STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510005	A. BUILDING: _____ B. WING _____	C 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBER GLEN ALZHEIMER'S SCC	1704 EAST AMBER LN URBANA, IL 61802

(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 Original investigation 179488 Violation cited: 295.2050 b) Type 2 violation	A 000		
A2050	Section 295.2050 Incident and Accident Reporting This Regulation is not met as evidenced by: Type 2 violation Section 295.2050 Incident and Accident Reporting b) The report shall be made by contacting the Department of Public Health Central Complaint Registry or by fax or by other electronic means within 24 hours after the occurrence of the incident or accident. These requirements were not met as evidenced by: Based on interview and record review the establishment failed report R1's fall with an injury to the Department of Public Health within 24 hours. This creates a substantial probability of harm to a resident or residents. Findings include: Interview: Interview with E1 and E2 confirmed that R1 sustained an injury post fall on 7/21/2024. The report of the fall was not submitted to the Department of Public Health until 10/15/24.	A2050		

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A2050	Continued From page 1 Record Review: Review of documents confirm that R1 sustaind an injury after a fall on 7/21/2024. The report was not submitted to the Department of Public Health until 10/15/24.	A2050		