STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510129	A. BUILDING: _____ B. WING _____	C 07/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LANE MEMORY CARE	875 RIVERTON ROAD RIVERTON, IL 62561

(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 Complaint Investigation 2648269/ IL00202691 No violations cited. Complaint Investigation 2678406/ IL00202735 Violations Cited: 295.4010 a) e) f) g) 1) A) C) 2) 3) h) 295.6000 a) 1) 2) 13) 295.6010 a) 1) 2) b) 1) 2) 3) 4) 5) 6) 7) c) d)	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 1 Violation Section 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. e) The service plan shall be reviewed and revised if necessary immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000). f) Based on the physician's assessment, the service plan may provide for the disconnection or removal of any kitchen appliance. (Section 15 of the Act)	A4010		

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A4010	Continued From page 1 g) Service plans shall address: 1) The level of service the resident is receiving, including: A) assistance with activities of daily living; C) special accommodations for the resident; 2) The amount, type, and frequency of health-related services needed by the resident; 3) Staff responsible for the provisions of the service plan; h) The service plan shall include all support services provided or arranged for by the establishment. Based on interview and record review, the Establishment failed to ensure an updated service plan was developed and implemented following changes in a resident's condition by failing to revise the service plan with individualized fall prevention interventions after each fall and failed to ensure documented fall prevention interventions were maintained in working order to prevent a fall with serious injuries for one resident (R4) of three residents reviewed for Service Plans and falls. These failures resulted in R4 sustaining multiple injuries including pelvic fractures and a subdural hematoma on 9/26/25 when R4 sustained a fall and her documented intervention of a personal alarm was found to not be functioning due to the batteries being dead. These failures create substantial probability of harm to all residents of the Establishment.	A4010		

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A4010	Continued From page 2 Findings Include: R4's Service Plan dated 5/27/25 documents R4 was admitted to the Establishment on 2/10/25 with diagnoses including confusion and memory disturbance. The Establishment's Incident Report dated 3/18/25 documents resident presents with ¾ inch laceration above left eyebrow, (skin closure strips) applied to laceration until healed. Resident unable to accurately detail how she injured herself, unwitnessed fall. R4's Service Plan dated 2/10/25 does not document the fall R4 sustained on 3/18/25 nor any fall interventions to reduce R4's risk of sustaining further falls. The Establishment's Incident Report dated 3/29/25 documents R4 presents with soreness of right arm, advised she had fallen in her bathroom. It continues, resident has a 2-inch-wide knot on her right bicep, ROM (range of motion) was normal. She requested Tylenol for discomfort, soreness on ride side. R4's Service Plan dated 2/10/25 does not document the fall R4 sustained on 3/29/25 nor any interventions to reduce R4's risk of sustaining more falls. The Establishment's Incident Report dated 5/24/25 documents R4 was heard calling out for help when a CNA (Certified Nurse Assistant) observed her lying on her back in her doorway. The resident did not have on any shoes and stated she slipped on her way to the dining room. Upon assessment the resident stated her left hip was hurting and she would rate the pain a 10.	A4010		

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A4010	Continued From page 3 The resident also stated she could not move her left leg which appeared to be rotated outward. R4's local hospital records dated 5/26/25 documents (R4) presents to emergency department memory care unit for a ground level fall. Patient brought in by EMS (Emergency Medical Services) who states patient was found down on the floor endorsing pain to the left hip. She states she has not ambulated since the fall. Diagnosis left intertrochanteric hip fracture. R4's Service Plan dated 5/27/25 documents on 5/27/25 R4 returned to the Establishment post-surgery and a bed alarm is now on R4's bed, when alarm sounds, care staff will respond and assist for fall prevention. The Establishment's Incident report dated 7/29/25 documents R4 was ambulating from dining room using walker, fell backwards to floor. Back brace was in place; resident did not hit head. Resident denies injury, ROM WNL (within normal limits), skin tear to left elbow, (skin closure strips) applied until healed. Resident ambulated with walker and began to complain of discomfort on right side and discomfort on inhalation. R4's Service Plan dated 5/27/25 does not document the fall R4 sustained on 7/29/25 nor a new intervention to reduce her risk of sustaining further falls. The Establishment's IDPH (Illinois Department of Public Health) report form dated 9/26/25 documents R4 fell at 7:40 AM on 9/26/25. Employee went to assist R4 to get dressed for the day. When care giver walked in, she did not see R4 in her chair, nor was her bed alarm sounding, R4 was found lying on her stomach halfway in her	A4010		

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A4010	Continued From page 4	A4010		

bathroom on the floor. Employee asked what happened, R4 replied "I slipped and fell." R4 was immediately assessed by writer (E2 Director of Nursing) and R4 was noted with a hematoma to her left forehead. It continues, ROM to extremities performed and noted with complaints of pain with outward rotation to left hip. Writer called 911, ambulance arrived and transported R4 via stretcher to local hospital. R4 was admitted with a pelvic fracture.

R4's local hospital records History and Physical dated 9/29/25 documents (R4) presenting as a category 2 trauma after a ground level fall at her memory care facility. Patient has a history of dementia. CT (computed tomography) scans of the head, spine, chest, abdomen, and pelvis were obtained. Patient was noted to have a subdural hematoma, acute T9 (thoracic) burst fracture, pubic bone fractures, and sacral fracture.

On 7/9/26 at 2:00 PM E2 Director of Nursing stated she knew why the bed alarm was not working. E2 states that the batteries were found to be dead in the bed alarm.

On 7/10/26 at 9:35 AM E2 Director of Nursing stated R4's Service Plan was not updated after she obtained a laceration on 3/18/25 nor was R4's Service Plan updated with a fall interventions after R4 fell on 3/29/25.

The Establishment's contract documents Assessments and Service Plans: At least 60 days prior to admission to Establishment a comprehensive assessment that includes an evaluation of the prospective resident's physical, cognitive and psychosocial condition shall be completed. It continues, the comprehensive assessment shall be updated annually and upon

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A4010	Continued From page 5 identification of a significant change in the resident's condition. The service plan shall be reviewed annually at the time of the update of the comprehensive assessment or more often based on a significant change in the resident's condition or when the resident's preferences or service needs change. The service plan shall provide the basis for the services delivered under this contract. The service plan will outline the services the resident is to receive including but not limited to what assistance with activities of daily living that may be necessary. The Establishment's census roster dated 7/8/26 documents there are 28 residents living at the Establishment.	A4010		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 2 Violation Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 1) The right to live in an environment that promotes and supports each resident's dignity, individuality, independence, self-determination, privacy, and choice and to be treated with consideration and respect;	A6000		

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A6000	Continued From page 6 2) The right to respect for bodily privacy and dignity at all times, especially during care and treatment; 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; Based on interview and record review, the Establishment failed to ensure residents were afforded their right to dignity, respect, and to be free from abuse by failing to protect residents (R5, R6, R7) from abusive treatment by a staff member. These failures create substantial probability of harm to R5, R6, R7, and all residents of the Establishment. Findings Include: 1. R5's Physician's Assessment form dated 3/31/26 documents R5 has diagnoses including Alzheimer's disease, anxiety, depression, and arthritis. R5's Service Plan dated 3/31/26 documents R5 requires assistance of one with ADLS (activities of daily living) . The Establishment's Employee Notice Form for E9 Resident Assistant documents on 4/30/25 E9 was getting a resident (R5) up for the day, while doing so another employee overheard E9 screaming at the resident (R5) saying "get up (R5) god dammit, get up" then saying "you won't listen and repeating these statements. 2. R6's Physician Assessment form dated 4/20/26 documents R6 has diagnoses including congestive heart failure, macular degeneration,	A6000		

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A6000	Continued From page 7	A6000		

and depression.

R6's Service Plan dated 4/24/25 documents R6 requires assistance of one with ADLS.

The Establishment's Employee Notice Form dated 6/4/25 documents second warning, resident reported E9 was very rude and rough with her when giving her a shower. Stated "I asked her to put towel on shower floor so it's not slick and E9 replied "no, no, no," and refused telling her (R6) to get in. R6 stated she (E9) seemed angry and had a stern face, barely washed her, and did not wash her privates. Resident (R6) stated to E9 "my front and back needs washed." R6 stated E9 replied "I did." R6 said "I know if I am washed or not and at one point in shower E9 yelled at her to sit down. It continues, R6 stated E9 was very rough putting her clothes on for her and R6 does not want E9 to care for her again.

3. R7's Physician Assessment form dated 9/8/25 documents R7 had diagnoses including Aortic Stenosis, Hard of Hearing, Gilbert's Syndrome, Hyperglycemia, Coronary Artery Disease and Stroke.

R7's Service Plan dated 6/18/25 documents R7 required assistance of one with ADLS.

The Establishment's Employee Notice Form dated 6/9/25 documents E9 was terminated on 6/9/25 for abuse. Writer (E2) watched camera following the incident and saw E9 smack a resident on arm. On 6/8/25 a family member reported to the nurse on duty that she witnessed E9 trying to wake up a resident sleeping in wheelchair while out in courtyard. Family member stated E9 slapped resident (R7) on his arm.

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A6000	Continued From page 8 E2 Director of Nursing was interviewed and questioned about abuse allegations. E2 stated that she was aware of the allegations with the resident aid (E9) on R5, R6 and R7. E2 stated that she did not immediately suspend E9 on the first and second allegation. E2 did not report the abuse allegations to the state either. E2 stated she did not have any investigation reports or follow up with any of the incidents. E2 states on the third report of abuse which was seen on camera with E9 slapping R7 that she terminated the employee; however nothing was reported to IDPH or an internal investigation done to determine if any other residents were abused The Establishment's undated Resident Rights policy documents 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: 3. The right to respect for bodily privacy and dignity at all times especially during care and treatment. 9. The right to be free of abuse or neglect. The Establishment's Resident roster dated 7/8/26 documents there are 28 residents living at the Establishment.	A6000		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr This Regulation is not met as evidenced by: Type 1 Violation	A6010		

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	ASL510129	A. BUILDING: _____ B. WING _____	C 07/10/2026

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A6010	Continued From page 9 Section 295.6010 Abuse, Neglect, and Financial Exploitation Prevention and Reporting a) When the establishment has a reasonable belief that a resident has been the victim of abuse, neglect, or financial exploitation, the establishment shall: 1) Notify the Department within 24 hours after receiving the allegation, by contacting the Assisted Living Complaint Registry by telephone, fax, or other electronic means. The establishment shall document this report and maintain documentation on the premises for 12 months after the date of the report. 2) Investigate and develop a written report within 14 days after the initial report. The establishment shall send the written report to the Department within 24 hours after it is completed and shall maintain a copy of the written report on the premises for 12 months after the date of the report. b) A written report of the investigation conducted pursuant to subsection (a)(2) shall contain at least the following: 1) Dates, times, and description of the alleged abuse, neglect or financial exploitation; 2) Description of any injury to the resident; 3) Description of any change in the resident's physical, cognitive, functional, or emotional condition; 4) Any actions taken by the licensee;	A6010		

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A6010	Continued From page 10 5) A list of individuals and agencies interviewed or notified by the establishment; 6) Names of witnesses to the alleged abuse, neglect, or financial exploitation; and 7) If the abuse, neglect, or financial exploitation is substantial, a description of the action to be taken by the establishment to prevent the abuse, neglect or financial exploitation from occurring in the future. c) Establishment employees and volunteers are obligated to report abuse, neglect, or financial exploitation of a resident to the establishment management and to the Department. d) When the establishment has a reasonable belief that abuse, neglect or financial exploitation occurred, the perpetrator, if an employee or volunteer, shall be removed from direct contact with residents. Based on interview and record review, the Establishment failed to ensure residents were free from abuse by failing to report 3 allegations of abuse involving one Resident Assistant (E9) to the Illinois Department of Public Health (IDPH); failed to suspend the employee pending the outcome of the abuse investigation; failed to complete and document thorough abuse investigations; and failed to submit the required final abuse investigation reports to IDPH. These failures allowed E9 to continue providing care after the initial allegation of abuse involving R5 on 4/30/25, resulting in subsequent allegations of verbal and emotional abuse of R6 on 6/4/25 and substantiated physical abuse of R7 on 6/8/25. These failures create substantial probability of severe harm to R5, R6, R7, and all residents of	A6010		

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A6010	Continued From page 11	A6010		

the Establishment. These failures began on 6/4/25 when E9 verbally abused R5 and the Establishment failed to report the allegation, failed to investigate the allegation to see if any other residents had been abused by E9, and failed to suspend E9 until a thorough investigation was completed to determine if E9 was a threat to other residents of the memory care Establishment. The Establishment's repeated failure to follow its abuse policy and reporting procedures and state reporting requirements allowed E9 continued access to vulnerable residents after the initial allegation of abuse.

Findings Include:

E9 Resident Assistant's New Hire Status Change form documents E9 was hired on 4/2/26.

1.The Establishment's Employee Notice Form dated 6/4/25 documents first warning on 4/30/25 E9 was getting a resident up for the day, while doing so another employee overheard E9 screaming at the resident and saying "Get up (R5), god dammit get up" then saying "you won't listen and repeating these statements. E9 was sent home by DON (Director of Nursing). Disciplinary Action: written warning, if above action happens again employee will be suspended or terminated. Corrective Actions to be taken Employee must never yell at a resident. Yelling at a resident is verbal abuse and not tolerated.

R5's Physician's Assessment form dated 3/31/26 documents R5 has diagnoses including Alzheimer's disease, anxiety, depression, and arthritis.

2.The Establishment's Employee Notice Form

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A6010	Continued From page 12	A6010		

dated 6/4/25 documents second warning, resident reported E9 was very rude and rough with her when giving her a shower. Stated "I asked her to put towel on shower floor so its not slick and E9 replied "no, no, no," and refused telling her (R6) to get in. R6 stated she (E9) seemed angry and had a stern face, barely washed her, and did not wash her privates. Resident (R6) stated to E9 "my front and back needs washed." R6 stated E9 replied "I did." R6 said "I know if I am washed or not and at one point in shower E9 yelled at her to sit down. It continues, R6 stated E9 was very rough putting her clothes on for her and R6 does not want E9 to care for her again.

R6's Physician Assessment form dated 4/20/26 documents R6 has diagnoses including congestive heart failure, macular degeneration, and depression.

3.The Establishment's Employee Notice Form dated 6/9/25 documents E9 was terminated on 6/9/25 for abuse. Writer (E2) Director of Nursing watched camera following the incident and saw E9 smack a resident on arm. On 6/8/25 a family member reported to the nurse on duty that she witnessed E9 trying to wake up a resident sleeping in wheelchair while out in courtyard. Family member stated E9 slapped resident (R7) on his arm.

R7's Physician Assessment form dated 9/8/25 documents R7 had diagnoses including Aortic Stenosis, Hard of Hearing, Gilbert's Syndrome, Hyperglycemia, Coronary Artery Disease and Stroke.

Attempted interviews of both R5 and R6 and both were alert but confused and unable to interview

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A6010	Continued From page 13 due to being poor historians. On 7/9/26 at 11:49 AM E2 confirmed she did not document any abuse investigations, do any witness investigations or follow up on allegations. The Establishment's undated Resident Abuse/Neglect Policy documents a resident of the Establishment has the right to be free from verbal, sexual, physical, and mental abuse by anyone, including staff members, other residents, consultants, volunteers, and staff from other agencies serving resident, family members, legal guardians, sponsors, friends or other individuals. All personnel must immediately report to the Administrator or Director of Nursing any incident or unusual occurrence with a resident. IDPH (Illinois Department of Public Health) Assisted Living and Shared Housing will be notified within 24 hours as noted in section 295-6010 of the Assisted Living and Shared Housing regulations. The Establishment's Resident roster dated 7/8/26 documents there are 28 residents living at the Establishment.	A6010		