STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510512	A. BUILDING: _____ B. WING _____	C 09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARTIS SENIOR LIVING OF LAKEVIEW	3535 NORTH ASHLAND AVENUE CHICAGO, IL 60657

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A 000	Initial Comment Complaint Investigation 2589011/IL197623 - unsubstantiated Facility reported Incident of 8/26/25 IL197471 - substantiated with violations at: 295.3000 a) Personnel Requirements 295.6000 a)1) Resident Rights 295.6010 a)2)b)1)5)6) Abuse, Neglect and Financial Exploitation	A 000		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: 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). Type 2 Violation These Requirements are not met as evidenced by: Based on interview and record review, one (E1 Executive Director) of one employee's failed to follow facility policy requiring written interviews for an abuse investigation involving 3 residents (R1, R2, R3) and failed to include sufficient information	A3000		

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A3000	Continued From page 1	A3000		

in the initial or final report to be able to adequately determine who was a witness to the events, when the allegations occurred and what they heard or saw. This deficient practice affected the abuse investigation involving 3 residents (R1, R2, R3) out of 3 residents reviewed for abuse and has the probability of affecting all future abuse investigations. This failure creates a substantial probability of harm to a resident or residents.

Findings include:

E1(Executive Director) is the abuse coordinator for the facility and initiated an investigation for an incident dated 8/26/25 involving R1, R2 and R3, all of whom have Dementia as a diagnosis.

Both the initial and final report describes the following behaviors by E3(care partner):

"Multiple care partners confirmed that (E3) demonstrated discourteous and unprofessional behavior, including yelling at residents;"

"(E3) refused to assist with resident transfers in accordance with ...(E3) stated, "I cannot assist residents who cannot transfer themselves," thereby creating a safety risk for those in (E3) care;"

"Further reports indicated (E3) continued to exhibit verbally aggressive and dismissive behavior toward residents. (E3) actions were found to be violation of residents' rights, professional standards of care, and the facility's policies."

Facility policy and procedure titled, "Abuse Reporting and Investigation) requires "an incident report, along with associate, resident, family or

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A3000	Continued From page 2	A3000		

other written statements, will be maintained on file in the administrative office."

Neither the initial or final report identify witnesses to events described compatible with either abuse or resident right to dignity/consideration/respect. Many of the terms E1 uses are not sufficiently defined to make a determination of whether abuse or dignity issue occurred or a combination of both.

On interview E1 referred to unnamed employee witnesses and documented in E3's disciplinary notice "interviews with several associates confirmed that this behavior has occurred previously." No dates or names of witnesses are attached to this statement and despite request for witness statements from E1, no statements were forwarded. On interview, E1 identified E5(Lead Care Partner) and E6 as witnesses to events described in the reportable accident/incident.

On 9/23/25 at 1:30 pm E5(lead Care Partner) recalled E3 as being impatient, having tone, attitude, and rushing unnamed resident. E6(Director of Business Services) on 9/23/25 at 1:00 pm described an incident with R1 in which he took his clothes off in public and E3 responding by telling R1 to put his clothes on. According to E6 there was nothing wrong with the way E3 handled that situation.

E1 did not follow facility abuse policy and procedure and did not document the investigation in a manner which includes enough detail to corroborate E1's determination and facility compliance.

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A6000	Continued From page 3	A6000		
A6000	Section 295.6000 Resident Rights	A6000		

This Regulation is not met as evidenced by:
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;

Type 2 Violation

These Requirements are not met as evidenced by:

Based on interview and record review, facility care partner(E3) failed to treat 3 residents (R1, R2, R3) with dignity out of 3 reviewed for compliance with resident rights in a total sample of 7. This failure creates a substantial probability of harm to a resident or residents.

Findings include:

E1(Executive Director) forwarded Incident/accident report of 8/26/25 which documents "discourteous and unprofessional behavior, including yelling at residents." R1 and R2 and R3 are identified as affected by the

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A6000	Continued From page 4 behavior of E3(Care Partner). The initial report describes E3 as using "aggressive language" toward residents. The final report indicates "multiple care partners confirmed that the employee demonstrated discourteous and unprofessional behavior, including yelling at residents." E3 is also accused of refusing to assist with resident transfers in accordance with their individualized safe transfer and ambulatory guidelines. According to the report an unidentified staff member witnessed E3 saying, "I cannot assist residents who cannot transfer themselves, thereby creating a safety risk for those in (E3's) care." On 9/23/25 at 9:30 am E1(Executive Director) was asked for written interviews related to alleged events of 8/26/25. No interviews were forwarded for review. Because of the lack of written interviews, E1 was asked to describe what happened between R1, R2, R3 and E3(care partner). E1 replied, "(E3, care partner) stated I'm tired of working with these people who can't ambulate. Fuckin people can't ambulate. All Dementia. When (E3) said this, (E3) was with 3 residents. Witnesses were (E4, care partner), (E5, Lead Care Partner), heard yelling of (E3). (E3) was impatient. Pushing (R3) wheelchair, and (R2) rollator. Trying to hurry up (R2). (R3) repetitively asking questions and is ambulating. So (E3) 3 residents taking to activity. Demonstrating impatience. Yelling at (R4) it was different date from the incident with the other 3 ..." R1 who is listed on the initial accident/incident report written by E1(Executive Director) is not included in E1's verbal explanation of what happened and without written statements	A6000		

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A6000	Continued From page 5 determination of what exactly was witnessed involving R1 cannot be determined. On 9/23/25 at 1:30 pm E5(Lead Care Partner) who was identified as witness to incident with R1, R2 and R3 was asked what had occurred. E5's response does not include the name of the resident affected by E3's behavior. On interview E5 could not recall the name of the resident affected by E3's behavior. E5 stated, "(E3) called (E5) to (unnamed) resident. Claimed had bowel movement. (E3) (saying) "get up, come on." Talking aggressive. Told (E3) chill. (E3) became defensive and said you not going to make it seem like I'm really mean to them, that I be cursing at them. When (E3) said its not about you cursing, I said it's the approach and tone. Sort of like do what she says right now. Resident can't move fast. (E3) rushing her(undefined). And not taking into consideration who we're dealing with. Tone was loud and had a edge and tired. Attitude fed up. (E3) had to come do it. That was my first encounter with (E3) ...(E3) told me this is too fuckin much. I'm tired of job ...(E3) was loudly talking ...Not treating residents with respect ..." Ultimately E1(Executive Director) reports that based on review, E3 failed to treat the residents with respect and dignity, a resident rights violation.	A6000		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr This Regulation is not met as evidenced by: Section 295.6010 Abuse, Neglect, and Financial Exploitation Prevention and Reporting	A6010		

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A6010	Continued From page 6 a) When the establishment has a reasonable belief that a resident has been the victim of abuse, neglect, or financial exploitation, the establishment shall: 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; 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. Type 2 Violation These Requirements are not met as evidenced by: Based on interview and record review, facility administration (E1, Executive Director) failed to: Follow facility abuse policy and procedure which requires written interviews of staff witnesses to an investigation into possible abuse involving 3 residents (R1, R2, R3) out of 3 reviewed for abuse;	A6010		

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A6010	Continued From page 7 Develop and document a credible timeline of events based on those interviews; As a result of the above deficient practice, based on E1's submitted investigation into an allegation of abuse, follow up determination of who witnessed what, when, was impeded. Because essential investigative detail is not included, follow up assessment/determination of E1's conclusions with respect to the allegation of abuse cannot be completed. This deficient practice has the potential to affect all future abuse investigations. This failure creates a substantial probability of harm to a resident or residents. Findings include: E1(Executive Director) is the abuse coordinator for the facility. E1 forwarded an initial report, final report and a copy of the disciplinary notice for E3(Care Partner). Initial incident refers to an 8/26/25 report in which E3(care partner) at approximately 4:00 pm "used aggressive language toward residents. The employee was suspended pending investigation ...Investigation initiated. Final report to follow." Who witnessed this event and what aggressive language was used are not defined." R1, R2 and R3 are identified in the incident/accident report as affected by E3's behavior. The initial and final report completed by E1(Executive Director) does not include names of witnesses, timeframes or sufficient detail to determine who was a witness and exactly what occurred. Although witness statements were requested of	A6010		

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A6010	Continued From page 8	A6010		

E1(Executive Director) none were forwarded. The final report refers to "multiple care partners confirmed that the employee(E3)) demonstrated discourteous and unprofessional behavior, including yelling at residents." None of these terms are defined.

Based on interview with E1 on 9/23/25 at 9:30 am E4(Care Partner), and E5(Lead Care Partner) were witnesses. But later in the same interview, E1 reports E4 walked out before giving a statement.

E5(Lead care partner) on 9/23/25 at 1:30 pm recalled witnessing E3 with sharp tone, loud and rushing a resident who cannot move quickly. E3 could not recall name of resident affected,

E1 during interview of 9/23/25 at 9:30 am identifies E4 (Care partner) and E5(Lead Care partner) as witnesses to yelling of 8/26/25. E1 described her impression of E3 after receiving reports, "(E3) was impatient, pushing (R3) in wheelchair and (R2) with rollator. Trying to hurry up (R2). (R1) was repetitively asking questions and is ambulating. So, (E3) 3 residents taking to activity. Demonstrating impatience. Yelling at (R4), it was different date from incidents with the 3 residents(R1, R2, R3). I have witness "put your pants on. Don't take pants off." Voice was elevated. (E6) witnessed this. Don't know exact date. I think (E3) was excited. Not abuse. (E6) complained about yelling at resident. Incident happened 8/26 at 4:00 pm. (E3) worked pm shift which starts at 2:30 pm. Resident assistant came to complain about yelling at resident at about 4:30 pm. (E3) sent home ..."

Given E1's interview of 9/23/25 at 9:30 am, what E6 witnessed was a loud voice by E3 towards R4

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A6010	Continued From page 9	A6010		

and not a conduct violation, it cannot be determined with accuracy who the "multiple partners" were that confirmed the discourteous and unprofessional behavior by E3. E3's disciplinary notice refers to "interviews with several associates confirm(ing) that this behavior has occurred previously." The lack of written statements by staff impedes discernment of what exactly was reported to E1 by whom and when and whether the statements amount to abuse or a resident rights violation. E1 determined this was a resident rights violation.

Facility policy titled, "Abuse Reporting and Investigation," defines abuse in part as "mental anguish," or "the willful deprivation by an associate of services necessary to maintain physical or mental health." Without witnesses to interview and or complete statements defining what exactly was stated process to verify E1's conclusions is impeded and determination of whether mental anguish occurred cannot be completed. Facility policy requires "a thorough investigation," and "an incident report, along with associate, resident, family or other written statements, will be maintained on file in the administrative office."

There is some indication based on final Incident/Accident report E3 "refused to assist with resident transfers in accordance with their individualized safe transfer and ambulatory guidelines." Who witnesses this, when and what residents could have been affected are not defined in the accident incident report.

E1's documentation of abuse allegation is insufficient and impedes determination of what exactly occurred in this case.