on me but he did not do it but was redirected easily right away. He has not tried to hit me any other time. Other residents, E2 stated, he does not think so. E2 stated he does not think R5 is aggressive, he just swings his arms. If you say his wife's name, he responds. He goes in and out of resident rooms yes and takes items sometimes and picks something, but he can be easily redirected by saying his wife's name. E2 has not seen or been told he takes other residents' food. E2 stated he thinks he was naked in a resident room one time without pants. He was in their bed naked. The nurses have told me he is aggressive. I have heard those reports. If he is aggressive maybe he is not. When E2 tells him he responds to me, but E2 is not there all the time. We lock doors to

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prevent R5 and other residents from going into room and taking stuff from other residents. R5 does go into other resident rooms and takes their stuff. Other residents have gotten upset when R5 has gone in their room and take their stuff. Yes, residents get upset when he takes their food. R5 usually sits in one area and when he wants to move around, they redirect him back to common area. The caregiver watches common area so when he tries to leave, they should redirect him back. I think sometimes he gets out without the caregivers knowing. Reason why the rooms are locked. It was one instance when he was in another resident's room naked before he went out to behavioral facility. He does not have a private caregiver. Facility caregivers cannot monitor him but every 2 hours they do location check. He likes to stay in the dining room, if they miss him that is how he goes into someone else's room. Yes, I think he hit caregivers before he was sent out.

On 6/15/2026 at 1:33pm E16, Caregiver stated she is familiar with R5. He never had any aggressive behaviors for me, but he has been aggressive. He needs to be monitored. He wanders into other residents' rooms, and he will pee in open areas hallways, bistros. He cannot tell you he needs to go sometimes. He needs help with toileting, needs help with dressing, he can feed himself, he eats with his hands, because he cannot remember to use utensils. Cannot take showers by himself. He sometimes will take other residents' food and other items, but mostly food. Residents get upset when he does that. He will eat other residents' food during dining if he is not monitored. He has gotten into other residents' bed and sometimes he has been naked. He is mostly food motivated and keeps a snack. Sometimes he will engage in activities and

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will sleep in chairs. Will snack and watch. Doors are locked because he wanders into other residents' rooms. Sometimes there are other residents having behaviors and R5 will get up and walk off so it is a lot at once to keep an eye on him. We do rounds and will find him. E16 stated she does not have R5 consistently when she works because she is only part-time. E16 stated, she has seen him get aggressive by hitting staff and caregivers.

R5's service plan dated 6.13.2026 documents in part,
Need: 03. Psychosocial category: Health Area: Psychosocial
Goal: Resident will maintain and/or maximize current level of functioning with disruptive/socially inappropriate behavior
Action: Behavior: Occasional issues R5 has current or history of occasional disruptive/socially inappropriate behavior disruptive, aggressive, or socially inappropriate behavior either verbally or physically improper. May required special tolerance or staff training. Care staff to monitor R5 for behavioral changes or patterns, including agitation, aggression, withdrawal, or repetitive actions. Identify triggers that may precipitate behavioral changes (environmental factors, pain, unmet needs, changes in routine). Use calm, respectful communication and approach R5 non-confrontationally. Provide structured, predictable routines to reduce confusion and frustration. Redirect or distract R5 with preferred activities during periods of agitation. Monitor for pain, discomfort, or illness that may affect behavior and report concerns. Document behavioral incidents,
interventions used, and resident response accurately. Communicate behavior patterns and

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concerns to nursing staff and interdisciplinary team. Notify healthcare providers if behaviors escalate, pose safety risks, or interfere with daily functioning.

R5's observation notes state the following:

05/26/2026 Behavior Staff reported that the resident was observed picking up and playing with his own feces. Writer attended and observed the resident attempting to fight staff during cleaning and showering. Resident was swearing and attempting to hit staff. Writer was able to redirect and reorient the resident with effective relief noted following administration of PRN Lorazepam. Resident was kept clean and dry and assisted to the dining room. HSD notified

05/14/2026 Behavior Aggressive with pushing

05/08/2026 Nursing The resident was reported being aggressive to one of the care staff. PRN Lorazepam was administered at 2:45 PM. The resident was redirected to sit at the 100 bistro.

05/07/2026 Behavior Resident was able to get out at the 100 hallway dining room with the other resident, caregiver was able to response the door alarm immediately and was able to take the 2 resident's back in the building with no problem, both remained calmed. DHS notified.

04/26/2026 Behavior At 5:37 PM- Staff reported that resident was observed picking up food from another resident's plate. So this another resident, slapped his hand in an attempt to stop him. Resident then pushed this another resident's left shoulder prompting this another resident to throw food at him twice, Staffs successfully intervened and separated both residents. Resident then was

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redirected. HSD was notified. PRN Lorazepam given at 5:40P and helpful. Resident is now calmed. Contacted the POA but did not answer.

04/14/2026 Nursing Resident aggressive with writer and other staff members. Resident got in my face yelling "Shut the f*** up!". PRN was given by writer, monitoring ongoing.

4/05/2026 Behavior Resident was escorted to bed by care giver. After care giver left, resident self-ambulated to restroom and turned on shower, flooding bathroom which went into room and under entrance door into the common area hallway. Care givers called back to room by NOD. Care givers dried up floor with towels and then requested resident to change his clothes. Resident refused many times. NOD tried to convince resident also but refused. Finally care givers convinced resident to change out of his drenched clothes and escorted him back to bed. Comfort medication was given to him by NOD.

03/31/2026 Nursing Resident was observed at approximately 12:00 AM by caregiver in another residents room lying on her bed naked. Caregiver had to redirect several times before removing him from the room and into his bed.

03/30/2026 Behavior Resident was observed punching another resident. Resident was not easily able to be redirected but eventually cooperated and was able to be led to his room and helped to bed. Writer gave PRN at approximately 8:00 PM. Monitoring continuous. DON, ED, POA and MD aware.

03/27/2026 Nursing The resident was observed walking last night with a piece of

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A4060	Continued From page 35 unknown material, odorless, blue in color. The resident may have taken a few bites of the material due to color staining in his mouth. The resident's mouth was brushed and rinsed. Most of the color were removed. No adverse effect noted at this time. The POA was notified this morning about the incident around 10:30 this morning. 03/26/2026 Move In Resident walks around in the dining room trying to take other residents foods, enters other residents room. Resident is difficult to redirected needs attended staff will continue monitor. 03/25/2026 Behavior Resident sleeping on and off, walking in the hallway, tried to enter other resident??s room, PRN Lorazepam given but not effective, will continue to monitor. 03/25/2026 Behavior Resident was observed entering another resident's room. He was redirected, however he immediately proceeded to a different room. 03/24/2026 Alert Charting - Behavior-New Resident alert/verbally responsive, took all meds without difficulty. Observed resident urinating in the water fountain, writer unable to redirect resident, noted becoming agitated. Writer attempted to educate resident and show him where the bathrooms were. 03/22/2026 Alert Charting - Behavior-New Resident behavior continues to be aggressive. Administered PRN to calm resident and escorted him to his room and into bed multiple times. Resident continues to enter other resident rooms. 03/20/2026 Family Communication At around 4	A4060		

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A4060	Continued From page 36 PM, this writer was called to redirect the resident out of another resident room. The resident was easily redirected but managed to go to another resident room for the second time 03/20/2026 Nursing Resident was noted needing redirecting during dinner time, several other residents got upset when resident was bumping into them , standing over them while they ate, going in and out rooms and private dining room where two families where having dinner with loved ones. Resident was easily redirected but continues to need redirecting several times. 03/19/2026 Alert Charting - New Move In Resident alert and oriented to self, good appetite at breakfast, resident continues with behavior issues ambulating with no walker, going into others resident??s rooms, PRN Lorazepam given with relief, resident currently in bed resting. 03/19/2026 Alert Charting - New Move In Resident is alert and oriented to self, resident had good appetite for lunch and dinner, tool his schedule medication as prescribed, the resident is going to resident rooms, staff redirected the resident continually, noted with behavior issue, resident walks without his wheelchair. Resident was given PRN Lorazepam for restlessness but not effective. needs attended staff will continue monitor. 03/18/2026 Alert Charting - New Move In Readmit f/u day 3. Resident noted with increased agitation and was observed entering another resident's room. When redirected and advised not to enter, he was initially non-cooperative and became aggressive; however, after a while, he was able to follow staff direction. Resident also, intermittently	A4060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510324	A. BUILDING: _____ B. WING _____	C 06/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A4060	Continued From page 37 refused to use the walker despite encouragement. 03/18/2026 Alert Charting - New Move In Resident was restless, walking on the hallway, unstable gait, confused, entering other resident??s room, was hungry, and was fed, went to bed late, will continue to monitor. Facility Policy On 6/14/2026 at 4:47pm per E1 email we follow the IDPH guidelines.	A4060		