STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510039	A. BUILDING: _____ B. WING _____	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GURNEE PLACE MEMORY CARE	505 N HUNT CLUB ROAD GURNEE, IL 60031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comment ANNUAL LICENSURE SURVEY CONDUCTED 295.2000 a) c) 3) 4) 295.2060 a) b) 1) 2) 295.3000 a) 295.4000 a) b) c) Facility Reported Incident IL199215 295.4010g)1)A-C)2)3)h) 295.4060 c) Complaint Investigation IL198972 - 295.400 previously cited on 12/2/25.	A 000		
A2000	Section 295.2000 Residency Requirements This Regulation is not met as evidenced by: . TYPE 2 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:	A2000		

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A2000	Continued From page 1 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; This requirement is not met as evidenced by: Based on observation, interviews and record review, the facility failed to ensure residents are appropriate to live in an assisted living or shared housing environment. This applies to three (R1, R2 and R3) out of three residents reviewed for residency requirements in a sample of four. This failure creates a substantial probability of harm to a resident or residents. Findings include: 1) On 1/6/26 at 9:24 AM observed R1 sitting on his wheelchair in the hallway. R1 had his feet on the floor and could not propel himself forward. R1 could not follow command from E3 (CNA-Certified Nursing Assistant) to lift up his feet so that E3 (CNA) could propel him. E3 tilted the wheelchair backwards to wheel him to his room. E3 (CNA) and E4 (CG-Caregiver) together helped R1 stand. Observed that both of R1's knees were bent as E3 and E4 held him up and changed his diaper. R1 could not stand by himself. 2) On 1/6/26 at 1:00 PM, observed R2 sitting in the wheelchair in her room. R2 alert, not oriented x 3 and confused. Observed E3 (CNA) and E4	A2000		

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A2000	Continued From page 2	A2000		

(CG) together transfer R2 from her wheelchair to bed. Observed that during transfer both of R2's knees were bent and R2 could not stand on her own or bear her own weight. After the perineal care was done, E3 and E4 together transferred R2 back into her wheelchair and wheeled her out of the room.

3) On 1/6/26 at 1:10 PM, observed R3 sitting on her wheelchair in her bathroom. R3 was alert, confused and in angry mood. E4 (CG) tried to help R3 stand. Observed that R3 was unsteady as she stood and both her knees were bent. In about 30 seconds, R3 flopped onto the toilet seat assisted by E4 (CG). E4 had to reposition R3 twice for R3 to be able to sit correctly to pass urine. After R3 was done, E4 helped R3 to stand. But in about 5 seconds, R3 sat back onto the toilet seat apologizing she cannot stand. Then E3 (CNA) and E4 (CG) together transferred R3 to her wheelchair

On 1/7/26 at 12:50 PM, R1's records were reviewed. R1 was a 65 years old male admitted on 12/26/22 with diagnoses to include Al Zheimer's disease and depression. R1's service plan (SP) dated 11/2/25 showed R1 needed extensive assist for bathing, dressing, toileting, ambulation and eating meals.

On 1/7/26 at 1:00 PM, R2's records were reviewed. R2 was a 91 years old female admitted on 10/13/25 with diagnoses to include dementia, schizophrenia, depression, anemia and hypothyroidism. R2's service plan dated 11/11/25 showed R2 required assistance for all ADLs.

On 1/7/26 at 2:00 PM, R3's records were reviewed. R3 was a 93 years old female admitted on 11/19/25 with diagnoses to include dementia,

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A2000	Continued From page 3 hypertension osteoarthritis, chronic obstructive pulmonary disease. R3's service plan dated 11/27/25 showed R3 required assistance for all ADLs. On 1/6/26 at 11:10 AM, E3 (CNA) stated R1, R2 and R3 required two persons assistance for transfer and they all required total assist for all ADLs (activities of daily living). On 1/6/26 at 1:35 PM, E4 (CG) stated R1, R2 and R3 required two persons assistance for transfer and they all required total assist for all ADLs (activities of daily living). On 1/8/26 at 3:00 PM, E1 and E2 agreed with the above findings.	A2000		
A2060	Section 295.2060 Quality Improvement Program This Regulation is not met as evidenced by: TYPE 3 VIOLATION Section 295.2060 Quality Improvement Program a) The establishment shall establish an effective quality improvement program that encompasses oversight and monitoring, resident satisfaction, and ongoing quality improvement and implementation of any plan that addresses improved quality services. The quality improvement process implemented by the establishment must benchmark performance, be customer centered, be data driven, and focus on resident satisfaction. (Section 30(a) of the Act) For the purpose of this Section, "benchmark" means creating points of reference from which	A2060		

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A2060	Continued From page 4 measurements can be made. b) A system shall be in place to facilitate the detection of issues and problems, to expedite the implementation of action, and to resolve problems. 1) Data analysis shall be used to identify and implement changes that will improve performance or reduce the risk of additional events. 2) The establishment shall maintain documentation that shows that data analysis has occurred and that actions, as appropriate, have been implemented to address identified issues and to resolve problems, as well as any follow-up actions taken by the establishment. This requirement is not met as evidenced by: Based on interviews and record reviews, establishment failed to establish and maintain an effective quality improvement program. Findings include: On 1/8/26 at 1:35 PM establishment QAPI (Quality Assurance and Performance Improvement) documents were requested. E1 (ED-Executive Director) stated, they don't have a binder with QAPI , but she has QAPI meeting minutes. On 1/8/26 at 1:45 PM the QAPI minutes were reviewed. It did not show any PIP (Performance Improvement Project) No other documents available to review. On 1/8/26 at 1:50 PM, E1 (ED-Executive Director) stated, this establishment has neither	A2060		

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A2060	Continued From page 5 documented nor implemented any specific action plan to improve the quality of an identified issue. Also there is no documentation of any follow up on any identified issues.	A2060		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: . TYPE 2 VIOLATION Section 295.3000 a) The establishment shall have staff sufficient in number with qualifications, adequate skills, education and experience to meet the 24 hour scheduled and unscheduled needs of residents and who participate in ongoing training to serve the resident population. (Section 35(a)(3) of the Act) This requirement is not met as evidenced by: Based on observations, interviews and record reviews, the establishment failed to ensure employees performed hand hygiene appropriately during resident care. This has the probability of cross-contamination and risk of infection for residents and creates a substantial probability of harm to a resident or residents. This applies to 3 out of 3 residents (R1, R2 and R3) reviewed for hand hygiene. Findings include:	A3000		

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A3000	Continued From page 6 1) On 1/6/26 at 9:24 AM observed E3 (CNA) and E4 (CG-Caregiver) together helped R1 stand. E3 wiped R1's bottoms and did not change gloves or do hand hygiene. Together E3 and E4 changed R1's disposable brief and sat him on his wheelchair. With same soiled gloves E3 replaced the clean pack of wipes and tidied R1's clothing. Both E3 and E4 removed their gloves, did not use hand sanitizer or wash their hands and wheeled R1 out of his room. With the same soiled hands E3 and E4 went into R2's room to provide care for R2. 2) On 1/6/26 at 1:00 PM, observed R2 sitting in the wheelchair in her room. R2 alert, not oriented x 3 and confused. Observed E3 (CNA) and E4 (CG) together transfer R2 from her wheelchair to bed. Observed E3 (CNA) removed R2's disposable briefs and cleaned the stool off R2's bottoms. E3 did not change gloves while providing perineal care or do hand hygiene. After the perineal care was done, E3 applied the clean disposable briefs with the same soiled gloves. Then E3 and E4 together transferred R2 back into her wheelchair with the same pair of soiled gloves. E3 made R2's bed with the same soiled gloves. E3 touched the wheelchair with the same soiled gloves to push it a little further. Then, E3 and E4 removed their gloves, did not perform hand hygiene and wheeled R2 out of the room. With the same soiled hands E3 and E4 went into R3's room to provide care for R3. 3) On 1/6/26 at 1:10 PM, observed R3 sitting on her wheelchair in her bathroom. R3 was alert, confused and in angry mood. E4 (CG) transferred R3 to the toilet seat. After R3 was done, E4 cleaned R3's bottoms. E4 did not perform hand hygiene or change gloves. With same soiled gloves touched R3's clothing, hands and back.	A3000		

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A3000	Continued From page 7 E4 and E3 together transferred R3 back to her wheelchair. E4 replaced the unused pack of wipes with same soiled gloves and wheeled R3 out of the bathroom. E3 and E4 removed their gloves, did not use hand sanitizer or wash their hands and left the room to assist the next resident. Facility policy on infection control revised in 10/2024 was reviewed. It showed, 'The community's executive director ensures the provision of a safe, sanitary and comfortable environment for residents. On 1/6/26 at 1:25 PM, E3 (CNA) and E4 (CG) stated they should have washed hands or used hand sanitizer before, during and after caring for any resident. On 1/8/26 at 2:00 PM, E1 (ED-Executive Director), E2 (HWD - Health and Wellness Director) agreed with the above findings.	A3000		
A4000	Section 295.4000 Physician/s Assessment This Regulation is not met as evidenced by: . TYPE 3 VIOLATION Section 295.4000 a) No more than 120 days prior to admission of a resident to any establishment, a comprehensive assessment that includes an evaluation of the prospective resident's physical, cognitive, and	A4000		

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A4000	Continued From page 8	A4000		

psychosocial condition shall be completed by a physician. The physician's assessment shall include documentation of the presence or the absence of tuberculosis infection in accordance with the Control of Tuberculosis Code. At the time of admission, the physician's assessment must reflect the resident's current condition.

b) At least annually, once a resident has moved into the establishment, a comprehensive assessment shall be completed by a physician.

c) A physician's assessment shall be completed by a physician upon identification of a significant change in the resident's condition.

These requirements were NOT MET as evidenced by:

Based on interviews and record review, the facility failed to ensure physician assessments are complete and are done in a timely manner.

This applies to 4 (R1, R2, R3 and R4) out of 4 residents reviewed for Physicians assessments in a sample of 4.

Findings include:

1) On 1/7/26 at 12:50 PM, R1's records were reviewed. R1 was a 65 year old male admitted on 12/26/22 with diagnoses to include Al Zheimer's disease and depression.
R1's initial Physician assessment dated 10/6/22 did not include any information on R1's TB (tuberculosis) status. R1's current Physician assessment dated 11/6/24 also did not include any information on R1's TB status. R1's current Physician's assessment was signed by E18

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A4000	Continued From page 9 (Nurse Practitioner) who was listed as a Nurse Practitioner on R1's face-sheet. 2) On 1/7/26 at 1:00 PM, R2's records were reviewed. R2 was a 91 year old female admitted on 10/13/25 with diagnoses to include dementia, schizophrenia, depression, anemia and hypothyroidism. R2's initial Physician assessment dated 10/8/25 did not include any information on R2's TB (tuberculosis) status. 3) On 1/7/25 at 2:00 PM R3's records were reviewed. R3's face-sheet showed R3 was admitted on 11/19/25 with diagnoses to include dementia, hypertension, osteoarthritis and chronic obstructive pulmonary disease. R3's Physician assessment before admission dated 11/5/25 did not include any information on R3's TB (tuberculosis) status and it was signed by a Nurse Practitioner. 4) On 1/8/25 at 10:00 AM R4's records were reviewed. R4's face-sheet showed R4 was admitted on 6/14/23 with diagnoses to include Al Zheimer's disease and osteoporosis. E1 (ED-Executive Director) stated R4's initial Physician assessment was not available. R4's current Physician assessment did not have a legible date and did not include any information on R4's TB (tuberculosis) status and the signature could not be identified as it did not include a name or NPI number or a title. On 1/8/25 at 2:45 PM, E2 (HWD-Health and Wellness Director) agreed with the above findings.	A4000		
A4010	Section 295.4010 Service Plan	A4010		

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A4010	Continued From page 10 This Regulation is not met as evidenced by: . TYPE 2 VIOLATION Section 295.4010 Service Plan g) Service plans shall address: 1) The level of service the resident is receiving, including: A) assistance with activities of daily living; B) dietary needs, if the establishment provides therapeutic diets; and 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; h) The service plan shall include all support services provided or arranged for by the establishment. This requirement is NOT MET as evidenced by: Based on observations, interview, and record review, the facility failed to update service plans as per the current condition of the resident and include health related services needed by the resident leading to inadequate provision of care.	A4010		

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A4010	Continued From page 11 This applies to 3 of 3 residents reviewed for accidents and supervision. This failure creates a substantial probability of harm to a resident or residents. Findings include: 1) On 1/6/26 at 9:24 AM observed R1 sitting on his wheelchair in the hallway. R1 had his feet on the floor and could not propel himself forward. R1 could not follow command from E3 (CNA-Certified Nursing Assistant) to lift up his feet so that E3 (CNA) could propel him. E3 tilted the wheelchair backwards to wheel him to his room. E3 (CNA) and E4 (CG-Caregiver) together helped R1 stand. Observed that both of R1's knees were bent as E3 and E4 held him up and changed his diaper. R1 could not stand by himself. 2) On 1/6/26 at 1:00 PM, observed R2 sitting in the wheelchair in her room. R2 alert, not oriented x 3 and confused. Observed E3 (CNA) and E4 (CG) together transfer R2 from her wheelchair to bed. Observed that during transfer both of R2's knees were bent and R2 could not stand on her own or bear her own weight. After the perineal care was done, E3 and E4 together transferred R2 back into her wheelchair and wheeled her out of the room. 3) On 1/6/26 at 1:10 PM, observed R3 sitting on her wheelchair in her bathroom. R3 was alert, confused and in angry mood. E4 (CG) tried to help R3 stand. Observed that R3 was unsteady as she stood and both her knees were bent. In about 30 seconds, R3 flopped onto the toilet seat assisted by E4 (CG). E4 had to reposition R3	A4010		

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A4010	Continued From page 12	A4010		

twice for R3 to be able to sit correctly to pass urine. After R3 was done, E4 helped R3 to stand. But in about 5 seconds, R3 sat back onto the toilet seat apologizing she cannot stand. Then E3 (CNA) and E4 (CG) together transferred R3 to her wheelchair

On 1/7/26 at 12:50 PM, R1's records were reviewed. R1 was a 65 years old male admitted on 12/26/22 with diagnoses to include Al Zheimer's disease and depression. R1's incident reports showed R1 fell seven times in the last one year - 12/11/24, 7/23/25, 8/28/25, 12/5/25, 12/7/25, 12/16/25 and 12/27/25, out of which three were with injuries. R1's service plan (SP) dated 11/2/25 did not include any fall precautions. The SP did not specify how R1 can be transferred. R1's SP was not signed by R1/R1's representative or the nurse or the manager.

On 1/7/26 at 1:00 PM, R2's records were reviewed. R2 was a 91 years old female admitted on 10/13/25 with diagnoses to include dementia, schizophrenia, depression, anemia and hypothyroidism. R2's incident report showed she fell on 12/18/25. R2's service plan dated 11/11/25 did not include any fall precautions. The SP did not specify how R2 can be transferred. The SP did not include her diet or the extent of assistance R2 needs for meals and ADLs (activities of daily living). R2's SP was not signed by R2/R2's representative or the nurse or the manager.

On 1/7/26 at 2:00 PM, R3's records were reviewed. R3 was a 93 years old female admitted on 11/19/25 with diagnoses to include dementia, hypertension osteoarthritis, chronic obstructive pulmonary disease. R3's incident report showed she fell on 12/17/25. R3's service plan dated 11/27/25 did not include any fall precautions. The

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A4010	Continued From page 13 SP did not specify how R3 can be transferred. The SP did not include her diet or the extent of assistance R3 needs for meals and ADLs. R3's SP was not signed by R3/R3's representative or the nurse or the manager. On 1/6/26 at 11:10 AM, E3 (CNA-Certified Nursing Assistant) stated R1, R2 and R3 are not on hospice. E3 stated, R1 and R2 need to be spoon fed and that they both cannot eat by themselves. E3 stated R1, R2 and R3 need total assists for all ADLs and require two persons to transfer. On 1/6/26 at 1:35 PM, E4 (CG) stated R1, R2 and R3 required two persons assistance for transfer and they all required total assist for all ADLs (activities of daily living). On 1/8/25 at 2:45 PM, E2 (HWD-Health and Wellness Director) agreed with the above findings.	A4010		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: TYPE 2 VIOLATION Section 295.4060 c) No persons shall be accepted for residency or remain in residence if the person's mental or physical condition has so deteriorated to render residency in such a program to be detrimental to the health, welfare or safety of the person or of other residents of the establishment. The	A4060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510039	A. BUILDING: _____ B. WING _____	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GURNEE PLACE MEMORY CARE	505 N HUNT CLUB ROAD GURNEE, IL 60031

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A4060	Continued From page 14	A4060		

assessment must be approved by the resident's physician and shall occur prior to acceptance for residency, annually, and at such time that a change in the resident's condition is identified by a family member, staff of the establishment, or the resident's physician. (Section 150(c) of the Act)

This requirement is not met as evidenced by:

Based on observations, interviews and record review, the facility failed to ensure:
1) Residents are monitored for safety.

This failure creates a substantial probability of harm to a resident or residents.

Findings include:

On 1/6/26 at 10:50 AM observed there were six residents in the 'Game room'. TV was on and no staff present. Three residents were sitting on broda chairs and napping. One resident sitting on the couch slouched sideways, napping. Two residents sitting in wheelchairs, alert and awake. Observed the residents were not being monitored or supervised.

On 1/6/26 at 11:16 AM, observed there were seven residents in the 'Game room' and no staff present. Observed two residents sitting on wheelchairs were sleepy and leaning forward. Observed the shoe lace for one of the residents was open and loose. Observed the residents were not being monitored or supervised.

On 1/7/26 at 10:28 AM, observed there were nine residents sitting in the 'Game room' either on the couch or in their respective wheelchair/broda

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A4060	Continued From page 15 chairs. Observed one resident leaning sideways on his wheelchair. Observed a resident's shoe lace was loose. Observed one resident was bending forward in her wheelchair trying to wear her shoes. Observed there was no staff member in the room to supervise them. On 1/6/26 at 11:10 AM E3 (CNA-Certified Nursing Assistant) stated it was very hard to have one person in the Game Room to watch the residents. E3 stated the resident to staff ratio is not proportional because of the high acuity of the resident population. On 1/6/26 at 11:20 AM E4 (CG-Caregiver) stated there was no-one to watch the residents in the game room because the acuity of residents was too high for the current staffing. On 1/6/26 at 11:36 AM, E2 (HWD-Health and Wellness Director) stated at times staff don't show up for work and E2 was not able to replace that staff for that shift. E2 stated during fire drill, staff is not able to evacuate all the residents within the stipulated timeframe of 13 minutes due to the high acuity of the residents.	A4060		