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AMBER GLEN ALZHEIMER'S SCC	1704 EAST AMBER LN URBANA, IL 61802

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A 000	Initial Comment Annual Licensure Survey entered on August 14, 2025 Violations cited: 295.2000 a)c)1)d)e) Type 1 Violation 295.2040 a)b)d)g)h) Type 1 Violation 295.3000 a)b) Type 1 Violation 295.4010 c)e) Type 3 Violation 295.4060 a)e)f)g)h)3)A)B)9)ii) Type 1 Violation Original Complaint Investigation/Facility Reported Incident: IL196918 Violations cited: 295.2000 a)c)1)d)e) Type 1 Violation 295.4010 c)e) Type 3 Violation 295.4060 a)e)f)g)h)3)A)B)9)ii) Type 1 Violation	A 000		
A2000	Section 295.2000 Residency Requirements This Regulation is not met as evidenced by: Type 1 Violation Section 295.2000 Residency Requirements a) No individual shall be accepted for residency or remain in residence if the establishment cannot provide or secure appropriate services, if the individual requires a level of service or type of service for which the	A2000		

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A2000	Continued From page 1 establishment is not licensed or which the establishment does not provide, or if the establishment does not have the staff appropriate in numbers and with appropriate skill to provide such services. (Section 75(a) of the Act) c) A person shall not be accepted for residency if: 1) The person poses a serious threat to themselves or to others; d) A resident with a condition listed in subsection (c) shall have their residency terminated in accordance with Section 295.2010. (Section 75(d) of the Act) e) Residency shall be terminated in accordance with Section 295.2010 when services available to the resident in the establishment are no longer adequate to meet the needs of the resident. This provision shall not be interpreted as limiting the authority of the Department to require the residency termination of individuals. (Section 75(e) of the Act) These requirements were not met as evidenced by: Based on interview and record review the establishment failed to ensure the appropriate residency of one (R2) of five residents reviewed for residency requirements from a total sample list of 24 residents reviewed. This failure caused harm to a resident and creates a substantial probability of harm to this resident and other residents. Findings include:	A2000		

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A2000	Continued From page 2	A2000		

The establishment provided resident roster dated 8/14/25 documents R2's admission to the establishment on February 28, 2025.

R2's undated face sheet documents admission diagnoses of Vascular Dementia with Mood Disturbances, Anxiety, Depression, Hypertension, Sleep Apnea, and Osteoarthritis.

R2's August 2025 medication administration record document the following psychotropic medications are routinely administered: Wellbutrin XL 300 Milligrams (MG) daily, Buspirone 5MG three times daily, Lexapro 10 MG daily, and Risperdal 0.5MG twice daily.

R2's progress notes dated 3/12/25 document resident behaviors that are not effectively redirected.

R2's progress note dated 3/17/25 document resident aggression walking throughout the facility very fast all night.

R2's progress note dated 4/5/25 document resident behavior as "manic-like" including banging aggressively on the kitchen door and yelling when dissatisfied, has a high level of energy.

R2's progress note dated 4/13/25 document an encounter between R1 and a staff member where R1 cursed at the caregiver and then cornered her in his room while punching pillows and yelling.

R2's progress note dated 4/20/25 documents agitation and aggression toward roommate and staff. R1 entered the room after his roommate had been toileted and was yelling about a urine smell. He then took of his roommate's blanket

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A2000	Continued From page 3	A2000		

and pulled the roommates brief off to smell it. This agitated R1's roommate and caused behaviors in the roommate.

R2's progress note dated 4/23/25 document R1 going back to his old room and roommate and swinging pillows toward the roommate aggressively. R1 pacing the facility.

R2's progress note dated 5/30/25 document that R1 was agitated and opened the window in his room at midnight multiple times, setting off the alarm.

R2's progress note dated 6/1/25 document aggression banging his fists on the nurse's station.

R2's progress note dated 7/31/25 document aggression toward another resident in the dining room.

On 8/14/25 at 10:30AM observed R1 in her room with her husband present. R1 has a large goose egg on her left temple that was yellow and purple in color. Her left knee and surrounding leg was purple and yellow and her right heel of her hand and left thumb were bruised and a laceration on the thumb was healing.

On 8/14/25 at 10:10AM, Z1 Private Caregiver stated that she was the first person to find R1 after her injury on 8/5/25. Z1 stated, "I heard R2 yell, "Get out of my room" to someone and so I stuck my head out of my resident's room to see R2 trying to help R1 up off of the floor by his door. R2 looked very guilty and basically threw R1 at me and then went back into his room. R1 had clearly been hit by the door as it was slammed on her. Her face and nose were red and her glasses

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A2000	Continued From page 4	A2000		

had fallen off and her thumb was mangled."

The facility provided state reportable dated 8/5/25 documents R2 yelling at R1 because R1 was in his room, followed by R1 ending up on the floor with injuries including a lacerated thumb, goose egg on her head and multiple bruises and was sent to the emergency room for computed tomography of her head due to the injury.

R2's progress note dated 8/5/25 document that R2 admitted to pushing R1 causing her to fall and become injured.

On 8/19/25 at 9:55AM, E10 Caregiver stated that last week she observed R2 yank R7 out of the dining room by R7's wheelchair while yelling at R7, "They aren't ready for you!" E10 stated that R7 is aggressive toward other residents especially in the dining room.

R2's progress note dated 8/17/25 document at 8:45AM, staff responded to alarms from R2's room. When they entered R2's room, R2's window was open and his screen had been removed. Staff were unable to locate R2 for 18 minutes when he was located in a nearby church.

On 8/18/25 at 2:30PM, observed the church where R2 went on 8/17/25. R2 had to walk past a retention pond through weeds and in the rain to get to the church from the establishment.

On 8/18/25 at 2:35PM, E1 Executive Director confirmed that she found R2 in the church on 8/17/25 and that he had gone past a retention pond, through a weed path, in the rain, to get to the church.

On 8/19/25 at 12:05PM E1 stated that she could

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A2000	Continued From page 5 not guarantee the safety of R2 or the safety of other residents from R2 due to his behaviors.	A2000		
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: d) The establishment shall conduct a tornado drill on each shift during February of each year for employees. g) Drills shall involve the actual evacuation of residents to an assembly point as specified in the emergency plan and shall provide residents with experience using various means of escape. If an establishment has an evacuation capability classification of impractical, those residents who cannot meaningfully assist in their own evacuation or who have special health problems shall not be required to participate in the drill; however, other requirements of the Life Safety Code will apply. h) A written evaluation of each drill shall be	A2040		

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A2040	Continued From page 6 submitted to the establishment manager and shall be maintained for one year from the date of the drill. The evaluation shall include the date and time of the drill, names of employees participating in the drill, and identification of any residents who received assistance for evacuation. These requirements were not met as evidenced by: Based on interview and record review the establishment failed to conduct a tornado drill in the month of February 2025 and failed to perform an evacuation drill over the past 12 months. These failures create a substantial probability of harm to all 44 residents who reside in the facility. Findings include: 1.) The establishment provided emergency drill binder documents one tornado drill performed on 3/3/25 at 5:10AM. On 8/18/25 at 10:00AM, E7 Maintenance Director stated that he was unaware that tornado drills had to be completed in February. 2.) The establishment provided emergency drill binder did not document any evacuation drills for the establishment in the past 12 months. On 8/19/25 at 12:05PM, E1 Executive Director confirmed that no evacuation drills had been held since she started at the facility and that E7 Maintenance Director did not have documentation of any completed in the past 12 months.	A2040		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng	A3000		

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A3000	Continued From page 7 This Regulation is not met as evidenced by: Type 1 Violation Section 295.3000 Personnel Requirements, Qualifications and Training 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) b) The establishment shall have on duty at all times at least one direct care staff person who has obtained cardiopulmonary resuscitation (CPR) training specific to adults, which includes a demonstration of the individual's ability to perform CPR, and who has current certification in CPR. These requirements were not met as evidenced by: Based on interview and record review the establishment failed to have at least one direct care staff person who has obtained cardiopulmonary resuscitation training including a return demonstration. These failures create a substantial probability of harm to all 44 residents who reside in the facility. Findings include: E9 Licensed Practical Nurses (LPN) Cardiopulmonary Resuscitation (CPR) card dated 2/9/25 documents certification in on-line CPR	A3000		

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A3000	Continued From page 8 training without a return demonstration. The establishment provided August 2025 nursing schedule documents that E9 LPN worked August 1, 4, 5, 9, 10, 11, 14, 15, and 18 of 2025 from 6:00PM to 6:00AM. The establishment provided August 2025 nursing schedule documents that on August 1, caregivers E12 and E13 worked from 10:00PM to 6:00AM. On August 4 with 2-3 additional caregivers including E11, E12, E13, or E14. On 8/19/25 at 10:30AM, E2 Wellness Director confirmed that E9 LPN, nor E11, E12, E13, or E14 caregivers had CPR cards on file that include a return demonstration.	A3000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 3 Violation Section 295.4010 Service Plan c) The service plan shall be signed and dated by all individuals involved in its development. 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).	A4010		

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A4010	Continued From page 9 These requirements were not met as evidenced by: Based on interview and record review the establishment failed to update and sign a service plan for two (R1, R2) of five residents reviewed for service plans from a total sample list of 24 residents reviewed. Findings include: 1.) R1's establishment provided service plan dated 11/19/24 does not document wandering behaviors, nor is it signed. 2.) R2's establishment provided service plan dated 8/15/24 does not document aggression toward other residents, nor is it signed. On 8/19/25 at 3:45PM, E1 Executive Director and E2 Wellness Director stated that the service plans were not updated with all residents' behaviors and changes and were not signed.	A4010		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Type 1 Violation 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)	A4060		

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A4060	Continued From page 10 e) No person shall be accepted for residency or remain in residence if the person is dangerous to self or others and the establishment would be unable to eliminate the danger through the use of appropriate treatment modalities. (Section 150(d) 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) g) If an establishment accepts any individuals with cognitive impairments that prevent them from safely evacuating the establishment independently, sufficient staff members shall be present and awake 24 hours a day to assist in evacuation. h) An establishment that offers to provide a special program for persons with Alzheimer's disease and related disorders shall: 3) Develop and implement policies and procedures that ensure the continued safety of all residents in the establishment including, but not limited to, those who: A) May wander; and B) May need supervision and assistance when evacuating the building in an emergency; 9) Develop emergency procedures and staffing patterns to respond to the needs of residents; (Section 150(f) of the Act) ii) emergency and evacuation procedures	A4060		

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A4060	Continued From page 11 specific to the dementia population; These requirements were not met as evidenced by: Based on observation, interview, and record review the establishment failed to ensure the appropriate residency for one (R1) resident with aggression toward other residents and eloping from the facility and failed to ensure the appropriate staffing for facility evacuations in case of emergency. These failures create a substantial probability of harm to all 44 residents who reside in the facility's Alzheimer's dementia program. Findings include: The establishment provided resident roster dated 8/14/25 documents 44 residents reside in the establishment. 1.) The establishment provided resident roster dated 8/14/25 documents R2's admission to the establishment on February 28, 2025. R2's undated face sheet documents admission diagnoses of Vascular Dementia with Mood Disturbances, Anxiety, Depression, Hypertension, Sleep Apnea, and Osteoarthritis. R2's August 2025 medication administration record document the following psychotropic medications are routinely administered: Wellbutrin XL 300 Milligrams (MG) daily, Buspirone 5MG three times daily, Lexapro 10 MG daily, and Risperdal 0.5MG twice daily. R2's progress notes dated 3/12/25 document resident behaviors that are not effectively	A4060		

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A4060	Continued From page 12 redirected. R2's progress note dated 3/17/25 document resident aggression walking throughout the facility very fast all night. R2's progress note dated 4/5/25 document resident behavior as "manic-like" including banging aggressively on the kitchen door and yelling when dissatisfied, has a high level of energy. R2's progress note dated 4/13/25 document an encounter between R1 and a staff member where R1 cursed at the caregiver and then cornered her in his room while punching pillows and yelling. R2's progress note dated 4/20/25 documents agitation and aggression toward roommate and staff. R1 entered the room after his roommate had been toileted and was yelling about a urine smell. He then took of his roommate's blanket and pulled the roommates brief to smell it. This agitated R1's roommate and caused behaviors in the roommate. R2's progress note dated 4/23/25 document R1 going back to his old room and roommate and swinging pillows toward the roommate aggressively. R1 pacing the facility. R2's progress note dated 5/30/25 document that R1 was agitated and opened the window in his room at midnight multiple times, setting off the alarm. R2's progress note dated 6/1/25 document aggression banging his fists on the nurse's station.	A4060		

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A4060	Continued From page 13 R2's progress note dated 7/31/25 document aggression toward another resident in the dining room. The facility provided state reportable dated 8/5/25 documents R2 yelling at R1 because R1 was in his room, followed by R1 ending up on the floor with injuries including a lacerated thumb, goose egg on her head and multiple bruises and was sent to the emergency room for computed tomography of her head due to the injury. On 8/14/25 at 10:10AM, Z1 Private Caregiver stated that she was the first person to find R1 after her injury on 8/5/25. Z1 stated, "I heard R2 yell, "Get out of my room" to someone and so I stuck my head out of my resident's room to see R2 trying to pick R1 up off of the floor by his door. R2 looked very guilty and basically threw R1 at me and then went back into his room. R1 had clearly been hit by the door as it was slammed on her. Her face and nose were red and her glasses had fallen off and her thumb was mangled." On 8/14/25 at 10:30AM observed R1 in her room with her husband present. R1 has a large goose egg on her left temple that was yellow and purple in color. Her left knee and surrounding leg was purple and yellow and her right heel of her hand and left thumb were bruised and a laceration on the thumb was healing. R2's progress note dated 8/5/25 document that R2 admitted to pushing R1 causing her to fall and become injured. On 8/19/25 at 9:55AM, E10 Caregiver stated that last week she observed R2 yank R7 out of the dining room by R7's wheelchair while yelling at R7, "They aren't ready for you!" E10 stated that R7 is aggressive toward other residents	A4060		

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A4060	Continued From page 14	A4060		

especially in the dining room.

R2's progress note dated 8/17/25 document at 8:45AM, staff responded to alarms from R2's room. When they entered R2's room, R2's window was open and his screen had been removed. Staff were unable to locate R2 for 18 minutes where he was located in a nearby church.

On 8/18/25 at 2:30PM, observed the church where R2 went on 8/17/25. R2 had to walk past a retention pond through weeds and in the rain to get to the church from the establishment.

On 8/18/25 at 2:35PM, E1 Executive Director confirmed that she found R2 in the church on 8/17/25 and that he had gone past a retention pond, through a weed path, in the rain, to get to the church.

On 8/19/25 at 12:05PM E1 stated that she could not guarantee the safety of R2 or the safety of others from R2 due to his behaviors.

The facility provided Alzheimer's Special Care Center Disclosure Statement documents that relocation, transfer or discharge of a resident may occur for the following reasons including: the safety of the resident or other residents in the community is endangered.

2.)The establishment provided resident roster dated 8/14/25 documents 44 residents reside in the establishment including 14 hospice residents and 19 non-ambulatory residents.

The establishment provided August 2025 nursing schedule documents 2-3 caregivers at night and 1 nurse are in the building from 10PM to 6:00AM.

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 _____	08/19/2025

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
A4060	Continued From page 15 The establishment provided emergency drill binder did not document any evacuation drills for the establishment in the past 12 months. On 8/19/25 at 12:05PM, E1 Executive Director confirmed that no evacuation drills had been held since she started at the facility and that E7 Maintenance Director did not have documentation of any completed in the past 12 months. On 8/18/25 at 3:55PM, E2 Wellness Director confirmed that from 10:00PM to 6:00AM there are 2- 3 Caregivers and 1 nurse in the building. On 8/19/25 at 12:05PM, E1 confirmed that there were 14 hospice residents and 19 non-ambulatory residents and stated that at this time she did not know how or if the establishment could effectively evacuate the establishment in case of emergency.	A4060		