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	ASL510575	A. BUILDING: _____ B. WING _____	02/04/2026

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TRULEE EVANSTON	1815 RIDGE AVENUE EVANSTON, IL 60201

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A 000	Initial Comment Annual Licensure Survey 295. 2040 5) g) h) 295. 3000 e) 2) A) B) f) 1) 2) n) 295. 3030 a) 295. 3040- 955.165 a)1), 955.145 a) 1) 2) 3) b) c) Entity Reported Incident Survey IL199796- 295.4010 d), 295.6000 a)1) 13), 295.6000 a) 2), 295.6010 a) 2) IL198928- No deficiency cited IL199346- No deficiency cited Complaint Investigation IL199038/25912187- No deficiency cited	A 000		
A2040	Section 295.2040 Disaster Preparedness This Regulation is not met as evidenced by: General Violation Section 295.2040 Disaster Preparedness 5) Orient each resident to the emergency and evacuation plans within 10 days after the resident's arrival. Orientation shall include assisting residents in identifying and using emergency exits. Documentation of the orientation shall be signed and dated by the resident or the resident's representative. g) Drills shall involve the actual evacuation of residents to an assembly point as specified in the emergency plan and shall provide residents with experience using various means of escape. If an establishment has an evacuation capability classification of impractical, those residents who cannot meaningfully assist in their own	A2040		

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A2040	Continued From page 1 evacuation or who have special health problems shall not be required to participate in the drill; however, other requirements of the Life Safety Code will apply. h) A written evaluation of each drill shall be submitted to the establishment manager and shall be maintained for one year from the date of the drill. The evaluation shall include the date and time of the drill, names of employees participating in the drill, and identification of any residents who received assistance for evacuation. These requirements are not met as evidenced by: Based on interview and record review, the establishment failed to: -Follow their policy and procedure for disaster and evacuation drills. -Indicate on policy and procedure, evacuation needs to be completed within 13 minutes or less. -Ensure residents were oriented to the emergency and evacuation plans including the location of exit doors within the required time frame from move-in to the community. This affected five (R3, R4, R7, R9, R12) of five residents reviewed for emergency preparedness orientation. This failure has the probability to affect all residents. Findings include: An onsite visit was conducted on 2/2/26 and 2/3/26. According to resident roster, there were 112 residents in the building at survey initiation. On 2/2/26 Fire drills were reviewed; the last annual survey was completed in April 2025. One night shift drill was done in March 2025. First shift:	A2040		

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A2040	Continued From page 2 5/29/25 10am, 7/23/25 10am, 9/25/25 10am- 49 residents signed in, 9/25/25 4:00pm- 14 residents signed, 1/8/26 10am- 43 residents signed in. There was no documentation of the assistance provided to residents documented. No time indicated what time the evacuation/ drill ended. Second shift: 5/29/25 4:00pm- only 14 residents signed in, 7/23/25 4:00pm- 12 residents signed in,1/8/26 4:00pm-11 residents signed in. There was no documentation of the assistance provided to residents documented. No time indicated what time the evacuation/ drill ended. On 2/2/26 at 12:22PM, E17 (Director of Facilities) said, about drills performed in the community. Conduct the drills every 2 months. As for evacuation, residents are not necessarily taken out from the building, "We do not do that, but we take them to the area of refuge located on every stair of each floor. We don't take them down (to ground level), there are 3 areas of rescue are on each floor." E18 said, Memory care is located on the third floor, residents are put in central area. The alarm goes through the whole building for around 10 minutes, The fire department instruction is to stay put, stay in apartment. In the event of real emergency and have to evacuate the residents it will take about half an hour. E18 said assistance provided to residents was not documented .... E18 said, there are 9 floors. The evacuation will take about 20-30 minutes to evacuate the building. There are fire doors in the elevators, all the units have fire doors, common areas and in between the apartment there are fire walls and can stay for 45 minutes. Establishment Policy and Procedure stated in part; Procedure: Fire, Evacuation & Disaster Plan	A2040		

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A2040	Continued From page 3 Related Policy: Disaster 8. Evacuation drills for employees and residents are planned every six months. Evacuation drills will include all employees and residents on the premises except for a resident whose medical record contains documentation stating that evacuation from the Community would cause harm to the residents, and sufficient caregivers to ensure the health and safety of residents not evacuated. This affords the staff the opportunity to practice the opportunity to practice efficient and effective evacuation ... Procedure: Evacuation Related Policy: Disaster Each evacuation drill will be documented and maintained for 12 months after the date of the drill that will include: 1. The date and time of the evacuation drill 2. The amount of time taken for employees and residents to evacuate the community. 3. If applicable: An identification of residents' assistance for evacuation and identification of residents who were not evacuated. On 2/3/26, resident and establishment records were reviewed. R3's record indicated that R3 moved into establishment on 10/14/2025, no orientation to the emergency and evacuation plans. R4's record indicated that R4 moved into establishment on 10/31/2025, no orientation to the emergency and evacuation plans. R7's record indicated that R7 moved into this establishment on 6/7/2025, acknowledgement of "Emergency Procedures" Book document was signed on 11/7/2025 R9's record indicated that R9 moved into establishment on 10/26/2025, acknowledgement	A2040		

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A2040	Continued From page 4 of "Emergency Procedures" Book document was signed on 11/25/2025 R12's record indicated that R12 moved into the establishment on 11/21/2025, no orientation to the emergency and evacuation plans. On 2/4/2026 at 10:25AM, E2 (Director of Wellness) said that the resident orientation is done on the day resident moves in.	A2040		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: General Violation Section 295.3000 Personnel Requirements, Qualifications and Training e) A file shall be maintained for each employee containing the following: 2) Documentation of: A) Freedom from pulmonary tuberculosis; B) Employee orientation; and f) In addition to the information required in subsection (e) of this Section, the file for each direct care employee shall contain documentation of: 1) Current certification in CPR, if applicable; 2) Initial health evaluation;	A3000		

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A3000	Continued From page 5 n) Prior to employing any individual in a position that requires a State professional license, the establishment shall contact the Illinois Department of Professional Regulation to verify that the individual's license is active. A copy of the verification shall be placed in the individual's personnel file (Source: Amended at 28 Ill. Reg. 14593, effective October 21, 2004) These requirements are not met as evidenced by: Based on interview and record review the establishment failed to ensure employee files contained the required documents for each employee. This deficient practice affected 14 employees (E2 E4, E5, E22, E25, E26, E29, E30, E31, E32, E33, E34, E35, E36) and has the probability to affect all residents. Findings include: E4 (Dining Staff) was hired on 8/13/25. The following were missing from E4's file: Health evaluation, Tuberculosis testing, employee orientation. The following Nurses did not have proof of current CPR training on file. E2 (Director of Wellness), Nurses: E5, E22, E25, E26, E29, E30, E31, E32, E33, E34, E35, E36. E36 did not have proof of current nursing license on file. On 2/2/26 at 1:38PM, E18 (Business Operations Director), said whatever was on file for these employees has been submitted for review. On 2/2/26 at 3:14PM E2 was given the list of	A3000		

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A3000	Continued From page 6 nurses that needs proof of CPR training. As 2/4/26 exit, none was provided.	A3000		
A3030	Section 295.3030 Initial Health Eval for Dir Care and FS empl This Regulation is not met as evidenced by: General Violation Section 295.3030 Initial Health Evaluation for Direct Care and Food Service Employees a) Each direct care and food service employee shall have an initial health evaluation, which shall be used to ensure that employees are not placed in positions that would pose undue risk of infection to themselves, other employees, residents, or visitors. b) The initial health evaluation shall be conducted not more than 30 days prior to and no later than 30 days after the employee's initial employment in the establishment. e) Each employee shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696). The test must meet one of the following time frames: These requirements are not met as evidenced by: Based on interview and record review, the establishment failed to ensure Initial health evaluation and Tuberculosis testing were completed for two (E4, E9) of seven employees reviewed. This deficient practice has the probability to affect all residents.	A3030		

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A3030	Continued From page 7 Findings include: On 2/2/26, selected employee files were reviewed. E4 (Dining Staff) was hired on 8/13/25. E9 (AL Caregiver) was hired on 8/1/25. There was no health evaluation and TB testing done for these two employees. On 2/2/26 at 1:38PM, E18 (Business Operations Director), said whatever was on file for these employees has been submitted for review. E18 submitted a TB testing and health evaluation for E9 completed in 2023, however there was no record presented of E9's last day of employment, prior to current re-hiring. On 2/2/26 at 3:14PM, E2 (Wellness Director) said, health evaluation was done before hire. On 2/2/26 at 3:18PM, E37 (Assisted Living Manager) said TB testing is done upon hire.	A3030		
A3040	Section 295.3040 Health Care Worker Background Check This Regulation is not met as evidenced by: General Violation Section 295.3040 Health Care Worker Background Check An establishment shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code. (Source: Amended at 36 Ill. Reg. 13632, effective August 16, 2012)	A3040		

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A3040	Continued From page 8 Section 955.165 Fingerprint-Based Criminal History Records Check a) Educational entities, other than secondary schools, and health care employers are required to check the Health Care Worker Registry before allowing a student to enter a training program or hiring an employee to determine: Section 955.145 Employment Verification a) Each health care employer or its designee shall provide an employment verification and update the demographic information for each employee and each contracted or subcontracted worker no less than annually. (Section 33(i) of the Act) 1) The health care employer or its designee shall log into the Health Care Worker Registry through a secure login in a method prescribed by the Department. (Section 33(i) of the Act) 2) The health care employer or its designee shall indicate employment and termination dates (separation dates) within 30 days after hiring or terminating an employee. (Section 33(i) of the Act) 3) The health care employer shall provide the employment category and type. (Section 33(i) of the Act) b) Failure to comply with this Section constitutes a licensing violation. A fine of up to $500 may be imposed upon a health care employer for failure to maintain these records. (Section 33(i) of the Act)	A3040		

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A3040	Continued From page 9 c) The information required in this Section shall be used by the Department of Public Health to notify any current employer of any disqualifying offenses that are reported by the Illinois State Police. (Section 33(i) of the Act) (Source: Amended at 49 Ill. Reg. 7999, effective May 22, 2025) These requirements are not met as evidenced by: Based on interview and record review, the establishment failed to utilize the Department's Registry Portal to check for employee eligibility and verify employment within 30 days of hire. This affected six (E4, E6, E7, E8, E9, E10) of six employees reviewed. This deficient practice has the probability to affect all residents. Findings include: On 2/2/26, Employee roster and selected employee files were reviewed. There was no documentation that the Registry Portal was used to check the required 6 internet searches. What was found were documents by an outside vendor checking employee eligibility. There were no documentations of these employees' verification completed within 30 days of their hire date. E4 (Dining Staff) was hired on 8/13/25. E6 (Assisted Living-AL Caregiver) was hired on 8/1/25. E7 (AL Caregiver) was hired on 8/29/25. E8 (AL Caregiver) was hired on 7/2/25. E9 (AL Caregiver) was hired on 8/1/25. E10 (AL Caregiver) was hired on 5/7/25.	A3040		

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A3040	Continued From page 10 On 2/2/26 at 12:06PM, E18 (Business Operations Director) confirmed there were no documentations the Registry Portal was used to check the employees eligibility. E18 said she is new in this position, and aware that new employees need to be verified.	A3040		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 2 Violation Section 295.4010 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) This requirement is not met as evidenced by: Based on observation, interview and record review, the establishment failed to implement appropriate interventions for aggressive behavior of one (R2) resident. This deficient practice affected two (R1, R9) residents and has the substantial probability to affect safety and freedom from physical, and emotional abuse for all residents in the memory care unit. Findings include: According to R1's face sheet, R1 is 79 years old.	A4010		

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A4010	Continued From page 11 R1 moved to the Memory Care unit on 9/22/25. R1's listed diagnoses are Cerebral infarction, unspecified, Nontraumatic intracerebral hemorrhage. On 2/3/26 at 11:07am, R1 was observed and interviewed with Z1 (Family Member), R1 was alert, well-kept appearance, independent with mobility. According to R2's face sheet, R2 is 87 years old. R2 moved to the Assisted Living unit on 7/7/25 and relocated to the Memory Care unit on 9/3/25. R2's listed diagnosis includes Alzheimer's disease. On 2/3/26 at 11:21AM, R2 was seen in apartment, with private caregiver. Independent with mobility, confused, unable to answer questions appropriately. According to R9's face sheet, R9 is 89 years old. R9's diagnosis includes Alzheimer's disease with late onset. On 2/3/26 at 2:45PM, R9 was observed ambulating with a walker. According to Z1, there were three reported aggressive incidents between R1 and R2. First Incident: On 12/3/26 11:07AM, Z1 said R1's husband, Z1 and R1 were all seated in the dining area, when R2 went over to where they were seated, R2 told R1 "You are sitting in my seat", R2 then took a swing at R1, but R2 missed because R1 ducked. Z1 said he got in between R1 and R2 to prevent R2 from hitting R1 any further, it took about 10 seconds for staff to get R2 away. Second Incident: Z1 said that in the first week of January between 9-10 late at night, someone reported it to Z1 of a second attack. That was when R1's family decided to initiate a private caregiver for R1. Third Incident: Z1 said, "This is what I have been told by (E3- Memory Care Director), (R2) made contact- "a hard shove" not punch. Mom was talking to nurse, and	A4010		

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A4010	Continued From page 12 (R2) wanted to talk to same nurse, she then shoved mom. These residents ...they should not be shoved ...Z1 said, "My mother was attacked 3 times by (R2), we talked with the facility administration, and nothing has been done. (R2) is aggressive to everyone including staff and other residents. Frustrating part is all are aware, (R2) screams, bites kick staff, and nothing has been done, it is incredibly frustrating, we have to hire a 24-hour private caregiver." Z1 was asked, with all these attacks if R1 is afraid of R2, Z1 said, "A little bit." On 2/4/26 at E12 (Terminated Caregiver) said on 1/7/26 E12 was escorting another resident when (R2) approached them. R2 wanted to walk with them. E12 agreed. (R1) came and asked for help. (R2) did not like that, (R2) tried pushing (R1), using (R2's) shoulder, it did not make contact because E12 intervened. E12 said, she put R1 behind her. E12 confirmed, R2 has been aggressive towards staff as well. R2's notes dated 1/17/26 documented," it was reported by staff member (E20- Memory Caregiver) that the resident (R2) was observed pushing another resident. Subsequently the resident was yelling, screaming, physically pushing staff members ...." On 2/4/26 at 12:03PM, E20 said, R1 was talking to E20 when "out of the blue (R2) just pushed (R1). It was like a shove "like a get out of my way kind of shove". E20 was asked if R1 staggered? E20 answered, "She moved a bit. She was not hurt." E20 was asked, if this happened before? E20 said, "Yes, unknown when, but they have confrontation before." Unit staff were interviewed:	A4010		

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A4010	Continued From page 13 -On 2/3/26 4:10PM, E14 (Memory Care (MC) Caregiver), confirmed R2 have aggressive behaviors, including personal experience of being grabbed on the arm, unprovoked. -On 2/4/26 at 9:02AM, E13 (MC Caregiver) confirmed R2 had aggressive behavior, R2 starts yelling then might try to push if without intervention... E13 said, she saw R2 attack R9, then R9 had to use the walker to defend herself. The 1:1 helped by intervening and distracting R2 but even with the 1:1 R1 still attacks staff and residents. E13 said, the regular staff cannot provide a 1:1 with R2 as they have other obligations to other residents. -On 2/4/26 at 10:06AM, E15 (MC Caregiver) said, E15 witnessed R2 trying to kick R1, but E15 stopped R2. -On 2/4/26 at 11:12AM, E25 (Licensed Practical Nurse) said, R2 can be aggressive towards everyone. R2's notes documented multiple aggressive behaviors (towards staff and other residents) including but not limited to the following incidents: 10/14/25 6:35AM- Resident awake and presents with exit seeking behavior. Staff attempted to redirect, and resident scratched and slapped the face of the CNA. 11/1/25 2:14PM- Resident was reported being combative while a CNA attempting to assist another resident ...resident followed them, pushed and kicked her left knee attempting to prevent her from assisting the resident. 12/27/25 6:20pm- ...Residents appeared agitated and observed with combative behaviors. NOD observed resident kicking the caregiver's leg. 1/2/26 10:01PM- The resident exhibited signs of agitation and showing aggressive behavior towards other residents and staff members .... After dinner, she attempted to hit another	A4010		

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	ASL510575	A. BUILDING: _____ B. WING _____	02/04/2026

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A4010	Continued From page 14	A4010		

resident, leading to staff intervention, during which the resident was seen kicking and punching the staff.
1/3/26 2:06PM The resident displayed aggressive behavior toward staff. Resident threw a glass of juice toward a care specialist, and then threw glassware unto the kitchen floor ...
1/17/26 2:18PM- staff member observed pushing another resident ...resident poured beverage over the head of a visiting family member without provocation.

On 2/3/26 at 2:57PM, E3 (Memory Care Director) said, interventions were in place for R2. R2 was being treated for Urinary Tract Infection (UTI). R2 was sent to the hospital on 1/17/26, she was diagnosed with COVID and Urinary Tract Infection. R2 was also referred to a behavioral hospital but they were unable to accept her because they would like to see if the behavior will subside after the UTI treatment. E3 was in constant communication with R2's family, 1:1 staff was put into place for R2 as soon as she returned from hospital. R2 was followed up by psychiatry and medications are being provided.

R2's Service Plan dated 1/10/26 stated in part.
Need- Disruptive Behaviors
Goal- (R2) may exhibit periods of agitation especially in the dining room area when she is not served promptly or if she has forgotten she has eaten. Non-pharm interventions: Allow (R2) to make decisions on choice of food and when she is finished with her meals, (R2) may become verbally aggressive with staff. Non pharm interventions: gently redirect resident away from triggering situations, offer meaningful activities such as walking and folding clothes, reduce environmental stimulation when agitation occurs.

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A4010	Continued From page 15 Documents reviewed indicated R2 had bouts of UTI as far back as 10/22/25, treatment was provided. R2 was also followed by Psychiatry and with psychiatric medications. Although these interventions were in place, it did not prevent R2 from getting aggressive to staff and residents such as R9 and with several attempts on R2's safety. These interventions were inadequate to address R2's aggression towards staff and residents. Although R2 was put on medications for UTI, which could have caused aggression, there was no intervention in place to ensure residents were safe from R2's aggression. R2's private caregiver was finally initiated after several attempts to attack R2.	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: 1) The right to live in an environment that promotes and supports each resident's dignity, individuality, independence, self-determination, privacy, and choice and to be treated with	A6000		

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A6000	Continued From page 16	A6000		

consideration and respect;

13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor;

These requirements are not met as evidence by:

Based on observation, interview and record review, the establishment failed to provide a safe environment for one (R1) resident resulting in physical and emotional abuse. This deficient practice creates a substantial probability of severe harm to a resident in the Memory care unit.

Findings include:

According to R1's face sheet, R1 is 79 years old. R1 moved to the Memory Care unit on 9/22/25. R1's listed diagnoses are Cerebral infarction, unspecified, Nontraumatic intracerebral hemorrhage. On 2/3/26 at 11:07am, R1 was observed and interviewed with Z1 (Family Member), R1 was alert, well-kept appearance, independent with mobility.

According to R2's face sheet, R2 is 87 years old. R2 moved to the Assisted Living unit on 7/7/25 and relocated to the Memory Care unit on 9/3/25. R2's listed diagnosis includes Alzheimer's disease. On 2/3/26 at 11:21AM, R2 was seen in apartment, with private caregiver. Independent with mobility, confused, unable to answer questions appropriately.

According to Z1, there were three reported aggressive incidents between R1 and R2.
First Incident:
On 12/3/26 11:07AM, Z1 said R1's husband, Z1

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and R1 were all seated in the dining area, when R2 went over to where they were seated, R2 told R1 "You are sitting in my seat", R2 then took a swing at R1, but R2 missed because R1 ducked. Z1 said he got in between R1 and R2 to prevent R2 from hitting R1 any further, it took about 10 seconds for staff to get R2 away.
Second Incident:
Z1 said that in the first week of January between 9-10 late at night, someone reported it to Z1 of a second attack. That was when R1's family decided to initiate a private caregiver for R1.
Third Incident:
Z1 said, "This is what I have been told by (E3-Memory Care Director), (R2) made contact- "a hard shove" not punch. Mom was talking to nurse, and (R2) wanted to talk to same nurse, she then shoved mom. These residents ...they should not be shoved. After the first one they said that (R2) will have full psyche work out, now (R2) have a 24-hour private caregiver." Z1 said, "My mother was attacked 3 times by (R2), we talked with the facility administration, and nothing has been done. (R2) is aggressive to everyone including staff and other residents. Frustrating part is all are aware, (R2) screams, bites kick staff, and nothing has been done, it is incredibly frustrating, we have to hire a 24-hour private caregiver." Z1 was asked, with all these attacks if R1 is afraid of R2, Z1 said, "A little bit."

On 2/4/26 at E12 (Terminated Caregiver) said on 1/7/26 E12 was escorting another resident when (R2) approached them. R2 wanted to walk with them. E12 agreed. (R1) came and asked for help. (R2) did not like that, (R2) tried pushing (R1), using (R2's) shoulder, it did not make contact because E12 intervened. E12 said, she put R1 behind her. E12 confirmed, R2 has been aggressive towards staff as well.

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R2's notes dated 1/17/26 documented," it was reported by staff member (E20- Memory Caregiver) that the resident (R2) was observed pushing another resident. Subsequently the resident was yelling, screaming, physically pushing staff members ...."

On 2/4/26 at 12:03PM, E20 said, R1 was talking to E20 when "out of the blue (R2) just pushed (R1). It was like a shove "like a get out of my way kind of shove". E20 was asked if R1 staggered? E20 answered, "She moved a bit. She was not hurt." E20 was asked, if this happened before? E20 said, "Yes, unknown when, but they have confrontation before."

Multiple staff interviews indicated R2 had aggressive behaviors not just to R1 but to staff and other residents.
2/3/26 4:10PM, E14 (Memory Care (MC) Caregiver), confirmed R2 have aggressive behaviors, including personal experience of being grabbed on the arm, unprovoked.
On 2/4/26 at 9:02AM, E13 (MC Caregiver) confirmed R2 had aggressive behavior, R2 starts yelling then might try to push if without intervention. E13 said, she saw R2 attack another resident. The 1:1 helped by intervening and distracting R2 but even with the 1:1 R1 still attacks staff and residents.
On 2/4/26 at 10:06AM, E15 (MC Caregiver) said, E15 witnessed R2 trying to kick R1, but E15 stopped R2.
On 2/4/26 at 11:12AM, E25 (Licensed Practical Nurse) said, R2 can be aggressive towards everyone.

R2's notes documented multiple aggressive behaviors (towards staff and other residents)

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A6000	Continued From page 19 including but not limited to the following incidents: 10/14/25 6:35AM- Resident awake and presents with exit seeking behavior. Staff attempted to redirect, and resident scratched and slapped the face of the CNA. 11/1/25 2:14PM- Resident was reported being combative while a CNA attempting to assist another resident ...resident followed them, pushed and kicked her left knee attempting to prevent her from assisting the resident. 12/27/25 6:20pm- ...Residents appeared agitated and observed with combative behaviors. NOD observed resident kicking the caregiver's leg. 1/2/26 10:01PM- The resident exhibited signs of agitation and showing aggressive behavior towards other residents and staff members .... After dinner, she attempted to hit another resident, leading to staff intervention, during which the resident was seen kicking and punching the staff. 1/3/26 2:06PM The resident displayed aggressive behavior toward staff. Resident threw a glass of juice toward a care specialist, and then threw glassware unto the kitchen floor ... 1/17/26 2:18PM- staff member observed pushing another resident ...resident poured beverage over the head of a visiting family member without provocation. Establishment's document titled "GP01-Abuse, Neglect, and Exploitation", with Policy date 6/1/25 stated in part: Policy: Resident abuse, neglect, and exploitation are prohibited. Should any resident experience abuse (by staff, residents, family, or others) or when abuse is suspected, staff and volunteers are required to immediately provide notification to persons/agencies as described in this policy. Staff will not be terminated nor reprimanded for	A6000		

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A6000	Continued From page 20 reporting suspected or actual cases of resident abuse. The term abuse as used in this policy also includes, but is not limited to, neglect, abandonment, exploitation, and any other form of abuse.	A6000		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr This Regulation is not met as evidenced by: General Violation Section 295.6010 Abuse, Neglect, and Financial Exploitation Prevention and Reporting a) When the establishment has a reasonable belief that a resident has been the victim of abuse, neglect, or financial exploitation, the establishment shall: 1) Notify the Department within 24 hours after receiving the allegation, by contacting the Assisted Living Complaint Registry by telephone, fax, or other electronic means. The establishment shall document this report and maintain documentation on the premises for 12 months after the date of the report. 2) Investigate and develop a written report within 14 days after the initial report. The establishment shall send the written report to the Department within 24 hours after it is completed and shall maintain a copy of the written report on the premises 12 months after the date of the report.	A6010		

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A6010	Continued From page 21 These requirements are not met as evidenced by: Based on interview and record review, the establishment failed to follow their Abuse reporting Policy and procedure affecting one (R1) resident and has the probability to affect all residents. Findings include: On 2/3/26 at 11:07AM, Z1 (Family Member), said R1 was attacked three times by R2 "We were sitting in the dining room with my dad; (R2) came over and said, "you're sitting in my seat" ... (R2) started to swing at my mother, but she ducked." Z1 said, staff came to help and took R2 away. Z1 said he got in between R1 and R2. On 2/3/26 at 2:57PM, E3 (Memory Care Director) said she was notified of this incident on 12/31/26, "he said day after Christmas." E3 said, R1's son did not report it because he assumed staff would know because someone took R2 away. E3 said, "(R1's son) said that he grabbed his mom, he put himself in between mom and (R2) ..." E3 said on 1/9/26, R1's another son reported that R2 raised arm at R1, no physical contact. Documents reviewed indicated establishment initiated an investigation for the two incidents. State reporting documents indicated there was no report sent to the department regarding incident 12/26/25. On 2/4/26 at 11:40AM, E1 said, "We did not report it (12/26/5 incident) because there was no physical contact, and we did not feel that it should be reported." State reporting documents indicated the final	A6010		

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A6010	Continued From page 22 report for incident dated 1/7/26 was sent on 1/30/26. E1 said, confirmed in was sent late. The initial report was sent as soon as it was received from R1's family member, however a copy cannot be found. Establishment's document titled "GP01-Abuse, Neglect, and Exploitation", with Policy date 6/1/25 stated in part: Procedure: 2. All staff and volunteers at Solera Senior Living are "mandated reporters." 3. Any Community staff member or volunteer has observed, suspects, has knowledge of, or is told by a resident or other staff member, of an incident which appears to be any form of abuse, the incident will be immediately reported to the Director of Nursing / Assistant Director of Nursing, and Executive Director. 4. Upon the notice of reported, observed, suspected, or at imminent risk of any form of abuse: c. A thorough investigation will be conducted by the Director of Nursing / Assistant Director of Nursing, or Executive Director. (1) i. A written report will be submitted to licensing within fourteen (14) days of the initial report. 1. The written report must be submitted to licensing within twenty-four (24) hours of completion.	A6010		