STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510160	A. BUILDING: _____ B. WING _____	C 08/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD AT MCHENRY (THE) (MC)	3350 CHARLES MILLER ROAD MCHENRY, IL 60050

(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 IL202912 295.4010c)d)e)	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 1 Violation Repeat Violation Section 295.4010 Service Plan c) The service plan shall be signed and dated by all individuals involved in its development. 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 were not met, as evidenced by: Based on interview and record review, the facility failed to ensure a service plan was updated after resident fall(s) and signed by the individuals	A4010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510160	A. BUILDING: _____ B. WING _____	C 08/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD AT MCHENRY (THE) (MC)	3350 CHARLES MILLER ROAD MCHENRY, IL 60050

(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
A4010	Continued From page 1	A4010		

involved in its development for 2 of 3 residents (R1, R2) reviewed for service plans in the sample of 3. This failure creates a substantial probability of severe harm to a resident.

The findings include:

R1's Observation notes show R1 fell nine times between 5/22/26 and 7/23/26. R1's service plan, not signed/dated by anyone, makes mention of two falls, one on 5/22/26 and one on 7/4/26, and begins to mention the date of another fall (on 7/23/26), but the sentence is not complete. R1's service plan does not list R1's fall. According to R1's Observation notes, she fell on 5/27/26 and was sent to the Emergency Department (ED) and had additional falls on 5/29/26, 6/5/26, 6/16/26, and 6/23/26 without being sent to the ED. Then R1 fell again on 6/26/26 and was sent to the ED. R1's After Visit Summary dated 6/26/26 from the hospital visit shows R1 was diagnosed with a sacral and coccyx fracture and head laceration. R1's face sheet dated 8/3/26 shows her husband is her Power of Attorney.

R2's Observation notes show R2 fell four times between 5/24/26 and 7/24/26 and was sent to the ED the last three of the four times. However, R2's Service plan, dated 5/3/26 to 8/3/26 shows R2's last fall occurred on 10/11/25. No falls after 10/11/25 were addressed or interventions added. R2's Service plan was not signed by anyone.

On 8/3/26 at 11:41 AM, E3, Memory Care Director, said service plans are done anytime there is an incident like a fall. E3 said the service plans are done by the Director of Nursing (DON), E2, and the Assistant Director of Nursing together with family members and she and the nurses add input. E3 said R1's service plan is not signed yet.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510160	A. BUILDING: _____ B. WING _____	C 08/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD AT MCHENRY (THE) (MC)	3350 CHARLES MILLER ROAD MCHENRY, IL 60050

(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
A4010	Continued From page 2 E3 said R1's husband lives next door in assisted living. On 8/3/26 at 1:36 PM, E2 said she is having to go through and catch up on the resident service plans as the former DON and Assistant DON both left abruptly. E2 said service plans are updated with any change of condition, like a fall. The purpose of the service plan is to direct the care staff on how to care for the residents and to provide a collaborative guideline to show families how they will care for their loved ones, and what the residents' care needs are. E2 said the nurse, caregiver, and family provide input into service plan along with the DON, ADON, and Memory Care director. E2 said she and the family are required to sign the service plan. E2 said they identify the root cause after a resident fall, and it is put in the service plan with corresponding interventions. The establishment's Individual Service Plan (ISP) (last dated 4.2026) shows an ISP must be completed for each resident in the establishment when there is a change in condition to meet the needs of residents and provide prompt and adequate treatment.	A4010		