STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	6020953	A. BUILDING: _____ B. WING _____	C 07/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARDWELL RESIDENCES	301 WESTON AVENUE AURORA, IL 60505

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A 000	Initial Comment Facility Reported Incident IL00202806 295.3000a) 295.4010a)d)e)	A 000		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: Type 1 violation Section 295.3000 Personnel Requirements, Qualifications and Training 295.3000a) a) The establishment shall have staff sufficient in number with qualifications, adequate skills, education and experience to meet the 24-hour scheduled and unscheduled needs of residents and who participate in ongoing training to serve the resident population. (Section 35(a)(3) of the Act) These requirements are not met as evidenced by: Based on interview and record review, the establishment failed to ensure fall policy and procedures were followed and ensure a nurse was available to assess a resident before moving them after a fall for one (R1) of three residents reviewed for accidents. This failure has the potential to affect all residents in the establishment and creates a substantial probability of severe harm or death to a resident or residents. The findings include:	A3000		

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A3000	Continued From page 1 Resident roster dated 07/24/2026 provided by E1 (Executive Director) showed a census of 57. Review of R1's medical records showed a move-in date of 06/15/2024 with a primary diagnosis of dementia. Mini Mental State Exam (MMSE) dated 09/22/2025 showed moderate cognitive impairment. Service plan dated and signed 03/20/2026 indicated R1 is confused and resides in the memory care unit. R1 needs monitoring for increased forgetfulness and confusion, is at risk for falls and needs monitoring for falls. R1's progress note dated 07/05/2026 at 09:30 AM documented, "report received from caregiver resident experience an unwitness fall and was found on the floor. Resident do not remember the cause of her fall. Resident was assisted safely from the floor to her wheelchair. Resident was assessed by writer and was alert and responsive. Assessment revealed a skin tear to the left elbow with a small amount of bleeding ...Daughter notified ...stated she spoke with resident early in the morning and she [R1] told her about her fall ..." On 07/24/2026 at 11:55 AM, E3 (Personal Care Assistant) said when a resident falls, caregivers are to get the nurse first to assess the resident before moving them. On 07/24/2026 from 12:23 - 12:45 PM, E4 (Licensed Practical Nurse) said verbatim regarding R1's fall on the morning of 07/05: she came in at 6:00 AM, then about an hour later the aide called me and said she (R1) had a fall incident. I went up there and they already assisted her up into the wheelchair. I assessed	A3000		

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A3000	Continued From page 2	A3000		

her and found a skin tear to left elbow that was bleeding a small amount. I cleaned it and put a bandage on. I did a head-to-toe assessment, looking for bumps on the head or bruises on her body, any pain or fractures. I don't know what time R1's fall had actually occurred; she was not on the floor when I went to assess her. There's no nurse that works on the overnight shift. R1 is alert at times and can sometimes tell staff how she fell. When I called the daughter, she said that she had already spoken to R1 earlier about the fall. She did not complain of any pain, just some discomfort to the elbow area. Regarding fall protocol, E4 said "the caregivers are not supposed to move the resident until after the nurse comes and does an assessment".

On 07/24/2026 at 12:50 PM, E2 (Memory Care Director) said he has been at the community since April 2026 and there has not been a fall in-service since then but there is one scheduled in August.

On 07/24/2026 from 12:54 - 01:10 PM, E5 (Certified Nursing Assistant) said verbatim regarding R1's fall on the morning of 07/05: she worked day shift on that day, came in at 6:00 AM and was told by E6 (Certified Nursing Assistant) she (R1) had fallen. Don't recall the time. She (E6) called the nurse and told her; not sure when. She (R1) was already up in her wheelchair when E5 found out that she had fallen. E5 then said, when a resident is found on the floor, "we get the nurse right away and the nurse does an assessment before we can even move them. If they are okay and not being sent out, we will get them up".

On 07/24/2026 from 02:25 - 2:38 PM, E6 (Certified Nursing Assistant) said verbatim

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A3000	Continued From page 3 regarding R1's fall on the morning of 07/05: she did not have a fall on the morning of 07/05 on day shift. When I came in, I was told by the night shift caregiver that R1 had fallen during the night. She said R1 "was okay and was not serious". I went to check on R1 after that and she was not on the floor. She was either in her chair or on her bed. I talked to her and asked her how she was doing. She was her usual self, and I asked her about the fall. She said she fell but could not tell me any details about the fall. E6 then said, "when we find a resident on the floor, we don't get them up. We are supposed to get the nurse, and the nurse does an assessment. After the assessment, the nurse determines if resident will be sent out or if we can get them up. On 07/24/2026 from 02:20 - 02:35 PM, E1 (Executive Director) and E2 (Memory Care Director) said verbatim regarding fall interventions and protocol: E1 said when a caregiver finds a resident on the floor, they are to call the nurse. There is no nurse scheduled for the overnight shift so "they should call the on-call supervisor prior to moving the resident. They know this is the fall protocol". E1 added that the "overnight shift should not get a resident up. If they hit their head or have apparent injury, they are to call 911". E2 said they can try to get the resident up to a sitting position while the on-call is on the phone. E1 and E2 said the on-call guides the caregiver to determine whether the resident will be sent out or if they can be assisted off the floor. On 07/24/2026 from 02:42 - 02:52 PM, E8 (Licensed Practical Nurse) said verbatim regarding fall interventions and protocol: caregivers are not to move the resident after a fall until after the nurse assesses them. The caregivers can't assess a resident.	A3000		

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A3000	Continued From page 4 Attempt to contact E9 (Personal Care Assistant) on 07/25/2026 regarding R1's AM fall on 07/05/2026 was unsuccessful. Note: no progress note was reviewed that indicated R1 had a fall on the overnight shift or that E9 (Personal Care Associate) contacted the manager on duty prior to assisting R1 up from the floor following a fall incident. Fall policy last approved 09/2025 reads in part: upon a resident fall event, an immediate assessment (if by a licensed clinician) and/or evaluation (if by a non-licensed, trained staff member) of the resident will be completed to determine any possible injury. The licensed nurse at the community will be promptly notified and consulted as appropriate. Any injuries noted will be communicated to the community licensed nurse for consideration or further director. Any post fall interventions determined will be implemented and documented in the resident's medical record ...	A3000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 2 Violation Section 295.4010 Service Plan 295.4010a)d)e) a) Based on the physician's assessment and	A4010		

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A4010	Continued From page 5	A4010		

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 residents' choices regarding the 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)
e) The service plan shall be reviewed and revised if necessary immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000).

These requirements are not met as evidenced by:

Based on observation, interview and record review, the establishment failed to ensure fall interventions were updated and individualized to meet the resident's condition and service needs for two (R1, R3) of three residents reviewed for accidents. This failure creates a substantial probability of harm to a resident or residents.

The findings include:

1. Review of incident log for the last three months showed R1 had a fall on 06/05/2026 at 09:32 PM, a fall with injury on 07/05/2026 at 02:01 PM, and a fall with injury on 07/05/2026 at 08:22 PM.

Review of R1's medical records showed a move-in date of 06/15/2024 with a primary diagnosis of dementia. Mini Mental State Exam (MMSE) dated 09/22/2025 showed moderate cognitive impairment. Service plan dated and signed 03/20/2026 indicated R1 is confused and

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A4010	Continued From page 6	A4010		

resides in the memory care unit. R1 needs monitoring for increased forgetfulness and confusion, is at risk for falls and needs monitoring for falls.

R1's post fall interventions were noted for R1's falls on 01/07/26, 01/19/26, and 07/05/26 that included supervision while in common areas to minimize resident to resident altercations, frequent checks during night for toileting needs, gripper socks when shoes cannot be worn, keep resident in view during high risk times if possible, and observe resident transferring in their shoes and assess for difficulties. No intervention was noted following the 06/05/26 fall incident.

On 07/24/2026 at 11:45 AM, R1 was noted alert to self and did not recall any recent falls. Due to dementia, R1 was not interviewable.

2. Review of incident log for the last three months showed R3 had falls on 05/31/2026 at 04:32 PM and 06/17/2026 at 12:53 PM and a fall with injury on 07/20/2026 at 06:02 PM.

Review of R3's medical records showed a move-in date of 10/04/2023 with a past medical history that included dementia, insomnia and major depressive disorder. Service plan dated and signed 06/17/2026 indicated R3 needs monitoring for increased forgetfulness and confusion, is alert and oriented times one, needs supervision with mobility.

R3's post fall interventions were noted for falls on 5/31 and 06/17 that included assure resident is wearing non-slip footwear at all times while ambulating, use gripper socks when shoes cannot be worn, and remove cluster from walkways and common areas. No interventions

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A4010	Continued From page 7 were noted for R3's fall on 07/20. On 07/24/2025 at 03:15 PM, R3 was observed at the dining room table on the memory care unit. R3 was not interviewable due to dementia. On 07/24/2026 at 02:35 PM, E1 (Executive Director) said after any fall occurs, it goes in the service plan and fall interventions are updated at time of fall. Unless it occurs on a weekend, then they are updated the next business day. Resident roster dated 07/24/2026 provided by E1 (Executive Director) showed a census of 57. Service Plan policy last approved 07/2026 reads in part: each resident will have a written plan of care that is developed based on initial assessment, annual comprehensive assessment, quarterly evaluations, and changes in resident needs ... Fall policy last approved 09/2025 reads in part: any resident who is identified to require fall reduction/management interventions through initial interview/assessment, during the ongoing routine assessment process or based upon a significant change in condition, will have this information documented as a part of the resident's medical record (i.e.: service plan) ...Any post fall interventions determined will be implemented and documented in the resident's medical record ...the resident's service plan will be updated, if necessary and/or with any significant change in condition, to include any additional fall reduction measures ...	A4010		