STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510308	A. BUILDING: _____ B. WING _____	C 02/28/2025

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EDEN VISTA JOLIET LLC (3320)	3320 EXECUTIVE DRIVE JOLIET, IL 60431

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A 000	Initial Comment Investigation of Facility Reported Incident of 2/5/25 IL186716 - 295.1060e) 295.2000a)6) 295.4010a)d)e)g)1)C)2)4)h)	A 000		
A1060	Section 295.1060 Remedies and Sanctions This Regulation is not met as evidenced by: General Violation Section 295.1060 Remedies and Sanctions a) The Department may impose the following remedies and sanctions upon an establishment that is found to have committed a violation: 1) In addition to other remedies, the Department may conduct a consultative conference with administrative staff who oversee the daily operations of the establishment to identify remedial actions to address a violation. At the Department ' s discretion the consultative conference may be part of the on-site review, via teleconference, or other means of communication. Failure to meet the requirements established in the consultative conference will result in a higher sanction if the establishment does not come into compliance. 2) A statement of correction shall be required for all levels of violation, either offered by the establishment or imposed by the Department. A statement of correction must be submitted by the licensee within 15 days after the notification to the establishment of the statement of finding or violation. A statement of correction must be in	A1060		

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A1060	Continued From page 1 writing and must contain: A) A description of the specific corrective action the establishment is taking for each finding or violation; B) A description of the steps that will be taken to avoid future occurrences; and C) A specific date by which the correction shall be completed. 3) An administrative warning may be imposed by the Department for any Type 3 violation. 4) Mandatory training may be required of establishment staff as a remedy for any violation. 5) A directed plan of correction may be imposed for initial violations and repeat violations after the establishment fails to submit or carry out its own statement of correction or the establishment's plan fails to address the issue. The Department may impose an immediate plan of correction for a Type 1 violation. 6) Fines shall be imposed as follows: A) The Department will impose a fine of up to $500 for an initial Type 2 violation. B) The Department will impose a fine of up to $1000 on any provider that has repeat Type 2 violations at a subsequent on-site inspection. C) The Department will impose a fine of up to $2000 for initial Type 1 violations. D) The Department will impose a fine of up to $10,000 on any provider that has a repeat Type 1	A1060		

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A1060	Continued From page 2	A1060		

violation or when the Director or the Director ' s designee determines that a serious and immediate threat exists.

7) A revocation of an establishment's license may occur when other remedies and sanctions have been progressively applied and the establishment has not achieved compliance. The decision to revoke a license may only be made by the Director of the Department or the Director ' s designee.

b) Remedies and sanctions shall be evaluated and imposed on the basis of the:

1) Gravity of the violation;

2) Severity of the violation;

3) Pattern of occurrences of the same or similar violations; and

4) History of compliance with the Act and this Part.

c) An unlicensed assisted living or shared housing establishment or an entity that violates Section 295.400(a), (b) or (c) shall be assessed a civil penalty not to exceed $3,000. The entity will also be referred to the Department's Bureau of Long-Term Care for review and possible referral to the Office of the Attorney General.

d) Any licensee preventing the Department from carrying out its duties under this Section shall have its license revoked or suspended and be subject to a fine of not more than $250 per day for each day the Department is prevented from carrying out its duties.

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A1060	Continued From page 3 e) Any establishment caring for a resident whose care needs exceed those authorized under the Act shall be fined $500 for the first violation and $1,000 for each subsequent violation. Each day a violation continues shall be deemed a separate violation. (Section 135(b) of the Act) The establishment shall not be found in violation if a sudden change in a resident's condition, making the resident ineligible for residency, has occurred within the last 72 hours, the establishment is actively attempting to find placement for the resident in an alternative care setting, and the establishment has initiated involuntary termination of residency proceedings. An establishment shall be deemed to be "actively attempting" to find alternative placement if the following occurs: 1) The establishment is assisting the resident in finding alternative placement; and 2) A reasonable relocation plan is in place, including a time frame and provision of services in the interim. f) An establishment that fails to conduct a health care worker background check as required by Section 295.3040 shall be fined $100 for each offense. These requirements were not met as evidence by: Based on interview and record review, the establishment failed to re-evaluate and address the needs of a resident when a change a change in condition was identified for one resident (R1) out of three residents reviewed for services in the sample. Findings include:	A1060		

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A1060	Continued From page 4 The Establishments "Change in Condition" policy revised 11/13/24 documents "Purpose: To ensure prompt notification of the resident, the attending physician, and Durable Power of Attorney/Responsible Party of changes in the resident ' s physical, psychosocial and/or mental condition and/or status. Procedure: 1. The physician and Durable Power of Attorney/responsible party will be notified when there has been a change that is sudden in onset, a change that is a marked difference in usual sign/symptoms and/or the signs/symptoms are unrelieved by measures already prescribed: 2. Specific information that requires prompt notification include, but is not limited to: f. Unusual or violent behavior; l. A significant change in the resident ' s physical/psychosocial/mental condition;" The Establishment's "Resident Service Plan" policy and procedure revised 2/15/23 documents "Policy: An individually designed resident service plan is developed by the Wellness Director and/or designee in consultation with the resident and family or others involved in the care of the resident prior to or at the time of move-in. Review of the service plan will be completed per state regulations/statutes. The service plan will be updated to reflect current resident needs, preferences, and interventions. Procedure: 1. The Service Plan is completed according to the resident's problems and needs identified during the assessment process and with input from the resident, resident representative, the resident's family as well as any other person as requested by the resident and/or per state guidelines. 2. The Service Plan form will be used to update the service plan and will create the level of care based on a point structure. 3. Resident and/or	A1060		

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responsible party will be updated on the level of care that is established from the service plan form. 4. Types and frequency of services to be provided by the resident's family or informal support systems should be stated. Establish goals of management, plans for intervention and implementation, as applicable. 5. Identify conditions to be observed and reported to the nurse, and/or supervisor. 6. Care givers should be involved with service plan development and review. 7. Services to be provided are to be clearly identified, with frequency of service (such as: shower assist of one. Resident requires assistance to wash feet and back but is otherwise able to complete the bathing process. Shower on Tuesday & Thursday, and Saturday morning prior to breakfast). 8. Outside agencies providing services to the resident should be clearly listed identifying what services the outside agency/person will provide. Including Hospice, Therapy, private aides, family. 9. The Service Plan will be individualized and kept current at all times."

R1's current Service Plan documents: "Focus: (R1) has had an actual fall with no injury. Date Initiated: 10/31/2024. Goal: (R1) will resume usual activities without further incident. Interventions: 2/2/25 fall; Family to provide a low bed. 2/5/25 fall; hospice to provide therapy for the loss of her husband Date Initiated: 11/07/2024 Revision on: 02/06/2025"

On 2/28/25 at 8:47 am, E1, Executive Director, stated that R1 had a hard time adjusting to her husband's (R4) passing.

On 2/28/25 at 11:08 AM, E4, Assistant Director of Nursing/ADON stated that R1 was having a hard time since her husband had passed.

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A1060	Continued From page 6 On 2/28/25 at 12:21 PM, E6, Caregiver, stated R1's cognitive status started declining before R4 passed away. It started when R4 was sent to the hospital. R1 became "really forgetful" and couldn't remember that R4 was in the hospital or passed away. Staff had to constantly remind R1 that R4 was in the hospital or that he passed away. E6 stated that R4 was "with it" and he was the one that always there to help R1 with her daily routine. When R4 was sent to the hospital, R1 did things like not wanting to go to bed from the couch. R1 would lay on the couch waiting for R4 to go to bed. E6 again stated they kept having to remind R1 that R4 passed away. E6 stated "We had to round on (R1) every 2 hours. It started around the time her husband left for the hospital. When I checked on her and asked if she needed to go to the bathroom, she couldn't remember if she had gone or not. She was very confused and forgetful." E6 verified that R1 was only orineted to self. On 2/28/25 at 12:45 PM, E7, Licensed Practical Nurse/LPN, stated that when R4 was sent to the hospital, R1 became bored and would ask where R4 was. The staff had to always remind her that he was in the hospital and that he passed away. The staff would bring R1 out to activities, but she wouldn't stay and would go back to her room. E7 stated R1 became more restless with R4 being gone, but she wasn't having any behaviors since returning from the psychiatric hospital and being put on Haldol and Namenda (memantine). E7 stated that R1 was only oriented to person. E7 also stated that R4 was cognitively intact and was the one who took care of R1. When R4 was sent to the hospital and passed away, she didn't have that guide anymore and needed more attention for her needs.	A1060		

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A1060	Continued From page 7 R1's Physician Order Sheet dated 2/2025 documents "Active Orders: MEMANTINE TAB HCL 10MG (milligrams) (Memantine HCl) ONE TABLET BY MOUTH TWICE DAILY. SERTRALINE TAB 100MG (Sertraline HCl) ONE TABLET BY MOUTH ONCE DAILY. HALOPERIDOL TAB 0.5MG (Haloperidol) ONE TABLET BY MOUTH TWICE DAILY. " R1's Psychiatric Behavioral Health notes dated 1/14/25 documents "Past Medical History: Hypertension, Anxiety, Dementia with psychosis, Hallucinations, History of psychiatric hospitalization (including (Local Psychiatric Hospital) for delusions and physical aggression), Depression, Multiple falls, History of hospitalization for dizziness." R1's Assessment and Negotiated Service plan summary is signed by the Power of Attorney on 5/8/23 and the Physician Assessment is signed 10/7/24. There are no documents showing an evaluation was completed when the establishment identified a change in condition for R1. R4's Nursing Notes dated 1/8/25 documents R4 was sent to a rehab facility. R4's Nursing notes dated 1/23/25 documents R4 was admitted to hospice facility and actively dying. On 2/28/25 at 1:15 PM, E3, Assistant Executive Director, E4, ADON and E5, Lead Certified Nursing Assistant/CNA, all stated they recognized the need for R1 to be placed in a memory care unit when R4 was sent to the hospital. E5 stated that R4 was cognitively intact and always cared	A1060		

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A1060	Continued From page 8 for R1, but when he was gone, R1's need for increased level of care became more apparent. E4 stated she knows a conversation took place about having R1 evaluated for a memory care unit, but doesn't have any documentation that anything was done. On 2/28/25 at 2:21 PM, E3, Assistant Executive Director, E4, ADON and E5, Lead CNA, all verified R1's "Round every 2 hours" was implemented during an in-service on 1/23/25 when they noted a change in R1's behavior and cognitive decline All confirmed the change in condition happened when R4 was sent to the hospital. E5 also verified that R4 was sent to the hospital on 12/24/24, did not return to the facility, and passed away at the hospice house on 1/29/25. On 2/28/25 at 3:30 PM, E1, Executive Director, stated the administration talked about having R1 evaluated for placement in the memory care unit, but nothing had been started.	A1060		
A2000	Section 295.2000 Residency Requirements This Regulation is not met as evidenced by: General 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 establishment is not	A2000		

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A2000	Continued From page 9	A2000		

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)

b) Only adults may be accepted for residency. (Section 75(b) 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;

2) The person is not able to communicate their needs in any manner and no resident representative residing in the establishment, and with a prior relationship to the person, has been appointed to direct the provision of services;

3) The person requires total assistance with 2 or more activities of daily living;

4) The person requires the assistance of more than one paid caregiver at any given time with an activity of daily living;

5) The person requires more than minimal assistance in moving to a safe area in an emergency. For the purpose of this Section, minimal assistance means that the resident is able to respond, with or without assistance, in an emergency to protect themselves, given the staffing and construction of the building;

6) The person has a severe mental illness, which for the purposes of this Section means a condition that is characterized by the presence of a major mental disorder as classified in the Diagnostic and Statistical Manual of Mental

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A2000	Continued From page 10 Disorders, Fifth Edition, Text Revision DSM-5-TR, where the individual is a person with a substantial disability due to mental illness in the areas of self-maintenance, social functioning, activities of community living and work skills, and the disability specified is expected to be present for a period of not less than one year, but does not mean Alzheimer's disease and other forms of dementia based on organic or physical disorders. Nothing in this Section is meant to prohibit an individual with a diagnosis of depression from living in an establishment so long as the resident is not substantially disabled in the areas of self-maintenance, social functioning, activities of community living, and work skills; 7) The person requires intravenous therapy or intravenous feedings unless self-administered or administered by a qualified, licensed health care professional; 8) The person requires gastrostomy feedings unless self-administered or administered by a licensed health care professional; 9) The person requires insertion, sterile irrigation, and replacement of catheter, except for routine maintenance of urinary catheters, unless the catheter care is self-administered or administered by a licensed health care professional; 10) The person requires sterile wound care unless care is self-administered or administered by a licensed health care professional; 11) The person is a diabetic requiring routine insulin injections unless the injections are self-administered or administered by a licensed health care professional;	A2000		

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A2000	Continued From page 11 12) The person requires treatment of stage 3 or stage 4 decubitus ulcers or exfoliative dermatitis; or 13) The person requires 5 or more skilled nursing visits per week for conditions other than those listed in subsection (c)(12) for a period of 3 consecutive weeks or more except when the course of treatment is expected to extend beyond a 3 week period for rehabilitative purposes and is certified as temporary by a physician. (Section 75(c) of the Act) 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) f) Subsection (d) of this Section shall not apply to terminally ill residents who receive or would qualify for hospice care and such care is coordinated by a hospice program licensed under the Hospice Program Licensing Act or other licensed health care professional employed by a licensed home health agency and the establishment and all parties agree to the continued residency. (Section 75(f) of the Act) g) Subsections (c)(3), (4), (5), and (9) shall not apply to individuals who are quadriplegic or paraplegic, or individuals with neuro-muscular	A2000		

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diseases, such as muscular dystrophy and multiple sclerosis, or other chronic diseases and conditions if the individual is able to communicate their needs and does not require assistance with complex medical problems, and the establishment is able to accommodate the individual's needs. (Section 75(g) of the Act)

h) For the purposes of subsections (c)(7) through (10), a licensed health care professional may not be employed by the owner or operator of the establishment, its parent entity, or any other entity with ownership common to either the owner or operator of the establishment or parent entity, including but not limited to an affiliate of the owner or operator of the establishment. Nothing in this Section is meant to limit a resident's right to choose their health care provider. (Section 75(h) of the Act)

i) Before a prospective resident's admission to an assisted living establishment or a shared housing establishment that does not provide medication administration as an optional service, the establishment shall advise the prospective resident to consult a physician to determine whether the prospective resident should obtain a vaccination against pneumococcal pneumonia or influenza, or both. (Section 76 of the Act)

These requirements were not met as evidence by:

Based on interview and record review, the facility failed to find appropriate placement for a resident that was identified as needing a higher level of care for one resident (R1) out of three residents reviewed for residency.

Findings include:

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A2000	Continued From page 13 The Establishments "Change in Condition" policy revised 11/13/24 documents "Purpose: To ensure prompt notification of the resident, the attending physician, and Durable Power of Attorney/Responsible Party of changes in the resident ' s physical, psychosocial and/or mental condition and/or status. Procedure: 1. The physician and Durable Power of Attorney/responsible party will be notified when there has been a change that is sudden in onset, a change that is a marked difference in usual sign/symptoms and/or the signs/symptoms are unrelieved by measures already prescribed: 2. Specific information that requires prompt notification include, but is not limited to: f. Unusual or violent behavior; l. A significant change in the resident ' s physical/psychosocial/mental condition;" The Establishment's "Resident Service Plan" policy and procedure revised 2/15/23 documents "Policy: An individually designed resident service plan is developed by the Wellness Director and/or designee in consultation with the resident and family or others involved in the care of the resident prior to or at the time of move-in. Review of the service plan will be completed per state regulations/statutes. The service plan will be updated to reflect current resident needs, preferences, and interventions. Procedure: 1. The Service Plan is completed according to the resident's problems and needs identified during the assessment process and with input from the resident, resident representative, the resident's family as well as any other person as requested by the resident and/or per state guidelines. 2. The Service Plan form will be used to update the service plan and will create the level of care based on a point structure. 3. Resident and/or	A2000		

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A2000	Continued From page 14	A2000		

responsible party will be updated on the level of care that is established from the service plan form. 4. Types and frequency of services to be provided by the resident's family or informal support systems should be stated. Establish goals of management, plans for intervention and implementation, as applicable. 5. Identify conditions to be observed and reported to the nurse, and/or supervisor. 6. Care givers should be involved with service plan development and review. 7. Services to be provided are to be clearly identified, with frequency of service (such as: shower assist of one. Resident requires assistance to wash feet and back but is otherwise able to complete the bathing process. Shower on Tuesday & Thursday, and Saturday morning prior to breakfast). 8. Outside agencies providing services to the resident should be clearly listed identifying what services the outside agency/person will provide. Including Hospice, Therapy, private aides, family. 9. The Service Plan will be individualized and kept current at all times."

On 2/28/25 at 8:47 AM, E1, Executive Director, stated that R1 was having a hard time adjusting since her husband had passed.

On 2/28/25 at 12:21 PM, E6, Caregiver, stated R1's cognitive status started declining before R4 passed away. It started when R4 was sent to the hospital. R1 became "really forgetful" and couldn't remember that R4 was in the hospital or passed away. Staff had to constantly remind R1 that R4 was in the hospital or that he passed away. E6 stated that R4 was "with it" and he was the one that always there to help R1 with her daily routine. When R4 was sent to the hospital, R1 did things like not wanting to go to bed from the couch. R1 would lay on the couch waiting for R4 to go to

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A2000	Continued From page 15	A2000		

bed. E6 again stated they kept having to remind R1 that R4 passed away. E6 stated "We had to round on (R1) every 2 hours. It started around the time her husband left for the hospital. When I checked on her and asked if she needed to go to the bathroom, she couldn't remember if she had gone or not. She was very confused and forgetful." E6 verified that R1 was only orineted to self.

On 2/28/25 at 12:45 PM, E7, Licensed Practical Nurse/LPN, stated that when R4 was sent to the hospital, R1 became bored and would ask where R4 was. The staff had to always remind her that he was in the hospital and that he passed away. The staff would bring R1 out to activities, but she wouldn't stay and would go back to her room. E7 stated R1 became more restless with R4 being gone, but she wasn't having any behaviors since returning from the psychiatric hospital and being put on Haldol and Namenda (memantine). E7 stated that R1 was only oriented to person. E7 also stated that R4 was cognitively intact and was the one who took care of R1. When R4 was sent to the hospital and passed away, she didn't have that guide anymore and needed more attention for her needs.

R1's Physician Order Sheet dated 2/2025 documents "Active Orders: MEMANTINE TAB HCL 10MG (milligrams) (Memantine HCl) ONE TABLET BY MOUTH TWICE DAILY. SERTRALINE TAB 100MG (Sertraline HCl) ONE TABLET BY MOUTH ONCE DAILY. HALOPERIDOL TAB 0.5MG (Haloperidol) ONE TABLET BY MOUTH TWICE DAILY. "

R1's Psychiatric Behavioral Health notes dated 1/14/25 documents "Past Medical History: Hypertension, Anxiety, Dementia with psychosis,

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Hallucinations, History of psychiatric hospitalization (including (Local Psychiatric Hospital) for delusions and physical aggression), Depression, Multiple falls, History of hospitalization for dizziness."

R1's medical record documents R1 is only oriented to self.

R1's Assessment and Negotiated Service plan summary is signed by the Power of Attorney on 5/8/23 and the Physician Assessment is signed 10/7/24. The establishment was unable to provide documentation showing an evaluation was completed when the establishment identified a change in R1's condition.

R4's Nursing Notes dated 1/8/25 documents R4 was sent to a rehab facility.

R4's Nursing notes dated 1/23/25 documents R4 was admitted to hospice facility and actively dying.

On 2/28/25 at 1:15 PM, E3, Assistant Executive Director, E4, ADON and E5, Lead Certified Nursing Assistant/CNA, all stated they recognized the need for R1 to be placed in a memory care unit when R4 was sent to the hospital. E5 stated that R4 was cognitively intact and always cared for R1, but when he was gone, R1's need for increased level of care became more apparent. E5 verified that R1 was not independent with most of her ADLS. She was only independent with transfering, walking and eating. R4 and the establsishment helped R1 with most of her cares. E4 stated she knows a conversation took place about having R1 evaluated for a memory care unit, but doesn't have any documentation that anything was done.

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A2000	Continued From page 17 On 2/28/25 at 2:21 PM, E3, Assistant Executive Director, E4, ADON and E5, Lead CNA, all verified R1's "Round every 2 hours" was implemented during an in-service on 1/23/25 when they noted a change in R1's behavior and cognitive decline. All confirmed the change in condition happened when R4 was sent to the hospital and R1 was only oriented to self. E5 also verified that R4 was sent to the hospital on 12/24/24, did not return to the facility, and passed away at the hospice house on 1/29/25. On 2/28/25 at 3:30 PM, E1, Executive Director, stated the administration talked about having R1 evaluated for placement in the memory care unit, but nothing had been started. E1 stated R1 was dealing with a lot and therefore they decided to wait to do the evaluation. E1 stated that even though R1 is more appropriate for the memory care unit, she felt that moving R1 would put more stress on the family during a time of grief.	A2000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: General Violaiton 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	A4010		

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A4010	Continued From page 18 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 c) The service plan shall be signed and dated by all individuals involved in its 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). g) Service plans shall address: 1) The level of service the resident is receiving, including: C) special accommodations for the resident; 2) The amount, type, and frequency of health-related services needed by the resident; 3) Staff responsible for the provisions of the service plan; 4) Any risk being negotiated; and	A4010		

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A4010	Continued From page 19 h) The service plan shall include all support services provided or arranged for by the establishment. These requirements were not met as evidence by: Based on observation, interview and record review, the establishment failed to create and revise a service plan with individualized interventions and goals for one resident (R1) out of three residents reviewed for falls in the sample. This failure resulted in R1 falling and sustaining a subarachnoid hemorrhage bilaterally and subdural hematoma. Findings include: The Establishment's "Resident Service Plan" policy and procedure revised 2/15/23 documents "Policy: An individually designed resident service plan is developed by the Wellness Director and/or designee in consultation with the resident and family or others involved in the care of the resident prior to or at the time of move-in. Review of the service plan will be completed per state regulations/statutes. The service plan will be updated to reflect current resident needs, preferences, and interventions. Procedure: 1. The Service Plan is completed according to the resident's problems and needs identified during the assessment process and with input from the resident, resident representative, the resident's family as well as any other person as requested by the resident and/or per state guidelines. 2. The Service Plan form will be used to update the service plan and will create the level of care based on a point structure. 3. Resident and/or responsible party will be updated on the level of care that is established from the service plan	A4010		

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A4010	Continued From page 20	A4010		

form. 4. Types and frequency of services to be provided by the resident's family or informal support systems should be stated. Establish goals of management, plans for intervention and implementation, as applicable. 5. Identify conditions to be observed and reported to the nurse, and/or supervisor. 6. Care givers should be involved with service plan development and review. 7. Services to be provided are to be clearly identified, with frequency of service (such as: shower assist of one. Resident requires assistance to wash feet and back but is otherwise able to complete the bathing process. Shower on Tuesday & Thursday, and Saturday morning prior to breakfast). 8. Outside agencies providing services to the resident should be clearly listed identifying what services the outside agency/person will provide. Including Hospice, Therapy, private aides, family. 9. The Service Plan will be individualized and kept current at all times."

The Establishment's "Fall Risk Management" policy and procedure revisited 5/23/22 documents "Policy: The community will assess residents for their potential to fall prior to move-in and on an ongoing basis, as needed while residing at the community to ensure resident safety. Procedure: 1. A falls risk assessment will be conducted on residents upon admission, annually, and with significant changes of condition. The assessment will review resident risk factors and potential for tendency to fall. 2. Associated risk and interventions will be outlined in resident ' s individual service plan. 3. When a resident experience a fall, the Director of Wellness or designee will: Notify the resident's physician, Seek emergency medical treatment when necessary, Notify the resident's responsible person, Revise the service plan accordingly

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A4010	Continued From page 21 and Update Fall Risk assessment. " R1' Nursing notes dated 2/2/25 documents "Resident observed lying supine on the floor by her bed in her bedroom. Resident stated, "I felt wet, and I tried to make it to the bathroom then, I felt dizzy and fell on the floor." ROM performed with no difficulty. Head-to-toe assessment done. No injury, swelling, bruising, or redness noted. Resident denied pain and discomfort. Resident transferred and assisted to a sitting position then to the bathroom. Vital signs obtained. Resident is assisted with a shower by staff." R1's Nursing notes dated 2/5/25 documents "At 4:15am resident was observed on the floor beside her bed. she has injury noted on her right eye with hematoma and bleeding. 911 called because resident is on blood thinners, and she has bleeding. she was picked up at 4:47am by the ambulance to the hospital. all responsible partners informed." R1's hosptial record dated 2/10/25 documents R1 was admitted to the Intensive Care Unit (ICU) with a diagnosis of Tramatic Brian Injury resulting from a subarachnoid hemorrhage bilaterally and subdural hematoma post fall. R1's current Service Plan documents: "Focus: (R1) has had an actual fall with no injury. Date Initiated: 10/31/2024. Goal: (R1) will resume usual activities without further incident. Interventions: 2/2/25 fall; Family to provide a low bed. 2/5/25 fall; hospice to provide therapy for the loss of her husband Date Initiated: 11/07/2024 Revision on: 02/06/2025" On 2/28/25 at 8:47 am, E1, Executive Director, stated that R1 had a hard time adjusting to her	A4010		

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A4010	Continued From page 22 husband's (R4) passing. On 2/28/25 at 10:45 AM, E4, Assistant Director of Nursing/ADON, verified the intervention for the 2/2/25 fall was to have the family provide a low bed. E4 stated she doesn't know if the low bed was delivered by the family, but we can go up to her room and look. E4 stated R1 is still at the hospitl in the ICU. On 2/28/25 at 11:08 AM, This surveyor entered R1's apartment along with E4. There is no low bed in R1's apartment. E4 verified there's no low bed and stated the family has not provided one yet. E4 was asked what interventions were put in place for R1 while the establishment was waiting on the family to provide a low bed. E4 stated she was not sure and would have to check on it. On 2/28/25 at 12:21 PM, E6, Caregiver, stated R1's cognitive status started declining before R4 passed away. It started when R4 was sent to the hospital. R1 became "really forgetful" and couldn't remember that R4 was in the hospital or passed away. Staff had to constantly remind R1 that R4 was in the hospital or that he passed away. E6 stated that R4 was "with it" and he was the one that always there to help R1 with her daily routine. When R4 was sent to the hospital, R1 did things like not wanting to go to bed from the couch. R1 would lay on the couch waiting for R4 to go to bed. E6 again stated they kept having to remind R1 that R4 passed away. E6 stated "We had to round on (R1) every 2 hours. It started around the time her husband left for the hospital. When I checked on her and asked if she needed to go to the bathroom, she couldn't remember if she had gone or not. She was very confused and forgetful." E6 verified that R1 was only orineted to self.	A4010		

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A4010	Continued From page 23 On 2/28/25 at 12:45 PM, E7, Licensed Practical Nurse/LPN, stated that when R4 was sent to the hospital, R1 became bored and would ask where R4 was. The staff had to always remind her that he was in the hospital and that he passed away. The staff would bring R1 out to activities, but she wouldn't stay and would go back to her room. E7 stated R1 became more restless with R4 being gone, but she wasn't having any behaviors since returning from the psychiatric hospital and being put on Haldol and Namenda (memantine). E7 stated that R1 was only oriented to person. E7 also stated that R4 was cognitively intact and was the one who took care of R1. When R4 was sent to the hospital and passed away, she didn't have that guide anymore and needed more attention for her needs. . On 2/28/25 at 12:58 PM, E4, ADON, confirmed that R1 was sent to a psychiatric hospital about a year ago and is being seen on a regular basis by (Psychiatry). E4 stated the Psychiatric Nurse Practitioner just saw (R1) and the most recent visit should be in the notes. R1's Physician Order Sheet dated 2/2025 documents "Diagnosis: HYPERLIPIDEMIA, UNSPECIFIED, ESSENTIAL (PRIMARY) HYPERTENSION, TYPE 2 DIABETES MELLITUS. Active Orders: MEMANTINE TAB HCL 10MG (milligrams) (Memantine HCl) ONE TABLET BY MOUTH TWICE DAILY. SERTRALINE TAB 100MG (Sertraline HCl) ONE TABLET BY MOUTH ONCE DAILY. HALOPERIDOL TAB 0.5MG (Haloperidol) ONE TABLET BY MOUTH TWICE DAILY. " R1's medical record does not include any diagnosis for the use of these medications.	A4010		

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A4010	Continued From page 24 R1's Psychiatric Behavioral Health notes dated 1/14/25 documents "Past Medical History: Hypertension, Anxiety, Dementia with psychosis, Hallucinations, History of psychiatric hospitalization (including (Local Psychiatric Hospital) for delusions and physical aggression), Depression, Multiple falls, History of hospitalization for dizziness." R1's Hospital records dated 2/10/25 documents "Patient is a 86 year old with a past medical history of .....dementia, schizoaffective disorder, recurrent falls..." R1's current Service Plan does not include R1's diagnosis of Dementia with psychosis, Hallucinations, History of psychiatric hospitalization (including (Local Psychiatric Hospital) for delusions and physical aggression) and Depression. R1's Service plan also does not include the antipsychotic medication haloperidol, the psychotropic medication sertaline, the Alzheimer's medication memantine or that R1 is being followed by Psychiatry. On 2/28/25 at 1:15 PM, E4, ADON, verified R1's medical record and Service Plan does not include R1's diagnosis of dementia with psychosis and depression or address R1's memantine, sertaline, and haloperidoal. On 2/28/25 at 2:21 PM, E3, Assistant Executive Director, E4, ADON and E5, Lead Certified Nursing Assistant, all verified the low bed was the only intervention for R1's 2/2/25 fall and no other interventions were implemented. They also verified R1's "Round every 2 hours" was implemented during an in-service on 1/23/25 after they noted a change in R1's behavior and	A4010		

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A4010	Continued From page 25 cognitive decline when R4 was sent to the hospital. E4 verified R1's psychiatry visits, behaviors and antipsychotics were not addressed in the service plan. E5 also verified that R4 was sent to the hospital on 12/24/24, did not return to the facility, and passed away on 1/29/25.	A4010		