STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5105793	A. BUILDING: _____ B. WING _____	C 10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTO-WHEATON	219 E PARKWAY DRIVE WHEATON, IL 60187

(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 Establishment Reported Incident Investigation of 10/8/25- IL198002- 295.2050 & 295.4010 cited.	A 000		
A2050	Section 295.2050 Incident and Accident Reporting This Regulation is not met as evidenced by: Type 3 Violation Section 295.2050 Incident and Accident Reporting a) An establishment shall report to the Department any serious incident or accident. For the purposes of this Section, "serious" means any incident or accident that causes physical or emotional harm or injury to a resident. A change in an individual's (resident's) condition that is due to health or medical decline is not a reportable incident or accident. b) The report shall be made by contacting the Department of Public Health Division of Assisted Living via email at DPH.LTCAL@illinois.gov or as requested by the Department within 24 hours after the occurrence of the incident or accident. c) A copy of the report shall be maintained by the establishment for one year after the date of the incident or accident. (Source: Amended at 47 Ill. Reg. 13264, effective August 30, 2023) These requirements were not met as evidenced by:	A2050		

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A2050	Continued From page 1 Based on interview and record review the establishment failed to report a fall with an injury for 1 of 3 residents (R1) reviewed for incident reporting in the sample of 4. The findings include: A Resident Incident Report shows on 9/10/25 at 3:00 AM, R1 was heard yelling for help in her room and was found on the floor. R1 said she had hit her head. 911 was called and R1 was sent to the hospital emergency room for examination and treatment. The report shows R1 had injuries which included a skin tear to her right wrist and redness to her face, she also complained of shoulder pain. R1 returned to the facility later that day. On 10/15/25 at 9:07 AM, E2 (Director of Nursing) said the establishment reports to the department any falls or incidents when a resident has to be sent to the hospital. The facility reportable incidents for 3 months were reviewed and there was no Illinois Department of Public Health (IDPH) reportable confirmation in the facility incidents for R1's fall with an injury on 9/10/25. On 10/15/25 at 2:25 PM, E2 said she could not find if she had reported R1's fall on 9/10/25 or not. E2 was not able to provide proof that the incident was reported or the IDPH reportable incident form that would have been completed and sent. A facility policy on incident accident reporting was requested during the survey and E2 said she was not able to provide one.	A2050		

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A4010	Section 295.4010 Service Plan	A4010		

This Regulation is not met as evidenced by:
Type 1 Violation

Section 295.4010 Service Plan

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 evidence by:

Based on interview and record review the establishment failed to immediately implement interventions into service plans to prevent falls, for 3 of 3 residents (R1, R2 & R3) reviewed for falls in the sample of 4. This failure resulted in sever harm to a resident.

The findings include:

1.) R1's face sheet shows she resides on the memory care unit at the establishment. R1's service plan last revised on 10/13/25 shows she requires total care with her activities of daily living (ADL's).

R1's fall risk assessments completed on 9/11/25 and 10/13/25 show she is at risk for falls.

A Resident Incident Report shows on 9/10/25 at 3:00 AM, R1 was heard yelling for help in her

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A4010	Continued From page 3	A4010		

room and was found on the floor. R1 said she was ready to get up and was trying to get out of bed and fell and hit her head. 911 was called and R1 was sent to the hospital emergency room for examination and treatment. The report shows R1 had injuries which included a skin tear to her right wrist and redness to her face, she also complained of shoulder pain. R1 returned to the facility later that day.

A Resident Incident Report and an Illinois Department of Public Health reportable incident form shows R1 had another fall in her room trying to get out of bed on 10/8/25.

R1's Nursing progress notes for 10/8/25 show R1 had a fall around 5:30 AM in her room, she was unable to move her left leg and complained of hip/leg pain. R1 was transported to a local emergency room and was admitted for a left femur fracture. R1's progress notes show R1 had surgical repair to her hip on 10/9/25. The progress notes show R1 returned to the establishment on 10/13/25 on hospice care.

On 10/15/25 at 8:32 AM, R1 was lying in bed, heavy bruising was seen on her left inner thigh and she had a bandage on her left hip and right wrist. R1 was unable to recall what happened during her fall.

On 10/15/25 at 1:10 PM, Z1 (R1's family) said it was only a matter of time before she had another fall and got injured like this. Z1 said the facility did nothing after the last fall R1 had to prevent the most recent fall.

R1's Service Plan was reviewed with this surveyor and E2 (Director of Nursing). The Service Plan does not show any immediately

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A4010	Continued From page 4 updated interventions were added after she fell on 9/10/25. R1's service plan does not list her falls and the establishment provided service and care plans are focused on goals for the resident and fail to identify specific interventions for R1 to prevent falls. 2.) R2's face sheet shows he residents on the memory care unit at the establishment and has diagnoses including dementia, and depression and anxiety. R2's fall risk assessments completed on 9/15/25, 9/27/25, and 10/2/25 all show he is a fall risk. Establishment provided Incident Reports show R2 had falls on 9/13/25 and again on 10/01/25. On 9/13/25 R2 was found on his floor on his right side by his recliner there was no injury identified. on 10/1/25 R2 was found lying on the floor of the common area by the television, R2 has a small "nick" noted on his left eyebrow. R2's service plan was reviewed with this surveyor and E2. The service plan does not show any immediately updated interventions were added after his falls on 9/13/25 or 10/1/25. R2's service plan does not list his falls and the establishment provided service and care plans are focused on goals for the resident and fail to identify specific interventions for R2 to prevent falls. 3.) R3's face sheet shows he resides on the memory care unit of the facility and has diagnoses including advanced dementia, psychosis and depression. R3's fall risk assessment completed on 9/19/25 shows he is at risk for falls.	A4010		

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A4010	Continued From page 5 R3's progress notes show he had a fall on 7/21/25 where he was found lying on the floor next to his recliner with no apparent injury. A facility provided Incident report shows R2 had another fall on 9/18/25 where he was again found on the floor next to his recliner. The facility was unable to locate the incident report for R3's fall on 7/21/25. R3's service plan was reviewed with this surveyor and E2. The service plan does not show any immediately updated interventions were added after his falls on 7/21/25 or 9/19/25. R3's service plan does not list his falls and the establishment provided service and care plans are focused on goals for the resident and fail to identify specific interventions for R3 to prevent falls. On 10/15/25 at 11:25 AM, E2 said after a fall at the facility they do a root cause to determine what happened. E2 said the service plans at the establishment focus on what services the facility provides and not on interventions added after a fall. E2 said they had recently changed the electronic medical record and they cannot add specific interventions into the system. On 10/15/25 at 1:42 PM, E6 (Licensed Practical Nurse) said the nurses do not update service plans after a resident fall, supervisors would do that. A policy on service plans and accidents incidents was requested from the E2 and was not able to be provided.	A4010		