STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL5105751	A. BUILDING: _____ B. WING _____	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER SENIOR LIVING OF SHILOH	1201 HARTMAN LANE SHILOH, IL 62221

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A 000	Initial Comment Annual Licensure- Violations cited: 295.2040 b) 5) c) d) 295.2060 a) b) 1) 2) 295.3000 a) b) 295.4000 a) 295.6000 13)	A 000		
A2040	Section 295.2040 Disaster Preparedness This Regulation is not met as evidenced by: Type 2 violation 295.2040 Disaster Preparedness b) Each establishment shall: 5) Orient each resident to the emergency and evacuation plans within 10 days after the resident's arrival. Orientation shall include assisting residents in identifying and using emergency exits. Documentation of the orientation shall be signed and dated by the resident or the resident's representative. c) At least six drills shall be conducted per year on a bimonthly basis. At least two of the drills shall be conducted during the night when residents are sleeping. All drills shall be held under varied conditions to: d) The establishment shall conduct a tornado drill on each shift during February of each year for employees. Based on interview and record review, the Establishment failed to ensure tornado drills were completed on all shifts in the month of February; conduct fire drills bi-monthly; as well as orientate R2 to emergency and evacuation plans within 10 days of admission. This failure creates a	A2040		

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A2040	Continued From page 1 substantial probability of harm to a resident or residents. Findings include: 1. On 9/15/2025 at 1:30 PM, E4, Environmental Service Director stated there were no tornado drills completed in February 2025, therefore, could not produce documentation. E4 stated the last tornado drill was documented and occurred in February 2024. 2. On 9/15/2025 at 1:30 PM, E4, Environmental Service Director stated a fire drill was not conducted anytime between 9/20/2024 and 4/14/2025 and he could not produce documentation of any being completed during that timeframe. The Establishment's Fire Safety and Emergency Plan documents the administrator and/or Environmental Services Director are responsible for ensuring simulations and drills are conducted as required by state law and facility policy and procedure, be monitored and evaluated for compliance and effectiveness to determine areas of needed improvement. It continues 3. The Establishments Resident Roster document R2 moved into the establishment's community on 1/9/2025. R2's Resident Orientation Checklist was signed and dated by R2 and the Establishment's Representative on 7/23/2025. The Check list documents, "Items to be reviewed with the resident upon move-in" and includes fire drills, demonstration of emergency procedures, and location of emergency exits.	A2040		

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A2040	Continued From page 2 On 9/16/2025 at 1:49 PM, E2, Health and Wellness Director stated R2's Resident Orientation was completed late on 7/23/2025 and confirmed that R2's move in dated was 1/9/2025. On 9/16/2025 at 2:45 PM, E8, Operations Specialist stated the Resident Orientation Checklist should be followed, serving as their policy.	A2040		
A2060	Section 295.2060 Quality Improvement Program This Regulation is not met as evidenced by: Type 3 violation Section 295.2060 Quality Improvement Program- a) The establishment shall establish an effective quality improvement program that encompasses oversight and monitoring, resident satisfaction, and ongoing quality improvement and implementation of any plan that addresses improved quality services. The quality improvement process implemented by the establishment must benchmark performance, be customer centered, be data driven, and focus on resident satisfaction. (Section 30(a) of the Act) For the purpose of this Section, "benchmark" means creating points of reference from which measurements can be made. b) A system shall be in place to facilitate the detection of issues and problems, to expedite the implementation of action, and to resolve problems. 1) Data analysis shall be used to identify and implement changes that will improve performance or reduce the risk of additional events. 2) The establishment shall maintain documentation that shows that data analysis has occurred and that actions, as	A2060		

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A2060	Continued From page 3 appropriate, have been implemented to address identified issues and to resolve problems, as well as any follow-up actions taken by the establishment. Based on interview and record review, the Establishment failed to review their performance by the residents and their families to help improve the care the Establishment provided, per their policy. Findings include: During record review, the Establishment failed to provide evidence that the Establishment had questioned the residents and their families to evaluate the Establishment care on various topics. On 9/16/2025, E8, Operational Specialist, confirmed there had not been any Quality Improvement since January of 2023, but it should be completed quarterly. The Establishment's Quality Excellence Performance Improvement Policy documents, "The purpose of the Quality Excellence Performance Improvement Program is a system that monitors resident outcomes and drives improvement in resident care and employee safety. This includes the delivery of quality care within (The Establishment's) mission and consistent with Federal and State Licensure requirements." It continues to document the Executive Director is responsible for the routine scheduling at least on a quarterly basis.	A2060		

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A3000	Continued From page 4	A3000		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: Violation Type 2 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. Based on interview and record review, the Establishment failed to ensure a staff member with CPR training was on duty at all times. This failure has the substantial probability of harm to a resident. Findings include: On 9/15/2025 at 9:30 AM E2, Health and Wellness Director stated there are 41 residents that reside in the facility. Review of the staffing schedule in conjunction with the review of the employees CPR training certifications, it is noted that E10 and E11 did not have current CPR certifications. Upon further review, it is noted that E10 and E11 were the only	A3000		

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A3000	Continued From page 5 staff working the night shift on 8/27/2025, 8/28/2025, 830/2025, 8/31/2025, 9/3/2025, 9/4/2025, 9/10/2025, 9/11/2025, 9/13/2025, and 9/14/2025. On 9/16/2025 at 1:42 PM, E6, Business Office Manager, stated both E10 and E11 are "both fairly new", had not taken the CPR course and were the only two staff members working the night shift on the dates mentioned above. The Establishment's First Aid and CPR Certification Policy dated 4/17/2024 documents, "Direct care staff will maintain current certification in CPR. The administrator will ensure that there will be at least one staff person at all times who has a current certification in CPR."	A3000		
A4000	Section 295.4000 Physician/s Assessment This Regulation is not met as evidenced by: Type 3 violation Section 295.4000 Physician's Assessment- a) No more than 120 days prior to admission of a resident to any establishment, a comprehensive assessment that includes an evaluation of the prospective resident's physical, cognitive, and psychosocial condition shall be completed by a physician. The physician's assessment shall include documentation of the presence or the absence of tuberculosis infection in accordance with the Control of Tuberculosis Code. At the time of admission, the physician's assessment must reflect the resident's current condition.	A4000		

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A4000	Continued From page 6 Based on interview and record review, the establishment failed to ensure R4's Physician's Assessment was completed by a physician and prior to moving into the establishment. Findings include: The Establishment's Resident Roster documents R4 Physical Move in Date was 9/18/2024. R4's Physician's Plan of Care is signed by E9, Advanced Practice Registered Nurse and dated 9/19/2024. On 9/16/2025 at 1:49 PM, E2, Health and Wellness Director stated resident's Physician Assessment should be completed prior to moving in. E2 confirmed R4 moved into the establishment on 9/18/2024 and his Physician's Assessment was not completed until 9/19/2024 by E9, who is a nurse practitioner.	A4000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 2 violation Section 295.6000 Resident Rights- 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; Based on interview and record review, the Establishment failed to ensure residents were free from misappropriation of narcotic medications. This failure has the substantial probability of harm to a resident.	A6000		

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A6000	Continued From page 7 Findings include: The Establishment's Incident Report dated 7/1/2025 documents, "Alleged Theft-In reviewing narcotic inventory, three entries were made showing (R4's) oxycodone (prescription narcotic pain medication) had been signed out on three occasions in June. When I (E12, Corporate Nurse) interviewed him, resident stated he has not received that medication for a long time and certain not in recent weeks." E7's personnel file documents E7 was terminated on 7/1/2025. It continues to document, "After doing a narcotic count in the community, it was found that (E7) had signed out 3 narcotics on 6/6/2025 at 9AM, 6/20/2025 at 9:30 AM, and 6/23/25 at 5:30 AM. This medication was DC'd (discontinued) and not on the MAR, No notes entered." The Establishment's Investigation Final Report documents, "numbers and times changed on the count list" (E7) was called in on to notify her of her suspension and investigation. It continues to document a caregiver called (former Executive Director) and informed her that nurse had changed the narcotic count and found more missing narcotics. Investigation findings document the 3 narcotics were missing from an old bubble packet and they were given in June. Resident said he cannot remember getting them from the nurse. It continues, "We have determined that 3 oxycodones were signed out of a bubble packet after the prescription had been removed on the MAR." On 9/16/2025 at 3:00 PM, E2 stated R4's oxycodone prescription had been ordered	A6000		

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A6000	Continued From page 8 9/27/2024 discontinued 2/11/2025. R4's Physician's Plan of Care dated 9/19/2024 documents R4 suffers from chronic pain related to osteoarthritis to his right knee and right shoulder. On 9/17/2025 at 11:54 AM, E12 stated she interviewed R4 and he stated he had not had his oxycodone "in forever" and that R4 was a good historian. E12 stated she discovered the diversion when she was getting an order to discontinue the medication. E12 stated the nurse signed the medication out but there was no documentation that R4 had received that medication. R4's Mini-Mental State Examination, undated, documents R4 scored 30/30, meaning R4 is cognitively intact. The Establishment's Resident Rights Policy dated 4/17/2024 documents each resident will be free from misappropriation of property and receive all prescribed medications in the dosage and at intervals prescribed by a practitioner.	A6000		