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A 000	Initial Comment Facility Reported Incident /IL198170 date of October 4, 2025. 295.4010a)b)1)2)3)c)d)e) 295.4060b)	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 2 Violation 295.4010 a) b) 1) 2) 3) c) d) e) Section 295.4010 Service Plan a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the Act) The establishment shall respect and accept the resident's choices regarding the service plan. b) The service plan shall be developed by: 1) The resident, resident's representative or any individual requested by the resident; 2) The manager or manager's designee; and 3) A registered nurse, if the resident is receiving nursing services or medication administration or is unable to direct self-care. c) The service plan shall be signed and dated by all individuals involved in its	A4010		

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A4010	Continued From page 1 development. d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act) 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). This Requirement is NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to ensure resident service plans were updated with current information, failed to be signed and dated by all individuals, failed to implement interventions to prevent falls and failed to update service plan interventions in response to residents' falls in accordance with establishment policy. This applies to 3 of 3 residents (R1, R2, R3) reviewed for falls in the sample of 3. This failure has the substantial probability to cause harm to a resident. The findings include: 1.R1's medical record showed, R1 was 92 years old, was admitted to the establishment on April 16, 2023, with diagnoses that included, unspecified dementia with agitation, age related osteoporosis, vitamin D deficiency and orthostatic hypotension. R1 was severely cognitively impaired with a score of 0/30 on the MMSE (Mini Mental State Examination) dated October 7,	A4010		

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2025. R1's service plan for ADL self-care performance revised on June 14, 2025, showed goal of R1 will demonstrate the appropriate use of walker to maintain independence with intervention for frequent reminders to use walker.

On October 27, 2025, at 1:30 PM, R1 was observed being pushed by staff in a wheelchair and sitting in a wheelchair in the common area. There was no walker available for R1.

R1's report of fall incidents listed R1 experienced falls on October 2, 4, and 5, and September 30, 27, and 25, 2025.

R1's service plan for high risk for falls was revised on June 17, 2025, there were no updated interventions for the falls after that date.

E2 (AL Nurse Manager) provided the last signed Service plan documented on March 1, 2023, that was signed by R1's daughter, and previous AL (Assisted Living) Manager, after multiple requests were made to review R1's most recent signed Service plan.

2. R3's admission record showed R3 had diagnoses that included dementia, Alzheimer's disease, unspecified, chronic kidney disease, stage 2 (mild), cognitive communication deficit, history of falling, other abnormalities of gait and mobility, other lack of coordination, and unsteadiness on feet.

R3's fall risk assessments dated August 31, 2025, and October 26, 2025, showed R3 to be a high risk for falls.

R3's incident log showed that R3 had fallen at least 13 times this year (1/11/25, 1/25/25,

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2/16/25, 5/14/25, 7/14/25, 8/30/25, 8/31/25, 9/1/25, 9/10/25, 9/11/25, 10/9/25, 10/23/25 and 10/26/25).

R3's service plan did not show any new interventions for her last 3 falls. R3's mobility service plan showed the following: R3 "has a history of falls which puts the resident at risk if she/he ambulates unassisted." R3's risk assessment for falls service plan showed that R3 was at high risk for falls related to poor safety awareness, and poor cognitions. R3's service plan was last signed by R3's representative on November 5, 2021.

R3's progress notes showed the following: On October 9, 2025, R3 was found on the floor in another resident's room; On October 23, 2025, R3 was found on the floor in the bathroom of another different resident's room and was sent to the hospital; and on October 26, 2025, R3 was going to sit down and fell on the floor.

On October 27, 2026, at 12:51 PM, R3 stated she doesn't remember ever falling. R3 stated she walks around the establishment with her walker.

On October 27, 2025, at 12:51 PM, E5 (Food Server) stated that she didn't know where R3 was. E5 stated R3 walks all around the establishment with her walker.

On October 27, 2025, at 2:26 PM, E3 (Registered Nurse) stated R3 ambulates independently with a walker. E3 stated R3 runs with her walker and that is why R3 falls because R3 is going too fast. E3 stated R3 is a high fall risk.

On October 27, 2025, at 4:02 PM, E7 (Registered Nurse) stated R3 just went back to her room with

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A4010	Continued From page 4	A4010		

her walker. E7 stated that R3 walks independently with her walker. E7 stated R3 is a fall risk.

On October 27, 2025, at 4:11 PM, E8 (Certified Nursing Assistant) stated that R3 requires a lot of redirection. E8 stated R3 wanders around the unit and walks independently with a walker.

3. Medication Review Report, printed March 15, 2025, shows R2's diagnoses included a history of falling, age-related osteoporosis, cerebral infarction, cognitive communication deficit, difficulty walking, neuromuscular dysfunction of bladder, and dementia.

Review of R2's clinical record nursing progress notes showed on July 27, 2025,September 24, 2025, October 15 and 26 2025, R2 fell at the establishment. The records showed R2's September 24, 2025, and October 26, 2025, falls resulted in R2 being sent to the hospital for evaluation.

On October 27, 2025, at 1:27 PM, E4 (Certified Nursing Assistant) stated R2 did not usually fall, and the staff keep R2 in visual view to keep her from falling.

On October 27, 2025, at 1:15 PM, R2 was sitting in her wheelchair watching a movie in the activity room. E3 (Registered Nurse) stated R2 required total care, did not ambulate, and used a wheelchair for mobility but was able to stand and pivot to transfer. E3 stated the staff keep R2 in the activity room for supervision to prevent future falls.

Review of R2's electronic Fall service plan showed R2 fell on September 14, 2022, March

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A4010	Continued From page 5 10,2023, April 17, 2023, May 5, 2023, June 20, 2023, June 7, 2024, January 18, 2025, and March 6, 2025. R2's fall service plan shows R2 had memory loss/dementia and difficulty making decisions in new situations and was at risk for falls due to decreased strength and vision. The fall service plan shows R2 had prior fall interventions including resident to stay in common areas to promote supervision (revised May 18, 2024), reminding R2 to use her walker and remind R2 to use her call device (initiated May 23, 2022, and revised June 7, 2024), and continue hourly rounds when in room and offer toileting assistance (initiated April 14, 2023, and revised on June 7, 2024). Review of the service plan shows the service plan was not updated to include new fall interventions after R2's falls on July 27,2025, September 24, 2025, October 15, 2025, and October 26, 2025, to attempt to prevent future falls. R2's electronic Risk Assessment for Falls service plan, initiated December 2, 2024, and revised September 26, 2025, showed R2 was at risk for falls related to cognitive deficit and inability to remember she is unable to walk. The service plan showed R2 was at high risk for falls related to vision impairments. R2's electronic ADL (Activities of Daily Living) service plan shows R2 had self-care performance deficits related to balance issues and cognitive impairment.) R2's ADL goal (revised on January 2, 2025) shows R2 will use a wheelchair for mobility due to unsteady gait. The service plan shows R2 was able to ambulate independently with her walker and was able to transfer to and from bed, chair, and toilet independently with staff to assist as needed (initiated April 14, 2025) The service plan also shows R2 needed limited	A4010		

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assistance with transfers and positioning in bed (initiated on April 14, 2023, and revised on May 18, 2024.)

R2's electronic Mobility service plan, initiated September 26, 2025, shows R2 always required guide or assistance due to physical problem or confusion with adaptive device. The plan also shows R2 requires extensive assistance with transfers.

On October 27, 2025, at 1:43 PM, E2 (Assisted Living Nurse Manager) stated R2 did not have a recently updated and signed service plan. At 2:24 PM, E2 provided R2's most recently signed service plan on file that was dated 4/5/25. At 3:31 PM, E2 stated after a fall she tries to determine what caused the fall and the service plan should reflect the interventions the establishment is putting into place to prevent further falls. E2 stated the service plan should reflect recent interventions put in place since her last falls including staff performing increased safety checks and toileting R2 more frequently as interventions to prevent further falls. E2 reviewed R2's electronic service plan and stated she did not see that the care plan was updated with new interventions since her more recent falls.

Resident Safety Policy/Procedure, reviewed May 19, 2025, showed, "Our community strives to make the environment as free from accident hazards as possible. Residents to prevent accidents are community-wide priorities.... When accident hazards are identified, the QAPI (Quality Assurance Performance Improvement) / Safety Committee shall evaluate and analyze the causes of the hazards and develop strategies to mitigate or remove the hazards to the extent possible. 5. Team members shall be trained on potential

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A4010	Continued From page 7 accident hazards and demonstrate competency on how to identify and report accident hazards to try to prevent avoidable accidents. 6. The QAPI Committee and staff shall monitor interventions to mitigate accident hazards in the community and modify as necessary. Individualized, Resident-Centered Approach to Safety 1. Our individualized resident-centered approach to safety addresses safety and accident hazards for individual residents. 2. The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. 3. The care team shall target interventions to reduce individual risks related to hazards in the environment. including adequate supervision and assistive devices. 4. Implementing interventions to reduce accident risks and hazards shall include the following: Communicating specific interventions to all relevant team members., assigning responsibly for caring out interventions, providing training as necessary, ensuring that interventions are implemented, and documenting interventions. The monitoring of the effectiveness of interventions shall include the following: a. Ensuring that interventions are implemented and consistently', b. Evaluating the effectiveness of interventions; c. Modifying or replacing interventions as needed; and evaluating the effectiveness of new or revised interventions. The Facility's policy titled "Assisted Living Service Care Plan" dated July 24, 2025, showed "Policy Statement ...A Service Care Plan means the written plan between a resident or resident's designated representative and the community about the services that will be provided to the resident ...Procedure ...2. The service /care plan and any revisions shall include a signature or	A4010		

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A4010	Continued From page 8 other authentication by AL/MC and by the resident's representative, documenting agreement on the services to be provided. 3.Service/care plans should be revised, if needed, based on resident reassessment and monitoring.4.AL/MC will implement and provide all services indicated in the service/care plan".	A4010		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Type 2 Violation 295. 4060 b) Section 295.4060 Alzheimer's and Dementia Programs b) No person shall be admitted or retained in an assisted living or shared housing establishment if the establishment cannot provide or secure appropriate care, if the resident requires a level of service or type of service for which the 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 150(b) of the Act) This Requirement was NOT MET as evidenced by: Based on interview and record review the establishment failed to provide increased staff monitoring, in accordance with their service plan, for a resident identified as high risk for falls, who	A4060		

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experienced multiple falls. This failure has the substantial probability to cause harm to a resident. This applies to 1 of 3 residents (R1) reviewed for falls in the sample of 3.

The findings include:

R1's medical record showed, R1 was 92 years old, was admitted to the establishment on April 16, 2023, with diagnoses that included, unspecified dementia with agitation, age related osteoporosis, vitamin D deficiency and orthostatic hypotension. R1 was severely cognitively impaired with a score of 0/30 on the MMSE (Mini Mental State Examination) dated October 7, 2025.

The establishment filed a report with the department regarding R1's fall incident that occurred on October 4, 2025. The report showed R1 experienced a fall while out on the patio with other residents. R1 got up from a seated position and fell backward, and her head hit the cement. R1 was transported to the local hospital for evaluation and returned the same day to the facility with no injury reported.

On October 27, 2025, at 1:30 PM, E4 (CNA) stated she was present on October 4, 2025, and had assisted the residents outside on the patio. E4 stated she was the only staff outside with the residents because there was no activity staff available to assist that day. E4 stated when it was her break time, she called her coworker to come to the patio and went to give her keys to her coworker and was no longer in the same area as the residents but closer to the patio door. E4 stated as she was about to leave the patio, she saw R1 stand up from the chair and fell backward

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but she could not get to R1 fast enough to intervene before R1 fell backward on the cement. E4 stated she then called for the nurse. E4 stated someone has to be with R1 all the time to keep an eye on her.

On October 27, 2025, at 1:40 PM, E3 (RN) stated R1 is very fast and needs to be supervised 1:1, but the staff try to keep R1 in common areas with other residents to monitor R1.

R1's high risk for falls service plan intervention dated September 3, 2024, showed to provide increased supervision by staff when resident is outside due to uneven terrain, residents poor safety awareness and increased fall risk.

R1's post fall investigation in response to R1's fall on October 4, 2025, dated October 8, 2025, provided by E2 (AL Nurse Manager) showed interventions include safety checks remain in place, the resident is to be toileted before meals and community programs by staff.

R1's report of falls showed between August 4 and October 27, 2025, R1 experienced 18 falls. On both August 4 and September 25, 2025, R1 experienced falls twice in the same day. The incident report list showed R1 experienced falls on August 4, (x2), 13, 14, 21, 29, 2025. R1 also experienced falls on September 1, 2, 8, 15, 25 (X2), 27, 30, 2025, and October 2, 4, 5, and 27, 2025. The department received reports of falls on August 13, September 15, September 30, and October 4, 2025.

On October 27, 2025, at 9:50 AM, R1's progress note showed R1 experienced a fall in her room and was found scooting on the floor. R1 had been observed sleeping on her couch just 5 minutes

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prior to being found on the floor. The progress note did not indicate whether R1 had call pendant available or not as outlined in the service plan.

R1's service plan to prevent falls included Resident to be reminded frequently to use call pendant when transferring especially when she is unsupervised in her room initiated on November 26, 2024, in response to fall on July 30, 2024. Staff to encourage resident to remain in common areas for increased supervision rather than in her room initiated on November 26, 2024, in response to falls on July 31,2025 and August 18, 2025.

On October 27, 2025, at 3:45 PM, E2 (AL Nurse Manager) stated R1 was very impulsive and had poor safety awareness and was in need of 1:1 caregiver but that was not approved by R1's POA (Power of Attorney) and there was no increase in the staffing hours to provide R1 with 1:1, or increased safety checks and more frequent rounding.

The facility's policy titled "Resident Safety" dated May 19, 2025, showed "Procedures ...Resident -Centered Approach to Safety ...3. The care team shall target interventions to reduce accident risks ...including adequate supervision and assistive devices ...4. Implementing interventions to reduce accident risks ...shall include the following ...communicating specific interventions to all relevant team members ...assigning responsibility for carrying out interventions ...ensuring interventions are implemented and documenting interventions ...Monitoring the effectiveness of interventions shall include ...a. ensuring that interventions are implemented correctly and consistently ...b. evaluating the effectiveness of interventions ... c. Modifying or replacing

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A4060	Continued From page 12 interventions as needed ...Certain resident risk factors include...c. falls".	A4060		