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 _____	06/26/2026

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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 Annual Licensure Survey conducted. VIOLATIONS: 295.2040 a) b) c) 1) 2) 3) 295.2060 a) b) 1) 2) 295.3020 c) d) 295.3040 Section 955.165 a) d) 1) 295.4060 a) c) f) i) A) C)	A 000		
A2040	Section 295.2040 Disaster Preparedness This Regulation is not met as evidenced by: Type 1 Violation Section 295.2040 Disaster Preparedness a) For the purpose of this Section, "disaster" means an occurrence, as a result of a natural force or mechanical failure such as water, wind or fire, or a lack of essential resources such as electrical power, that poses a threat to the safety and welfare of residents, personnel, and others present in the establishment. b) Each establishment shall: 1) Have a written plan for protection of all persons in the event of disasters, for keeping persons in place, for evacuating persons to areas of refuge, and for evacuating persons from the building when necessary. The plan shall address the physical and cognitive needs of residents and include special staff response, including the procedures needed to ensure the safety of any resident. The plan shall be amended or revised whenever any resident with unusual needs is admitted.	A2040		

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A2040	Continued From page 1 c) At least six drills shall be conducted per year on a bimonthly basis. At least two of the drills shall be conducted during the night when residents are sleeping. All drills shall be held under varied conditions to: 1) Ensure that all personnel on all shifts are trained to perform assigned tasks; 2) Ensure that all personnel on all shifts are familiar with the use of the fire fighting equipment in the facility; 3) Evaluate the effectiveness of disaster plans, procedures and training. The NFPA 101 Life Safety Code outlines essential fire safety regulations for assisted living facilities, focusing on construction, operational features, and compliance with health care standards. This requirement was NOT MET as evidenced by: Based on interviews and record review, the establishment failed to ensure staff and residents were aware of and prepared during fire and tornado emergencies by conducting drills in compliance with NFPA 101 Life Safety Code. This applies to all the residents in the facility reviewed for safety. This failure creates a substantial probability of severe harm or death to a resident or residents. Findings include: On 6/24/26 at 1:45 PM, facility binder for disaster preparedness was reviewed. It showed the Tornado drill was conducted on 2/25/26 with no	A2040		

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A2040	Continued From page 2 time recorded on the sign-in sheet. The sign-in sheet included the signature of few staff. It did not include any record of resident participation. E1 (ED-Executive Director) stated no other tornado drill was done. The records for the fire drills were as follows: 3/12/26 at 10:05 AM - No record of residents participation in this drill. E1 (ED) stated residents participated in this drill. The ones that were able to move were moved near the emergency exit door. No one exited the building. The rest were left in their rooms. 5/22/26 at 3:50 PM - Residents did not participate. 4/21/26 at 5:40 AM - Residents did not participate. No documentation was found about any fire drills conducted other than on the dates mentioned above, in the last one year. On 6/24/26 at 2:05 PM E1 (ED-Executive Director) stated residents are not evacuated from the building during a fire drill. On 6/25/26 at 12:00 PM E1 (ED) and E2 (HCC-Health Care Coordinator) agreed Fire drills are required to be done at least bi-monthly in various shifts.	A2040		
A2060	Section 295.2060 Quality Improvement Program	A2060		

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A2060	Continued From page 3 This Regulation is not met as evidenced by: Type 2 Violation Section 295.2060 Quality Improvement Program a) The establishment shall establish an effective quality improvement program that encompasses oversight and monitoring, resident satisfaction, and ongoing quality improvement and implementation of any plan that addresses improved quality services. The quality improvement process implemented by the establishment must benchmark performance, be customer centered, be data driven, and focus on resident satisfaction. (Section 30(a) of the Act) For the purpose of this Section, "benchmark" means creating points of reference from which measurements can be made. b) A system shall be in place to facilitate the detection of issues and problems, to expedite the implementation of action, and to resolve problems. 1) Data analysis shall be used to identify and implement changes that will improve performance or reduce the risk of additional events. 2) The establishment shall maintain documentation that shows that data analysis has occurred and that actions, as appropriate, have been implemented to address identified issues and to resolve problems, as well as any follow-up actions taken by the establishment. This requirement is not met as evidenced by: Based on interviews and record reviews, establishment failed to establish and maintain an effective quality improvement program.	A2060		

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A2060	Continued From page 4 This failure creates a substantial probability of harm to a resident or residents. Findings include: On 6/23/26 at 3:00 PM establishment QAPI (Quality Assurance and Performance Improvement) documents were requested. E1 (ED-Executive Director) presented a binder that included the QAPI policy, the list of members of the QAPI committee, schedule for meetings and the plan for conducting QAPI. Binder did not include any current or previous projects that they worked on. On 6/23/26 at 3:00 PM, E1 (ED-Executive Director) stated, this establishment has not implemented any specific action plan to improve the quality of an identified issue. E1 stated there is no documentation of any resident satisfaction survey or any measurable data that could be used for QAPI.	A2060		
A3020	Section 295.3020 Employee Orientation and Ongoing Training This Regulation is not met as evidenced by: Type 2 Violation Section 295.3020 Employee Orientation and Ongoing Training Each manager and direct care staff member shall complete a minimum of 8 hours of ongoing training, applicable to the employee's responsibilities, every 12 months after the starting	A3020		

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A3020	Continued From page 5 date of employment. This requirement is not met as evidenced by: Based on interviews and record review, the establishment failed to ensure employees completed the required in-services annually. This applies to 5 of 5 employees (E8, E10, E11, E13, E15) reviewed for annual continuing education. This failure creates a substantial probability of harm to a resident or residents. Findings include: On 6/24/26 at 2:15 PM employee files were reviewed with E1 (ED-Executive Director). It showed the following employees did not have any record of the required 8 hours of annual in-services: 1) E8 (RA-Resident Assistant) 2) E10 (LPN- Licensed Practical Nurse) 3) E11 (LPN) 4) E13 (RA) 5) E15 (Housekeeper) On 6/24/26 at 3:00 PM E1 (ED) stated all staff must complete their required 8 hours of in-services annually. E1 stated he could not find any records of in-service for the employees mentioned above.	A3020		
A3040	Section 295.3040 Health Care Worker Background Check This Regulation is not met as evidenced by:	A3040		

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A3040	Continued From page 6 Type 2 Violation Section 295.3040 Health Care Worker Background Check An establishment shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code. Section 955.165 Fingerprint-Based Criminal History Records Check a) Educational entities, other than secondary schools, and health care employers are required to check the Health Care Worker Registry before allowing a student to enter a training program or hiring an employee to determine: d) Any student, applicant, or employee to whom the Act and this Part apply and who desires to be included on the Department of Public Health's Health Care Worker Registry shall authorize the Department of Public Health or its designee to request a fingerprint-based criminal history records check to determine if the individual has a conviction for a disqualifying offense by completing and signing an authorization and disclosure form. This authorization shall allow the Department of Public Health to request and receive information and assistance from any State or governmental agency. (Section 33(b) of the Act) 1) A health care employer may initiate a fingerprint-based criminal history records check required by the Act or this Part for any of its employees or volunteers to whom the Act and this Part apply. This requirement was not met as evidenced by:	A3040		

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A3040	Continued From page 7 Based on interviews and record reviews, establishment failed to conduct a finger-print based criminal history records check or it was not done in a timely manner. This applies to 2 out of 6 employees reviewed for healthcare workers background check. This failure creates a substantial probability of harm to a resident or residents. Findings include: On 6/24/26 at 2:15 PM, personnel files of E1 (ED-Executive Director), E8 (CNA-Certified Nursing Assistant), E12 (Cook), E13 (CNA), E14 (CNA) and E15 (Housekeeper), were reviewed for healthcare worker's background check. The files showed finger-print based criminal history records check was not done for E12 (Cook). E12's DOH (Date of Hire) was 8/6/25. E1's (ED) DOH was 2/10/26. E1's finger-print based criminal history records check was done on 6/24/26. That is 4.5 months after hire. On 6/24/25 at 3:30 PM E1 (ED) stated Establishment was required to conduct a finger-print based criminal history records for all staff upon hire.	A3040		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Type 1 Violation	A4060		

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A4060	Continued From page 8 Section 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. (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) i) Training requirements for individuals working in a special program: 2) Staff training: A) All staff members must receive, in addition to the training required in Section 295.3020, four hours of dementia-specific orientation prior to assuming job responsibilities without direct supervision within the Alzheimer's/dementia program. Training must cover, at a minimum, the following topics: C) Direct care staff must annually complete 12 hours of in-service education regarding Alzheimer's disease and other related dementia disorders. Topics may include	A4060		

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A4060	Continued From page 9 This requirement is not met as evidenced by: A. Based on observation, 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 4 of 5 residents (R1, R2, R3 and R5) reviewed for residency requirements in the sample of 5 . B. Based on interviews and record review, the facility failed to ensure employees received dementia related orientation and completed the required in-services annually for the dementia program. This applies to 6 out of 9 employees (E8, E10, E11, E12, E14, E15) reviewed for Dementia related in-service. This failure creates a substantial probability of severe harm to ra resident or residents. Findings include: A. 1) On 6/24/26 at 1:00 PM, observed E7 (CNA-Certified Nursing Assistant) toilet R1. E7 assisted R1 to stand up from her wheelchair. Observed that R1 was leaning backwards, R1's knees were bent and her legs were unsteady as she stood up. R1 could not pivot. E7 (CNA) turned R1 and made her sit on the toilet by pushing her onto the seat. After R1 was done using the toilet, E7 cleaned R1's bottoms, wore new briefs for R1, and pulled up her pants. E7 lifted R1 back from the toilet seat, turned her and made her to sit on the wheelchair. Observed R1 required total assist for transfer, mobility and toileting. 2) On 6/24/26 at 1:15 PM, observed E6 (CNA-Certified Nursing Assistant) take R2 to the	A4060		

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A4060	Continued From page 10	A4060		

toilet. E6 lifted R2 off the wheelchair by holding her pants and from under her arms. R2 held onto the bar on the wall and stood up. Observed R2 was very unsteady on her feet and her knees were bent. R2 was not able to stand straight. R2 was not able to pivot. E6 turned R2 and pushed her down onto the toilet to make her sit on the toilet. After R2 was done, E6 wiped her bottoms, pulled up her briefs and pants, and lifted her back onto the wheelchair. Observed R2 required total assist for transfer, mobility and toileting.

3) On 6/25/26 at 10:30 AM observed E6 (CNA) provide morning care for R3. R3 was lying in bed. Alert, oriented to self, able to converse in simple small sentences. Pleasant demeanor. Observed E6 provide perineal care for R3 in bed. E6 changed R3's gown for street clothes. Then E6 (CNA) and E8 (CNA) together lifted R3 by holding R3 up from under her arms (one on each side) and lifted her onto the wheelchair. Observed R3 did not take even one step with her feet. Observed R3 did not participate in dressing, toileting, mobility or transfer.

4) On 6/24/26 at 11:00 AM observed E9 (CNA) giving a shower to R5. Observed R5 did not participate in the activity at all. E9 did all parts of the procedure for R5. After coming out of the bathroom, E9 wore the shirt for R5. R5 was alert, oriented x 2-3, able to converse well. Observed R5 required total assist for bathing, grooming and dressing.

On 6/23/26 at 2:00 PM R1's records were reviewed.

R1's face-sheet showed R1 was an 87 years old female admitted on 11/28/25 with diagnoses to include Congestive Heart Failure,

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A4060	Continued From page 11 Encephalopathy, Diabetes Mellitus, Hypertension and Gout. R1's service-plan dated 5/27/26 showed R1 required extensive assist for toileting, dressing, mobility, evacuation in an emergency, bathing and transfers. R1 needed moderate assist with grooming. On 6/24/26 at 9:00 AM R2's records were reviewed. R2's face-sheet showed R2 was an 88 y/o female admitted on 8/7/25 with Dx to include Alzheimer's Disease, Depression, Encephalopathy and Anxiety. R2's service plan dated 5/19/26 showed R2 required hands on assistance for toileting, bathing, dressing, evacuation in an emergency and extensive assist for grooming, transfers and mobility. On 6/24/26 at 10:00 AM R3's records were reviewed. R3's face-sheet showed R3 was a 92 y/o female admitted on 9/20/22 with diagnoses to include Dementia, Hypertension, Ataxia, Alzheimer's disease, Mitral Valve disorder and osteoporosis. R3's service plan dated 5/7/26 showed R3 required total or extensive assist for bathing, dressing, toileting, transfer, mobility, oral hygiene and emergency evacuation. On 6/24/26 at 11:30 AM R5's records were reviewed. R5's face-sheet showed R5 was a 93 year old	A4060		

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A4060	Continued From page 12	A4060		

male admitted on 8/6/25 with diagnoses to include Congestive Heart Failure, Hypertension, Anxiety, Dementia and Atrial Fibrillation.

R5's service plan dated 6/19/26 showed R5 required hands on or extensive assist for bathing, grooming, dressing, toileting, transfers, mobility and evacuation in an emergency.

On 6/23/26 at 11:00 AM E4 (CNA) stated R1, R1 and R3 required total assist for mobility, toileting, bathing, grooming, dressing and oral care.

On 6/24/26 at 1:00 PM E7 (CNA) stated there are times when two persons are needed to transfer R1.

On 6/23/26 at 11:15 AM, E6 (CNA) stated R2 and R3 required total assist for all ADLs except eating.

On 6/25/26 at 10:00 AM, E6 (CNA) stated R3 cannot bare weight at all. E6 stated since R3 is small in stature, E6 could carry R3 for transfers or else she would need two persons to transfer R3.

B. On 6/24/26 at 2:15 PM employee files were reviewed with E1 (ED-Executive Director).
It showed the following employees completed less than 12 hours of annual in-service related to Dementia disorders.
1) E8 (RA-Resident Assistant) - Zero hours
2) E10 (LPN- Licensed Practical Nurse) - Zero hours
3) E11 (LPN) - Zero hours
4) E12 (Cook) - Zero hours
5) E14 (RA) - Zero Hours
6) E15 (Housekeeper) - Zero hours

The personnel files did not include any record of

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A4060	Continued From page 13 dementia related orientation for the following employees: 1) E8 (RA) 2) E10 (LPN) 3) E12 (Cook) 4) E14 (RA) 5) E15 (Housekeeper). On 6/24/26 at 3:00 PM E1 (ED) stated all staff must complete their required dementia related in-services annually. E1 stated he could not find any records of dementia related orientation or in-service for the employees mentioned above.	A4060		