STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510368	A. BUILDING: _____ B. WING _____	C 06/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE OAKS ASSISTED LIVING	1055 SILVER LAKE RD CARY, IL 60013

(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 IL202284 295.4010d) 295.6000a)5)13)	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 1 Violation-Repeat 295.4010d) Section 295.4010 Service Plan d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act) These requirements were not met, as evidenced by: Based on interview and record review, the establishment failed to ensure service plan interventions were followed for 1 of 3 residents (R1) reviewed for falls in the sample of 3. This failure resulted in a fall with a wrist fracture for R1. This failure creates a substantial probability of severe harm to a resident or residents. The findings include:	A4010		

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A4010	Continued From page 1 On 6/12/26 at 9:39 AM E3, Licensed Practical Nurse (LPN), said R1 was a fall risk and fell twice recently; once on Saturday 6/6/26 and again on Sunday (6/7/26). E3 said on 6/6/26 E4, Caregiver, reported that R1 started walking without her walker and was exit seeking near the doors in the memory care unit. R1 was originally doing activities when she got up without her walker and E4 approached R1 and was walking with her. R1 got agitated and tried to shoo E4 away. R1 lost her balance and fell. E3 said E4 called her and when she (E3) arrived, R1 was lying on her left side parallel to the wall. E4 reported that R1 hit her head on a ledge on the wall as she was falling. E3 said she called 911, the paramedics arrived and rolled her on the gurney. R1 was holding her left hand/wrist, and it was swollen. E3 said R1 used a walker to ambulate and was not oriented at all at her baseline. On 6/12/26 at 10:28 AM, E4 said she was one of the caregivers for R1 on 6/6/26. R1 stood up from her wheelchair and started walking. E4 said she had R1's arm and reminded her to sit down for dinner. E4 said R1 continued walking with E4 holding onto her. R1 lost her balance and fell onto the floor in the hallway. E4 said as R1 was falling, she hit her head on the wall. E4 said she thinks she remembers seeing a walker in R1's room but only works on an "as needed" basis and is not familiar with all the residents. On 6/12/26 at 12:19 PM, E5, LPN, said R1 is not oriented at all at her baseline, doesn't talk unless she wants to and if she talks it's generally not about anything that is currently happening, but whatever is happening in her private world. E5 said R1 ambulated freely with her walker and had exit seeking behavior.	A4010		

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A4010	Continued From page 2 On 6/12/26 at 1:07 PM, E2, Director of Nursing (DON) said she did an investigation into R1's fall (6/6/26) where she fractured her wrist. E2 said R1 was supposed to be walking with her assistive device (walker) which she was not. E2 said R1 normally uses her walker, but that day she was in a wheelchair; R1 typically doesn't use a wheelchair. R1's Progress Notes documented by E3 and dated 6/6/26 at 4:27 PM show that the nurse was called to the memory care family room for a witnessed fall. Upon arrival, R1 was observed lying on her left side on the floor parallel to the wall. The caregiver reported R1 "was ambulating in hallway without use of assistive device" when R1 lost her balance and fell. R1 hit her head on the wall ledge and landed on her left side. R1's Progress Notes dated 6/6/26 at 8:56 PM show E7, Wellness Nurse, spoke with a nurse at the emergency room and was told R1 had a left wrist fracture. R1's Progress Notes dated 6/6/26 at 9:06 PM show R1 returned to the establishment at 8:45 PM with her arm in a sling. R1's Progress Notes dated 6/6/26 at 9:30 PM show R1 unwrapped the ace bandage, the gauze and the cast placed from the hospital. R1's current Service Plan effective 5/8/26 shows R1 will maintain and/or maximize her current level of functioning with mobility/ambulation. R1 uses a walker to assist with mobility needs. Care staff will frequently remind R1 to use her walker. R1's service plan does not indicate a need for R1 to use a wheelchair. Staff are to ensure R1 has her	A4010		

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A4010	Continued From page 3 walker when she is ambulating. The establishment's Incident Form for R1's fall on 6/6/26 shows R1 sustained a fracture of her upper extremity; a significant injury.	A4010		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 1 Violation-Repeat 295.6000a)5)13) 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: 5) The right to receive the services specified in the service plan, to review and renegotiate the service plan at any time; and to be informed of the cost of the changes; 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; These requirements were not met, as evidenced by: Based on interview and record review, the establishment neglected to provide interventions contracted in the service plan for 1 of 3 residents (R1) reviewed for falls in the sample of 3. This	A6000		

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A6000	Continued From page 4	A6000		

failure resulted in a fall with a wrist fracture for R1. This failure creates a substantial probability of severe harm to a resident or residents.

The findings include:

On 6/12/26 at 9:39 AM E3, Licensed Practical Nurse (LPN), said R1 was a fall risk and fell twice recently; once on Saturday 6/6/26 and again on Sunday (6/7/26). E3 said on 6/6/26 E4, Caregiver, reported that R1 started walking without her walker and was exit seeking near the doors in the memory care unit. R1 was originally doing activities when she got up without her walker and E4 approached R1 and was walking with her. R1 got agitated and tried to shoo E4 away. R1 lost her balance and fell. E3 said E4 called her and when she (E3) arrived, R1 was lying on her left side parallel to the wall. E4 reported that R1 hit her head on a ledge on the wall as she was falling. E3 said she called 911, the paramedics arrived and rolled her on the gurney. R1 was holding her left hand/wrist, and it was swollen. E3 said R1 used a walker to ambulate and was not oriented at all at her baseline.

On 6/12/26 at 10:28 AM, E4 said she was one of the caregivers for R1 on 6/6/26. R1 stood up from her wheelchair and started walking. E4 said she had R1's arm and reminded her to sit down for dinner. E4 said R1 continued walking with E4 holding onto her. R1 lost her balance and fell onto the floor in the hallway. E4 said as R1 was falling, she hit her head on the wall. E4 said she thinks she remembers seeing a walker in R1's room but only works on an "as needed" basis and is not familiar with all the residents.

On 6/12/26 at 12:19 PM, E5, LPN, said R1 is not

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A6000	Continued From page 5	A6000		

oriented at all at her baseline, doesn't talk unless she wants to and if she talks it's generally not about anything that is currently happening, but whatever is happening in her private world. E5 said R1 ambulated freely with her walker and had exit seeking behavior.

On 6/12/26 at 1:07 PM, E2, Director of Nursing (DON) said she did an investigation into R1's fall (6/6/26) where she fractured her wrist. E2 said R1 was supposed to be walking with her assistive device (walker) which she was not. E2 said R1 normally uses her walker, but that day she was in a wheelchair; R1 typically doesn't use a wheelchair.

R1's Progress Notes documented by E3 and dated 6/6/26 at 4:27 PM show that the nurse was called to the memory care family room for a witnessed fall. Upon arrival, R1 was observed lying on her left side on the floor parallel to the wall. The caregiver reported R1 "was ambulating in hallway without use of assistive device" when R1 lost her balance and fell. R1 hit her head on the wall ledge and landed on her left side.

R1's Progress Notes dated 6/6/26 at 8:56 PM show E7, Wellness Nurse, spoke with a nurse at the emergency room and was told R1 had a left wrist fracture.

R1's Progress Notes dated 6/6/26 at 9:06 PM show R1 returned to the establishment at 8:45 PM with her arm in a sling.

R1's Progress Notes dated 6/6/26 at 9:30 PM show R1 unwrapped the ace bandage, the gauze and the cast placed from the hospital.

R1's current Service Plan effective 5/8/26 shows

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A6000	Continued From page 6 R1 will maintain and/or maximize her current level of functioning with mobility/ambulation. R1 uses a walker to assist with mobility needs. Care staff will frequently remind R1 to use her walker. R1's service plan does not indicate a need for R1 to use a wheelchair. Staff are to ensure R1 has her walker when she is ambulating. The establishment's Incident Form for R1's fall on 6/6/26 shows R1 sustained a fracture of her upper extremity; a significant injury.	A6000		