STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510494	A. BUILDING: _____ B. WING _____	C 02/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERADO ST CHARLES	4058 E MAIN STREET ST CHARLES, IL 60174

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A 000	Initial Comment Facility Reported Incident IL199944 - 295.3000a) IL199897 - 295.4010a)e) IL198930 - 295.4010a)e)	A 000		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: Type 2 Violation Section 295.3000 Personnel Requirements, Qualifications and Training 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) Based on observation, interview and record review, the facility failed to recognize a resident in the facility and failed to prevent elopement for one resident (R1) out of three residents reviewed. This failure allowed R1 to walk out of the building and creates a substantial probability of harm to a resident or residents. Findings include: R1 is a 68 year old male the admitted to the facility on 11/28/25.	A3000		

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A3000	Continued From page 1 On 2/6/25 at 9:34 am, a staff member was asked to point out R1. This surveyor questioned if the staff member pointed out the correct resident as R1 appeared to be a visitor. R1 observed sitting at the dining room table with other residents watching the activities group. On 2/6/25, through out the day, several residents observed walking around the facility and around the reception desk in the front lobby. R1 progress note dated 1/2/26 documents "Resident awake during shift and had both meals in his room. This nurse attempted to administer Resident's medication but Resident continually refused; stated that he had already received his medication today. This nurse attempted to explain that he had not received his medication and then Resident got angry, threw his remote control and kicked this nurse out of his room. Resident then refused noon medication. Resident came out of his room in the afternoon looking for his mother, then went back into his room. Resident came out of room again with a coat on along with many shirts on hangers under his arm; this nurse asked Resident where he was going and he said "back to earth". Resident stood in the front lobby with his items but did not attempt to go out of the community. This nurse spoke to POA, (Power of Attorney) in regard to situation with Resident last night and today and requested NP, to see Resident; (POA) agreed to visit today." R1's progress notes dated 1/14/26 documents "Resident approached front desk and asked receptionist to let him out of the community. Receptionist did not recognize that this was a resident. Receptionist let resident out of building. Receptionist notified caregiver about individual	A3000		

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A3000	Continued From page 2	A3000		

due to him walking towards the back of the building. Caregiver went outside and brought resident back into the building. Resident came into building without behaviors. No injuries noted. Behavior mapping initiated for 30-minute checks. Psych NP here to see resident for exit-seeking behavior. POA mailbox full and unable to leave voicemail, but sent message to call back. Notified PCP (Primary Care Provider).

On 2/6/26 10:18 am, E1, Executive Director, stated "(R1) went to the front lobby with his coat on and asked to be let out. The receptionist (E3) initially didn't let him out and asked him to sign out. (R1) told her that he didn't sign in because he came through the back door. She then let him out. There's a binder in the front that has all the residents in it with their photo and the receptionist should have checked the binder. After (R1) got outside, he turned right and started walking around the building. The receptionist said something didn't sit right in her stomach so she had a caregiver go outside and check and it was (R1). He was only outside for maybe a minute before staff grabbed him." During the interview, this surveyor mentioned that R1 looked like a visitor and there is another female resident that also looks like a visitor. E1 stated "Yeah, we have some younger residents here that don't look like residents. We have a resident that's only 48. I think that's how (R1) was able to leave. He doesn't look like a typical resident . When (E3) asked him questions, (R1) was able to respond appropriately and he's never had exit seeking behaviors before." E1 was asked if the behavior that took place on 1/2/26, would have been a precursor to exit seeking behavior. E1 stated "Well yes, technically it would be, but there was more going on at that time with his behaviors and we asked the NP (Nurse Practitioner) to assess

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A3000	Continued From page 3 him about adjusted his medications." E1 stated they did a reeducation on elopement and checking the elopement binder.	A3000		
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. e) The service plan shall be reviewed and revised if necessary immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000). Based on interview and record review, the facility failed to add interventions appropriate for a resident with severe cognitive impairment for one resident (R2) out of three residents reviewed for service plans. This failure resulted in R2 falling causing a fracture of the left superior pubic ramus and creates a substantial probability to cause severe harm to other residents. Findings include:	A4010		

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A4010	Continued From page 4 R2's MMSE (Mini-Mental State Examination) dated 7/11/25 documents a score of 9/30 indicating R2 has a severe cognitive impairment. R2's medical record documents a diagnosis of dementia. R2's service plan documents: Resident will maintain and/or maximize safety with mobility/transfer; will minimize injury related to falls Actual Fall Date Health Services 9/19/25 - Resident educated to wait for assistance with transfers, call light within reach 1/4/26 - Resident educated on call light use, call light within reach, care staff to assist with toileting needs every 2 hours and as needed 1/9/26 - INTERVENTIONS INCLUDE PT/OT EVALUATION ONCE SEEN BY ORTHOPEDIC SPECIALIST, FALL MAT IN PLACE IN BEDROOM NEXT TO BED WHEN RESIDENT IS SLEEPING, BED ALARM IN PLACE R2's progress note dated 9/19/25 documents "Laundry worker reported to this writer that resident had slipped off the bed while trying to sit up. Laundry worker told resident he would get assistance but before he could resident had already slid off the bed. Was not witnessed how resident got to floor as associate was putting clothes into the closet. This writer called to 402 and observed resident on her buttocks on the floor next to her bed. Resident observed for injury and none noted. Denied pain and discomfort. No change in ROM (Range of Motion). Assisted up from floor with 2 person." R2's progress note dated 1/4/25 documents	A4010		

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A4010	Continued From page 5 "Resident observed in supine position in bathroom with her shoe under her head, knees bent, hands folded on stomach. Resident unable to articulate what happened. When resident asked if anything hurts she patted her bottom. Denies hitting head. No visible injuries. No c/o pain as she was assisted to wc (Wheelchair). Resident did say she was cold. ROM WNL (Within Normal Limits). No change to LOC (Level of Consciousness) . Perrla. Neuro checks initiated." R2's progress note dated 1/6/26 documents "Resident complaining of back pain, resident was having a hard time with transferring, also guarding her stomach while sitting in chair, PRN miralax given and prn acetaminophen given both with positive effect. Resident had a x-large bowel movement after lunch. MD made aware of residents pain awaiting response." R2's progress noted dated 1/8/26 documents "Resident continues to be very guarding of her and stiffen up and yells out when caregiver try to transfer her. Message left for POA. New orders received from (MD) for lidocaine patch x 10 days and xrays to be be completed." R2's progress note dated 1/9/26 documents "Resident with ongoing pain since fall on 1/6/26 with transfers. Resident had xray completed on 1/8/26. Xray confirmed resident has a fracture of pubis. New order received for tramadol from (MD) for pain management. POA was in the community and made aware. POA requested that resident not have acetaminophen and tramadol at the same time. Acetaminophen will be on hold while on tramadol. Script faxed to (Pharmacy). POA will also contact orthopedic previously seen for hip and let us know when resident will be seen."	A4010		

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A4010	Continued From page 6 On 2/6/26 11:32 am, E1, Executive Director and E2, Wellness Director, were asked if R2 had a MMSE assessment done since July 2025. E1 stated "No, (R2) has severe cognitive deficient and anyone having a MMSE below 10, we don't do a MMSE." E1 and E2 were asked if remind and educate R2 to use call light and ask for assistance was an appropriated fall intervention with a resident that has severe cognitive impairment. E1 stated they put that in the service plan to allow the residents right to participate in care and have a certain level of independence. It was then asked if someone with a moderate to severe cognitive deficient could remember to do so. E1 and E2 did not directly answer if it was an appropriate interventions and only asked what interventions should they put.	A4010		