STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL5106155	A. BUILDING: _____ B. WING _____	C 12/23/2025

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INDIGO AT ELMHURST (THE)	123 WEST BRUSH HILL ROAD ELMHURST, IL 60126

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A 000	Initial Comment Entity Reported Incident Investigation IL00198827 Incident date 11/18/25 violations cited IL00198549 Incident date 10/20/25- violations cited 295.1070- 11) 295.2000- a) c) 3) 4) 295.2050-a), b) 295.4010- a) d) Complaint Investigation IL00198884/ 25711923- violations cited 295.6000- a) 13) 295.7000- 9) 10)	A 000		
A1070	Section 295.1070 Annual on-Site Review and Complaint Procedure This Regulation is not met as evidenced by: General Violation Section 295.1070 Annual On-Site Review and Complaint Investigation Procedures d) An establishment shall not restrict or hamper access by Department staff to the building, residents or designated records required to conduct routine or periodic review or investigations. A resident may limit access to their private dwelling space to reviewers, except if suspected violations exist that may pose a threat to the resident's or others' health, safety or well-being. A resident may also elect to limit access to themselves and their records, except as required as a condition of payment for publicly	A1070		

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A1070	Continued From page 1 funded housing and/or services. This requirement was not met as evidenced by: Based on observation and interview, the establishment failed to provide requested documents in a timely manner. This affected time utilization of survey. Findings include: An onsite visit was conducted on 12/22/25 and 12/23/25. Entrance conference was initiated on 12/22/25 at 8:47AM with E15 (Life Engagement Coordinator). Request of documents to be reviewed was initiated. During the survey, it was noticed that there was delay of submission of requested documents. At 10:40AM, majority of the documents requested has not been received. The Incident reports needed to select additional resident sample still not received. The Electronic Health Records access restricted surveyors to view some residents, which required surveyors to request a printed copy of residents 'documents. On 12/22/25 at 2:05PM, E1 (Community Director) confirmed there was delay of document submission to Surveyors because of the process that needs to be followed. All documents are to be reviewed first by the Regional Nurse before submission to Surveyors. This issue was again encountered on 12/23/25. E1 acknowledged that the delay was again due to the procedure that needs to be followed.	A1070		

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A2000	Continued From page 2	A2000		
A2000	Section 295.2000 Residency Requirements This Regulation is not met as evidenced by: Type 1 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 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) c) A person shall not be accepted for residency if: 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;	A2000		

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A2000	Continued From page 3 This requirement was not met as evidenced by: Based on observation, interview and record review the establishment failed to ensure one (R2) of two residents reviewed meet residency requirements. This deficient practice creates a substantial probability of severe harm to a resident and potential residents' proper placement. Findings include: According to R2's documents, R2 moved to the community on 9/26/25. R2's face sheet indicated, R2's diagnoses include Dementia in other diseases classified elsewhere, moderate with agitation, and Constipation. On 12/22/25 at 11:30AM, R2 was observed in TV area with peers. R2 was seated on a specialized geriatric chair. R2 was unable to answer question, apart from "I am fine." R2's progress notes or Internal Investigation documented R2's fall history: -10/5/25 7:54PM- Unwitnessed fall, complained of left shoulder pain and right lower extremity swelling, redness and warm to touch. -10/9/25 at 2:45am, staff heard yelling in R2's apartment. R2 was found on the floor next to bed, reported R2 hit head, a laceration to the head was observed. R2 was sent to local Emergency Department. R2 returned to the community on 10/12/25. R2's hospital documents were obtained and reviewed. R2's CT dated 10/9/25 of the head result stated in part, "Acute subdural hematoma along the right parietal convexity measures up to 4mm thickness. There is also trace of acute	A2000		

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A2000	Continued From page 4	A2000		

subdural hematoma over the left temporal convexity, 2mm. Left frontal scalp hematoma. Additional right scalp laceration with small hematoma." Hospital notes also indicated there were multiple lacerations noted to the head. Scalp laceration was repaired with 4 sutures.
-10/20/25 around 9:30AM, R2 was complaining of severe pain to her right arm, R2 was assessed by E2 (Licensed Practical Nurse). R2's right arm was red and swollen. R2 was unable to move right arm. R2 was sent to the hospital and subsequently admitted for Right Humerus Fracture, surgery was not required. The investigation concluded that R2 had an unwitnessed fall sometime between the evening of 10/19/25 and the morning of 10/20/25, and was able to get herself up independently and did not inform staff.
R2's hospital medical records dated 10/20/25 stated Xray to the Right Humerus resulted to "Acute periprosthetic fracture of the right humeral mid-diaphysis with focal angulation." CT (Computed Tomography) of the head dated 10/20/25 indicated R2 had small left frontal sub galeal hematoma.
Notes indicated R2 went to a rehab facility and returned to the community on 11/6/25 with right arm sling. Upon return, R2 was also admitted to Hospice the with a diagnosis of Vascular Dementia secondary to sequelae of cerebral vascular disease, per hospice documents dated 11/6/25.

On 12/22/25 at 10:51am, E2 (Licensed Practical Nurse) said, prior to R2's move into the community, R2 lived with elderly sister. E2 said, "She kept on falling at home, hospital let them know that she cannot go back home and had to go to a community." E2 also said, R2 requires two persons assist for transferring, bathing, toileting.

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A2000	Continued From page 5 During an evacuation, and if R2 in in bed, R2 requires two persons assist to transfer from bed to wheelchair using a Hoyer lift. E2 said R2 requires two persons assist for all (Activities for daily Living- ADL's) because R2 cannot bear weight and even at the beginning, R2 required two persons assist because of aggressive behavior. E2 said, "I have not witnessed her propel her wheelchair the whole time she was here." On 12/22/25 11:13PM, E3 (Resident Assistant) confirmed R2 requires two persons assist for Activities of Daily Living (ADL). E3 said, because mechanical lift cannot be used in the bathroom, gait belt is used instead. Two persons will be assisting to stand up R2 and the third person to wipe. R2 cannot stand up independently, and for evacuation, if in bed R2 requires two persons to assist. E3 said, "She cannot get herself up". R2's Service Plan with an activation date of 9/23/25 (new move-in) identified the following: NEED: Neurocognitive. Action: Communication: Moderate Impairment. Resident has current or history of frequent difficulty communicating and receiving information, cannot follow instructions with using the telephone and other communication devices. Discipline: Resident Assistant. Action: Orientation: Moderate Impairment. Resident has current disorientation to person, place, time, or situation even in familiar surroundings and requires supervision and oversight for safety. NEED: Mobility/Ambulation: Action: Level of assistance- Mobility/ Ambulation: ... Ambulates with walker and SBA (Standby Assist). Self-propel with wheelchair when going longer distances ...	A2000		

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A2000	Continued From page 6 NEED: Transferring Action: Level of assistance- Transfers with SBA using walker and gait belt... NEED: Fall Potential Action: Ensure resident is wearing proper footwear, walkways are free of clutter. Remind to call for assistance if needed. Despite awareness of R2's history of falls prior to admission, there was no sufficient interventions in place to prevent or mitigate falls. E2 also indicated that R2 used wheelchair, and even at move in, she has never seen R2 propel her own wheelchair. E2 indicated R2 is alert, oriented x1- to self only, and confused. E3 also indicated that even at move in, R2 already requires two persons assist for ADL's, "cannot stand up on her own." After sustaining two falls with major injuries R2's Service Plan with an activation date of 11/10/25 indicated the following: NEED: Mobility/Ambulation: Action: Resident utilizes: Gait belt Action: Level of assistance- Mobility/ Ambulation. Total. Mechanical lift used wit transfers during this time. Resident resistant to standing at this time ...requires total assistance from staff member(s) for all mobility/ambulation needs or requires hands assistance on routine basis. Resident utilizes mechanical lift with assistance of two staff. Action: Level of assistance-Evacuation ...requires total physical assistance to evacuate residence or to request emergency assistance. (R2) is a Hoyer lift two assist transfer. NEED: Fall Potential Action: Fall Potential- 10/20/25: Offer (R2) assistance with toileting every four hours. Ensure (R2) 's need are met. 1. Ensure walkways are free of clutter. 2. Encourage (R2) to call for assistance if needed. 3. 10/5/25: Two assist with Hoyer lift for all transfers. 4. Staff propels	A2000		

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A2000	Continued From page 7 wheelchair at all times. 5. 10/20/25: Routine assistance (every four hours) with toileting, transferring. Other ADL needs did not specify on R2's service plan how many staff were needed for assistance. However, staff who provides the ADLs indicated, R2 required two persons assist for all ADL's.	A2000		
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. These requirements are not met as evidenced by: Based on interview and record review, the establishment failed to follow their Incident and	A2050		

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A2050	Continued From page 8 Accident Policy and Procedure, affecting one (R2) resident in a sample of four. Findings include: According to R2's documents, R2 moved to the community on 9/26/25. R2's face sheet indicated, R2's diagnoses include Dementia in other diseases classified elsewhere, moderate with agitation, and Constipation. R2's progress notes documented the following: -10/9/25 at 2:45am, staff heard yelling in R2's apartment. R2 was found on the floor next to bed, reported R2 hit head, a laceration to the head was observed. R2 was sent to local Emergency Department. R2's hospital documents were obtained and reviewed. R2's hospital documents documented the following injuries: 10/9/25 of "Acute subdural hematoma ... multiple lacerations noted to the head. Scalp laceration was repaired with 4 sutures." There was no documentation that state agency was notified of this incident. Establishment Policy and Procedure titled "Incident &Accident Reporting" Effective Date/Revised Date: 10/1/22 stated in part' Department Reporting; An incident or accident that has significant negative effect on the health, safety ...of a resident shall be reported to the Department ... If unable to access online portal. Department of Public Health Complaint Registry can be contacted or fax within 24 hours. On 12/22/25 at 1:35PM, E1 (Community Director) said, incident is reported within 24 hours to Public	A2050		

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A2050	Continued From page 9 Health. This process was not followed.	A2050		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 1 Violation 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. 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) These requirements are NOT met as evidenced by: Based on observation, interview and record review, the establishment failed to provide sufficient oversight and implement individualized fall interventions for two (R1, R2) of three residents with diagnosis of Dementia, have cognitive impairment, and history of multiple falls.	A4010		

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A4010	Continued From page 10 This deficient practice resulted to: -R1 sustaining Left Hip fracture, and subsequent admission to hospice care. -R2 sustaining the following serious injuries: Acute subdural hematoma and laceration to the head with 4 sutures and Right Humerus Fracture from different incidents. The establishment also failed to follow Safety check/ Visual checks policy and procedures for one (R4) resident who has history of fall and requires assistance with Activities with Daily Living. This deficient practice affected three (R1, R2, R4) residents and caused severe harm to a resident and creates the substantial probability to cuase sever harm to other residents. Findings include: An onsite visit was conducted on 12/22/25 to 12/23/25. According to R1's documents, R1 moved to the community on 8/19/24. R1's diagnoses include but not limited to Dementia in other diseases classified elsewhere, Unspecified fall, subsequent encounter, Unsteadiness on feet, Difficulty in walking, not elsewhere classified, Muscle weakness (generalized), and Essential Hypertension. R1 passed away on 11/25/25 at the age of 89. R1's Progress Notes documented fall incidents with or without injury: 4/23/25- observed on the floor lying ...appears to have been on his way to the toilet ...Transported to hospital. No documentation of injury. 7/17/25 6:12PM- Resident discovered on the floor... Transported to hospital. No documentation of injury.	A4010		

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A4010	Continued From page 11 7/31/25 6:12PM- found resident on the floor in the bathroom. 10/15/25 10:53PM- Resident had unwitnessed fall while ambulating with his walker in his room ...assessed by writer abrasion on right elbow. 11/18/25 7:25PM- Care partner heard a noise and upon entering resident's room, resident was observed on the floor in a supine position. Resident unable to state what happened. Resident was complaining of pain to left side and sustained a small skin tear to left elbow. Summary of Investigative Conclusion, stated in part; R1 was observe sleeping in room at 7:00PM, observed on the floor at 7:25PM. R1 requires one person assistance for transferring and mobility ...likely stood independently, lost balance and fell. R1's progress notes dated 11/19/25 indicated R1 was admitted in the hospital with a diagnosis of Left Hip fracture. 11/20/25 notes indicated, R1 was assessed while in the hospital, per hospital staff R1 required total assistance with toileting, transferring and bed mobility, not currently making attempts at standing independently, Hospice to evaluate. On 11/20/25, R1 returned to the community. R1's Hospice admission document indicated, R1 was admitted on 11/20/25 to hospice with a diagnosis of Alzheimer's Dementia. "He was referred to hospice based on a major decline following multiple falls ...hospitalized with a femoral neck fracture. Surgery recommended however given advanced dementia the family declined... R1s notes on 11/25/25 indicated, R1 was pronounced deceased on 11/25/25 at 2PM. R1's document titled "Physician's Assessment Form" dated 8/27/25 documented R1 required x1 assist for dressing, transferring, bathing, personal hygiene and medication administration.	A4010		

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A4010	Continued From page 12 R1's Service Plan with Activation Date of 10/31/25 documented the following: NEED: Neurocognitive Category Action: Communication: Moderate Impairment. Resident has current or history of frequent difficulty communicating and receiving information; cannot follow instructions; has frequent difficulty following instructions with using the telephone and other communication devices. Action: Orientation: Moderate Impairment. Resident has current or history of occasional disorientation to person, place time or situation even in familiar surroundings and requires supervision and oversight for safety. NEED: Psychosocial Category Action: Occasional behavior Issues. Resident has current or history of occasional disruptive, aggressive or socially inappropriate behavior, either verbally, or physically improper ...Frequently resistive to care. NEED. Mobility/ambulation Category Action: Level of assistance: Mobility/Ambulation: Total hands assist x1. Requires total assistance from staff member (s) for all mobility/ambulation needs or requires hands on assistance on routine basis ...utilizes: walker standby assist x1 staff. NEED: Escorts Category Action: Level of assistance-Escorts. Moderate hands-on assist x1 when ambulating ...may require assistive device for mobility/ambulation. NEEDS: Transferring Category Action: Level of Assistance- Transferring: Moderate hands-on assist x1 staff ...requires occasional hands-on assist with transfers and or changes in position ...requires gait belt. NEED: Fall Potential Category Action: Ensure resident is wearing proper footwear, walkways are free of clutter. Remind resident to call for assistance if needed.	A4010		

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A4010	Continued From page 13 NEED: Falls GOALS: Resident will not sustain any injuries related to falls. Action: Night light left on in: Staff to leave bedside lamp on. Resident does ambulate with walker at all times without calling for assistance. On 12/22/25 at 10:51AM, E2 (Licensed Practical Nurse) said, R1 has been a fall risk since move in, used walker to ambulate, sometimes not. Alert, orientated x1 and unable to verbalize needs. According to E2, being unsteady on his feet, especially when not using walker was identified as contributory factor for fall. On 12/22/25 at 11:13AM, E3 (Resident Assistant) said prior to the 11/18/25 fall, R1 used to walk around with a walker. R1 used to be in physical therapy, but it was stopped. E3 said since then E3 noticed the decline. E3 said, she noticed decline around August or September, R1 required more staff assistance. There was no course of action put into place with R1's noncompliance with mobility device, not calling for assistance. ---- According to R2's documents, R2 is 84 years old. R2 moved to the community on 9/26/25. R2's face sheet indicated, R2's diagnoses include Dementia in other diseases classified elsewhere, moderate with agitation, and Constipation. On 12/22/25 at 11:30AM, R2 was observed in TV area with peers. R2 was seated on a specialized geriatric chair. R2 was unable to answer question, apart from "I am fine." R2's progress notes or Internal Investigation documented R2's fall history:	A4010		

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A4010	Continued From page 14 -10/5/25 7:54PM- Unwitnessed fall, complained of left shoulder pain and right lower extremity swelling, redness and warm to touch. Sent to local hospital, no documented injury. -10/9/25 at 2:45am, staff heard yelling in R2's apartment. R2 was found on the floor next to bed, reported R2 hit head, a laceration to the head was observed. R2 was sent to local Emergency Department. R2's hospital documents were obtained and reviewed. R2's CT dated 10/9/25 of the head result stated in part, "Acute subdural hematoma along the right parietal convexity measures up to 4mm thickness. There is also trace of acute subdural hematoma over the left temporal convexity, 2mm. Left frontal scalp hematoma. Additional right scalp laceration with small hematoma." Hospital notes also indicated there were multiple lacerations noted to the head. Scalp laceration was repaired with 4 sutures. R2 returned to the community on 10/12/25. -10/20/25 around 9:30AM, R2 was complaining of severe pain to her right arm, R2 was assessed by E2 (Licensed Practical Nurse). R2's right arm was red and swollen. R2 was unable to move right arm. R2 was sent to the hospital and subsequently admitted for Right Humerus Fracture, surgery was not required. The investigation concluded that R2 had an unwitnessed fall sometime between the evening of 10/19/25 and the morning of 10/20/25, and was able to get herself up independently and did not inform staff. R2's hospital medical records dated 10/20/25 stated Xray to the Right Humerus resulted to "Acute periprosthetic fracture of the right humeral mid-diaphysis with focal angulation." CT (Computed Tomography) of the head dated 10/20/25 indicated R2 had small left frontal sub galeal hematoma.	A4010		

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A4010	Continued From page 15 Notes indicated R2 went to a rehab facility and returned to the community on 11/6/25 with right arm sling. On that day, R2 was also admitted to Hospice with a diagnosis of Vascular Dementia secondary to sequelae of cerebral vascular disease, per hospice documents. On 12/22/25 at 10:51am, E2 (Licensed Practical Nurse) said, prior to R2's move into the community, R2 lived with elderly sister. E2 said, "She kept on falling at home, hospital let them know that she cannot go back home and had to go to a community." E2 also said, R2 requires two persons assist for transferring, bathing, toileting. During an evacuation, and if R2 in in bed, R2 requires two persons assist to transfer from bed to wheelchair using a Hoyer lift. E2 said R2 requires two persons assist for all (Activities for daily Living- ADL's) because R2 cannot bear weight and even at the beginning, at move in, R2 required two persons assist because of aggressive behavior. On 12/22/25 11:13PM, E3 (Resident Assistant) confirmed R2 requires two persons assist for Activities of Daily Living (ADL). E3 said, because mechanical lift cannot be used in the bathroom, gait belt is used instead. Two persons will be assisting to stand up R2 and the third person to wipe. R2 cannot stand up independently, and for evacuation, if in bed R2 requires two persons to assist. E3 said, "She cannot get herself up". R2's Service Plan with an activation date of 9/23/25 (new move-in) identified the following: NEED: Neurocognitive. Action: Communication: Moderate Impairment. Resident has current or history of frequent difficulty communicating and receiving information, cannot follow instructions with using	A4010		

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A4010	Continued From page 16	A4010		

the telephone and other communication devices.
Discipline: Resident Assistant.
Action: Orientation: Moderate Impairment. Resident has current disorientation to person, place, time, or situation even in familiar surroundings and requires supervision and oversight for safety.
NEED: Mobility/Ambulation:
Action: Level of assistance- Mobility/ Ambulation: ... Ambulates with walker and SBA (Standby Assist). Self-propel with wheelchair when going longer distances ...
NEED: Transferring
Action: Level of assistance- Transfers with SBA using walker and gait belt...
NEED: Fall Potential
Action: Ensure resident is wearing proper footwear, walkways are free of clutter. Remind to call for assistance if needed.
Despite awareness of R2's history of falls prior to admission, there was no sufficient interventions in place to prevent or mitigate falls. E2 also indicated that R2 used wheelchair, and even at move in, she has never seen R2 propel her own wheelchair. E2 indicated R2 is alert, oriented x1- to self only, and confused. E3 also indicated that even at move in, R2 already requires two persons assist for ADL's, "cannot stand up on her own."
After sustaining two falls with major injuries R2's Service Plan with an activation date of 11/10/25 indicated the following:
NEED: Mobility/Ambulation:
Action: Resident utilizes: Gait belt
NEED: Fall Potential
Action: Fall Potential- 10/20/25: Offer (R2) assistance with toileting every four hours. Ensure (R2) 's need are met. 1. Ensure walkways are free of clutter. 2. Encourage (R2) to call for assistance if needed. 3. 10/5/25: Two assist with Hoyer lift for all transfers. 4. Staff propels

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A4010	Continued From page 17 wheelchair at all times. 5. 10/20/25: Routine assistance (every four hours) with toileting, transferring. --- According to R4's documents, R4 is 92 years old. R2 moved into the community on 8/6/25. R2's diagnoses include but not limited to Anemia, Essential Hypertension, Anxiety, Chronic Kidney Disease. On 12/22/25 at 12:13PM, R4 was observed seated on a wheelchair. R4 stated he was "fine". R4's Incident Forms documented multiple falls: 8/13/25- observed on the floor...stated trying to urinate in the garbage can...small laceration to left and right elbow...did not pull call lights for assistance ... 10/8/25 8:34am: was complaining of pain to left hip.....reported he "fell upstairs". There was no fall noted or reported by staff so unsure exactly when this "fall upstairs" occurred (Resident has only one floor occupied by residents). R4 was sent the hospital and diagnosed with Closed Left Hip Fracture requiring surgery. According to Incident investigation completed, "staff denied knowledge of resident falling or assisting him up from fall. Visual check documentation was reviewed, and visual checks were completed however all visual checks except the 11pm check on 10/7/25 were signed out on 10/8/25 at 0724am at the end of E14's (Certified Nursing Assistant) shift. Per interview with E14 she did complete visual checks as scheduled, she did not get all documentation completed until the end of her shift" R4's Physician's Assessment Form dated 8/27/25, indicated R4 requires x1 assistance for	A4010		

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A4010	Continued From page 18 dressing, toileting, transferring, bathing and personal assistance. R4's admission notes dated 8/6/25, R4 requires one person assist with transfers, self-propel on wheelchair, alert, oriented x1-2. Policy document titled, "Safety Checks/Visual Check" with an Effective/Revised Date of 10/15/22 stated in part; Policy: ...the need for and frequency of safety check/visual checks shall be identified. Safety checks shall be documented in the resident chart. Procedure: 3. Staff member makes visual contact of resident, whether resident is awake or sleeping. 4. Document visual check in incident chart according to scheduled time. RA does check per instructions. The key is for residents to be viewed through out an entire shift and ensure resident safety.	A4010		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 1 Violation 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. 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor.	A6000		

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A6000	Continued From page 19 These requirements were not met as evidenced by: Based on interview and record review, the establishment failed to ensure that residents are free from neglect, which resulted in a fall with injury for one (R3) of three residents reviewed. This deficient practice has the probability to affect all residents. Findings include: R3's medical record showed R3 moved into the establishment on 11/4/2023, resided in the memory care unit, and had multiple diagnoses, including but not limited to Essential Hypertension, dementia, Hypelipidemia, Irritable Bowel Syndrome, Osteoarthritis, Anxiety Disorder. R3's Service Plan dated 9/23/2025 indicated that R3 Level of Assistance-Transferring: Not Applicable - Bed-bound. Resident is bed-bound. Level of Assistance-Mobility/Ambulation: Ax2 with pivot transfers, propel in high back wheelchair. R3's Progress Notes indicated the following: 9/25/2025 at 10:24AM, "Call placed to Hospice, alerted that patient was transitioning at this time and requested a visit. Hospice nurse to come out and evaluate patient." 9/29/2025 at 6:01AM, "This writer was called to patient room at 11:22pm by care partner, upon entering patient room, patient showed no signs of life. All breathing had ceased. And patient was pulseless. This writer reached out to hospice. hospice RN (registered Nurse) arrived at	A6000		

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A6000	Continued From page 20 11:45Pm confirmed time of death of 11:22PM." On 12/22/2025 at 12:19PM, Z2 (Hospice Nurse) said that in the hospice admission documents stated that R3 had a recent fall and apparently R3 hit her hip. Z2 said that R3 decline very fast. Z2 said that when she came to see R3 her left side looked like hip fracture, one leg looked shorter than the other. Z2 said "I asked if she had a fall, on the admission said that she had a recent fall, staff didn't know when the fall was but, in the admission, records stated that R3 had a recent fall." On 12/22/2025 at 12:23PM, E7 (Resident Assistant) said that she does not recall any falls for R3. On 12/22/2025 at 1:34PM, E8 (Resident Assistant) said that she does not remember the day but that R3 fell a few days after coming back from the hospital, E8 said that R3 was sitting in a wheelchair because R3 came back weak, E8 said that she was taking the trash out and when she was coming back, she saw R3 walking and that she told R3 to sit down in the wheelchair and ran towards R3 but it was too late, R3 was already on the floor, E8 said that she was working with another Care Partner that day and both of them called E2 (Licensed Practical Nurse/LPN), E8 said that it was around 2:30PM and that she left and had E2 and the PM Care Partner helping R3 up. On 12/22/2025 at 1:59PM, E9 (Resident Assistant) said did not witness any fall for R3. E9 said that R3 was in a wheelchair because R3 was weak and that R3 tried to stand up but didn't fall. On 12/22/2025 at 2:30PM, E2 said that R3 had	A6000		

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A6000	Continued From page 21	A6000		

sustained falls while in this community, E2 said that R3 apparently have a fractured hip when returned from the hospital, E2 said that hospice nurse assessed R3, but nothing was done. E2 said thar R3 complained of a lot of pain and the hospice nurse was notified, nurse came back and didn't give any orders. E2 said that even the family was confused as when this could have happened, if it was in the hospital or here. E2 further said "I was not notified of any fall."

On 12/22/2025 at 2:44PM, Z3 (Agency Certified Nursing Assistant/CNA) said that she worked once in this establishment, she remembers R3 been bed bound, no falls during her shift.

On 12/22/2025 at 3:21PM, Z4 (Agency CNA) said that she worked the overnight shift and that she didn't have any falls during her shift. Z4 said that nobody gave her report that day.

On 12/23/2025 at 9:15AM, E12 (Housekeeper) said that she didn't witness R3 falling, but that she was cleaning a room and heard when the Care Partners said, "Oh she fell". E12 said that on of the Care Partners was E8.

On 12/23/2025 at 9:22AM (Certified Nursing Assistant) said that she heard that R3 fell, but that she didn't witness any falls.

On 12/23/2025 at 9:41AM, E1 (Executive Director) said "I don't remember the date or the specific about a fall, I need to check the notes."

On 12/23/2025 at 9:58AM, E6 (LPN) said that he does not recall any falls and was not aware that resident fell. E6 said that R3 was sent out to hospital over the weekend, stayed in the hospital a few days and then came back.

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A6000	Continued From page 22 On 12/23/2025 at 12:40PM, E11 (Resident Assistant) said that R3 had a fall, E11 said that she didn't witness the fall because she was off that day, but when she returned to work, she was informed by Care Partners and nurse on duty, that R3 had fallen and to keep an eye on her. She said that she does not remember the date this incident happened, but it was a week or two before R3 passed away. During this investigation, records reviewed included schedules, reportable incidents and resident records, including progress notes, and service plan. Review of Hospice documentation indicated the following: Start of Care 9/19/2025- No indication of pain, facility reports no issues of pain. "83 F with recent fall, suspected she hit her head." 9/23/2025 physician's note indicated in part ... "she has multiple falls. She was also noted to have an acute SDH on CT scan." 9/26/2025- "Patient is in pain when touching left hip and provided medication for pain, prior to arrival." 9/28/2025- "Left hip injury present." R3's hospital records were requested, no records received up the end of this investigation.	A6000		
A7000	Secton 295.7000 Resident Records This Regulation is not met as evidenced by: Type 2 Violation Section 295.7000 Resident Records	A7000		

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A7000	Continued From page 23 9) Notation of known accidents, incidents or injuries. 10) Documentation of any significant change in a resident's behavior or physical, cognitive, or functional condition that would trigger an assessment or evaluation, and action taken by employees to address the resident's changing needs. These requirements were not met as evidenced by: Based on interview and record review the facility failed to document a witnessed fall that resulted in major injury for one (R3) of three residents reviewed. This failure has the probability to affect all residents. Findings include: R3's medical record showed R3 moved into the establishment on 11/4/2023, resided in the memory care unit, and had multiple diagnoses, including but not limited to Essential Hypertension, dementia, Hypelipidemia, Irritable Bowel Syndrome, Osteoarthritis, Anxiety Disorder. During interviews with establishment employees. On 12/22/2025 at 1:34PM, E8 (Resident Assistant) said that she does not remember the day but that R3 fell a few days after coming back from the hospital, E8 said that R3 was sitting in a wheelchair because R3 came back weak, E8 said that she was taking the trash out and when she was coming back, she saw R3 walking and that she told R3 to sit down in the wheelchair and ran towards R3 but it was too late, R3 was already on the floor, E8 said that she was working with	A7000		

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A7000	Continued From page 24 another Care Partner that day and both of them called E2 (Licensed Practical Nurse/LPN), E8 said that it was around 2:30PM and that she left and had E2 and the PM Care Partner helping R3 up. Subsequent interviews with staff indicated that there was a fall. However, there is no documentation regarding any fall. R3's progress Notes were reviewed. No falls were noted. Reviewed of Hospice documentation indicated the following: Start of Care 9/19/2025- No indication of pain, facility reports no issues of pain. "83 F (female) with recent fall, suspected she hit her head." 9/23/2025 physician's note indicated in part ... "she has multiple falls. She was also noted to have an acute SDH on CT scan." 9/26/2025- "Patient is in pain when touching left hip and provided medication for pain, prior to arrival." 9/28/2025- "Left hip injury present." R3's hospital records were requested, no records received up the end of this investigation.	A7000		