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	ASL5106098	A. BUILDING: _____ B. WING _____	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN OAKS SENIOR LIVING	14595 WEST ROCKLAND ROAD LIBERTYVILLE, IL 60048

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A 000	Initial Comment Licensure Annual Survey	A 000		
A2040	Section 295.2040 Disaster Preparedness This Regulation is not met as evidenced by: Type 3 Violation Section 295.2040 Disaster Preparedness a) For the purpose of this Section, "disaster" means an occurrence, as a result of a natural force or mechanical failure such as water, wind or fire, or a lack of essential resources such as electrical power, that poses a threat to the safety and welfare of residents, personnel, and others present in the establishment. b) Each establishment shall: 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. c) At least six drills shall be conducted per year on a bimonthly basis. At least two of the drills shall be conducted during the night when residents are sleeping. All drills shall be held under varied conditions to. These requirements were not met as evidenced by: Based on interview and record review, the establishment failure to provide orientation within	A2040		

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A2040	Continued From page 1 10 days to two (R1, R3) residents. Failed to conduct fire drills as require by the Department. These failures have the probability to affect all residents in the establishment. Findings include: R1 moved into the community on 7/18/24. There was no resident orientation submitted for review. R3 moved into the community on 6/18/24. There was no resident orientation submitted for review. On 4/1/25 at 3:59pm, E11 (Director of Nursing), if they have not submitted the Resident orientation as requested, then resident orientation was not completed. Upon reviewed of establishment fire drills on 4/1/2025, it was noted that fire drills were conducted as follows: 5/14/2024 2nd shift 3:30PM- 3:15PM 1/29/2025 1st shift 9:28am-9:36AM 2/19/2025 2nd shift 3:20PM- 3:35PM 3/11/2025 3rd floor 5:50Am- 6:15AM On 4/1/25 at 2:14PM, E1(Executive Director) said that the last Fire drill for last year was 5/14/2025 and that she couldn't find more.	A2040		
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	A3000		

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A3000	Continued From page 2 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) b) The establishment shall have on duty at all times at least one direct care staff person who has obtained cardiopulmonary resuscitation (CPR) training specific to adults, which includes a demonstration of the individual's ability to perform CPR, and who has current certification in CPR. 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. These requirements were not met as evidence by: Based on interview and record review, the facility failed to ensure license and Cardiopulmonary Resuscitation (CPR) cards were on employee files for 12 (E2, E3, E11, E114, E15, E16, E17, E18, E19, E20, E21, E22) nurses out of 14 nurses reviewed. This failure has the probability to affect all residents in the establishment. Findings Include: On 4/1/2025 employee files, professional license and CPR cards were requested to E10 (Business Office Manager) Per Establishment's Employee Roster, there are 14 nurses employed. Professional Nursing Licenses and CPR card were requested several times. E10 provided licenses and CPR card for	A3000		

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A3000	Continued From page 3 only 3 nurses. The employee reviewed for Professional Nursing Licenses and CPR Card were: E2 (Memory Care Manager)- No license and CPR Card E3 (Wellness Nurse)- No license and CPR Card E11 (Director of Nursing) - No license E14 (Wellness Nurse)- No license and CPR Card E15 (Wellness Nurse)- No license and CPR Card E16 (Wellness Nurse)- No license and CPR Card E17 License, no CPR card E18(Wellness Nurse) No license and CPR Card - E19(Wellness Nurse)- No license and CPR Card E20 (Wellness Nurse)- No license and CPR Card E21 (Wellness Nurse)- No license and CPR Card E22 (Wellness Nurse)- expired CPR These findings were discussed with E1 (Executive Director and E10 (Business Office Manager).	A3000		
A4000	Section 295.4000 Physician/s Assessment This Regulation is not met as evidenced by: Type 3 Violation Section 295.4000 Physician's Assessment 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 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	A4000		

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A4000	Continued From page 4 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 are not met as evidenced by: Based on interview and record review the establishment failed to ensure annual Physician Assessment was completed by Physician as required for one (R5) resident and failed to ensure an Annual Physician assessment was completed and on residents' file for two (R2, R4) residents. These affected 3 of 5 residents reviewed for this requirement. Findings include: An onsite visit was conducted on 4/1/25. Physician Evaluation for residents selected for review was requested from E11 (Director of Nursing). R5's document titled Annual Physical Medical Evaluation dated 12/13/24 was completed by a Nurse Practitioner. There was no Annual Physician assessment submitted for R2 and R4. On 4/2/25 at 9:55am, E11 said she will look for the Physician assessment as requested. There was no document submitted for review as of the	A4000		

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A4000	Continued From page 5 time of exit.	A4000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 3 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. b) The service plan shall be developed by: 1) The resident, resident's representative or any individual requested by the resident; 2) The manager or manager's designee; and 3) A registered nurse, if the resident is receiving nursing services or medication administration or is unable to direct self-care. c) The service plan shall be signed and dated by all individuals involved in its development. d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery	A4010		

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A4010	Continued From page 6	A4010		

contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act)

e) The service plan shall be reviewed and revised, if necessary, immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000).

These requirements are not met as evidenced by:

Based on interview and record review, the establishment failed to ensure resident's elopement interventions are revised to include individualized interventions following one (R1) resident's elopement. The establishment also failed to ensure residents's service plans are signed by Resident or Resident Representative. This deficient practice has the probability to affect all residents.

Findings include:

Per R1's Electronic Health Record (EHR), R1 is 82 years old. R1 moved to the Memory Care unit on 7/18/24. R1's diagnoses include but not limited to Dementia. R1's Mini- Mental State Examination (MMSE) score dated 7/18/24 was 6/30 indicating Severe cognitive impairment. Marked impairment. Likely to require 24- hour supervision and assistance with ADL.

R1's incident report sent to the Department indicated, that on 3/18/25 at about 7am, E12 (Housekeeper), discovered R1 outside the building. R1 was then brought back by E12 and another staff inside the building.

On 4/1/25 at 3:10pm, E12 said R1 was unaccompanied when he saw R1 outside of the

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A4010	Continued From page 7 establishment. R1's Service Plan dated 3/6/25 stated in part; Behavior: Wandering - Notify other caregivers about (R1)'s wandering behavior .... This service plan has not been revised to include individualized service plan following R1's successful elopement. R2's Service plan dated 1/10/25 was not signed by the resident or resident representative. R4's Service plan dated 3/24/25 was not signed by the resident or resident representative. On 4/1/25 at 3:25pm, E2 (Memory Care Director) acknowledged resident or resident's representative have service plan signed. However, some of the resident service plans submitted for review by E2 and E11 (Director of Nursing) were not signed by residents or resident representative.	A4010		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 2 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: 5) The right to receive the services specified in the service plan, to review and renegotiate the	A6000		

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A6000	Continued From page 8	A6000		

service plan at any time; and to be informed of the cost of the changes;

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 evidenced by:

Based on interview and record review, the establishment failed to ensure, one (R1) resident who have Dementia, and assessed with severe cognitive impairment was supervised to prevent elopement from a secured Memory Care unit. This deficient practice has the probability to affect all residents in the Memory Care.

Findings include:

An onsite visit was conducted on 4/1/25. At approximately 2:25pm, on observation, the entrance to the Memory care unit was locked. The door required a code to be entered on the keypad to get into the unit, the same system was needed to get out of the unit.

Per R1's Electronic Health Record (EHR), R1 is 82 years old. R1 moved to the Memory Care unit on 7/18/24. R1's diagnoses include but not limited to Dementia. R1's Mini- mental State Examination (MMSE) score dated 7/18/24 was 6/30 indicating Severe cognitive impairment. Marked impairment. Likely to require 24- hour supervision and assistance with ADL.

R1's incident report sent to the Department indicated, that on 3/18/25 at about 7am, E12 (Housekeeping Supervisor), saw R1 outside of the building. R1 was then brought back by E12

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A6000	Continued From page 9 and another staff inside the building. On 4/1/25 at 3:10pm, E12 said R1 was unaccompanied when he saw R1 outside of the establishment. According to document titled "Incident- Team Member Statement of Events" E12 was in the Therapy room, "I looked at the window and observed memory care resident (R1) toward the front of the building on the sidewalk around(?) the corner. This was at 7:00am. I ran down the front of the building to meet her and I escorted her into the building ...." E12 stayed with R1 at the lobby until the nurse meet them at the front desk. Incident investigation submitted to surveyor, including photographs of R1 getting out of the Memory Care unit's main entrance was reviewed. The photos dated 3/18/25 have time stamped on the upper left corner; 6:42:57: The photo showed the Memory Care unit main entrance door was close. 6:43:11: The door was open and a resident with a walker (which was identified as R1), was seen coming out of the door. 6:43:50: R1 was now outside of the Memory care unit. The door remained open. Another resident can be seen near the open door. No staff was visible on the photograph. 6:44:20: R1 was seen with her walker out of the Memory care unit, the door was partially closed, another resident was still visible at the open door. No staff was visible within the camera frame. 6:44:29: R1 was seen outside the unit. Door was now closed. 6:44:54: R1 was not visible on the photo. Door was open, another resident was seen by the door. 6:45:10: Door was closed. No resident was seen within the vicinity.	A6000		

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A6000	Continued From page 10 6:58: R1 was seen getting out from a side door. This door has no alarm system. 7:01: E12 seen going out of the main entrance. 7:02: E12 and another staff seen at the main entrance escorting R1 into the building. According to the photos, R1 was left unsupervised for 15 minutes allowing her to successfully get out from a secured unit. E23's (Resident Assistant) document tiled, "Incident- Team Member Statement of Events" stated in part, "I came into the Memory Care around 6:09am and the first thing I saw was (R1) right at the door. I redirected her back to the living room." On 4/1/25 3:18pm: E1 (Executive Director) said, the alarm did not go off when the door was opened. The reason of which was unknown. R1 was able to get out from the side door, that has no alarm. E1 was asked how often the memory care unit main entrance was checked, E1 said, it's unknown how often, but the Maintenance checks the door. E1 said, in Memory Care, the residents are checked every two hours. R1's Service Plan dated 3/6/25 stated in part; Behavior: Wandering Notify other caregivers about (R1)'s wandering behavior .... This service plan has not been updated after R1's elopement.	A6000		