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	ASL510398	A. BUILDING: _____ B. WING _____	C 03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STORYPOINT ROMEOVILLE AL	605 S EDWARD DR ROMEOVILLE, IL 60446

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A 000	Initial Comment Complaint investigation survey: IL200476: no violations cited Facility Reported Incident survey: IL199647/FRI 12.23.25: 295.6000 a) 1) 13) IL199907/FRI 1/25/26: 295.6000 a) 1) 13) IL200480/FRI 2.13.26: 295.2000 a) 3) 5)	A 000		
A2000	Section 295.2000 Residency Requirements This Regulation is not met as evidenced by: VIOLATION Section 295.2000 Resident 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) 3) The person requires total assistance with 2 or more activities 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	A2000		

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able to respond, with or without assistance, in an emergency to protect themselves, given the staffing and construction of the building;

These requirements were not met as evidenced by:

Based on record review and interviews, the establishment failed to reassess 1 of 4 resident (R3) for continued admission after showing a physical decline.

This failure involves 1 of 3 residents reviewed (R3).

These failures has the probability to affect residents who reside in the establishment.

Findings include:

R3 is a 77 year old resident who moved into the establishment 1/26/24. R3 has diagnoses including Parkinson's disease, Hypertension, Abnormal gait and mobility and Morbid obesity.

The progress notes for January 2026 through February 2026 show in part the following:

-1/15/26 23:00 (11:00pm) R3 required 3 person assist to transfer from wheelchair to his recliner, also noted R3 with bilateral edema, no redness noted, R3 denies pain.

-1/21/26, R3 having difficulty with pivoting using walker and buckles knees

-1/22/26: R3 requires 2-3 assistance of staff to assist with toileting and transferring. R3 has 2-3 bowel movements in one shift. It is very strenuous on staff members. R3t is beginning to

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A2000	Continued From page 2	A2000		

break down on bottom, bottom has some redness. In therapy today R3 had a hard time standing and assisting with therapy reported his left knee hurt PRN (as needed) pain medication was applied. Plan of care ongoing. E3 (wellness director) and NP (nurse practitioner) aware.

-1/29/26, Incident Note: R3 stated he got up from his recliner and walked to bathroom using his walker, R3 did have his shoes on. R3 fell at doorway of bathroom. R3 said he hit his head so R3 was sent out to a local hospital.

-2/12/26: Therapy and writer (E5, LPN) were transferring R3 using gait belt to stand and pivot from wheelchair to recliner. Wheelchair was next to recliner, R3 was standing to pivot and knees buckled. R3 was lowered to the floor. No injuries. 911 was notified and assisted with transferring R3 off the floor to recliner. R3 and therapy stated he had hard time in therapy today. R3 said his knees are weak today.

-2/12/26: R3 needed 3 assist to transfer from recliner to wheelchair. R3 not able to move his feet at times, needs assist.

-2/13/26 09:17: R3 was transported to local hospital per R3's request to go to that hospital, R3 was sent out due to right ankle swollen/painful to touch, unable to bare weight on ankle.

-2/18/26: R3 is admitted to Rehab Center for 6 weeks due to fracture to right ankle per Z2.

On 3/9/26 at 1:05pm via telephone, E5 (LPN) stated, "R3 has Parkinson's and uses a motorized wheelchair. This incident happened in R3's room. Me and the physical therapist was trying to transfer R3. R3 didn't give us any warning, R3's

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A2000	Continued From page 3 knees just buckled. The therapist suggested calling the paramedics for transfer assist. It took 4 of them to get R3 off the floor and into his recliner. This happened around 1-3pm. The next morning R3 was sent out to the hospital, R3 hands and feet tend to swell, not so much his ankles. R3 was becoming stable. R3 was a 1-2 person assist." The service plan dated 8/22/25 was not revised with interventions to address R3's increased need (2-3 person) for assistance with transfer and pivoting. This service plan shows R3 needs assistance with evacuation, bathing, toileting, transferring, mobility and dressing. There is no correlation of care between establishment staff and physical therapy staff.	A2000		
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,	A6000		

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A6000	Continued From page 4 privacy, and choice and to be treated with consideration and respect; 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; These requirements were not met as evidenced by: Based on record review and interview the establishment failed to ensure: -a resident was free from physical abuse. This failure involves 1 of 4 residents (R 1) reviewed for abuse. This failure resulted in R1 being violently punched by an employee. -the safety of 1 of 4 residents (R2) reviewed for abuse. R2 displayed several instances of confusion. This failure resulted in R2 walking out of the front door of the assisted living building and wandered across the road to the memory care building in extremely cold temperatures. These failures creates the substantial probability of severe harm or death to R1,R2 and other residents. Findings include: 1. R1 is a 94 year old resident who moved into the establishment on 5/22/14. R1 has diagnoses including Asthma, Atrial fibrillation and Arthroplasty. On 3/2/26 at 1:00pm, E3 (wellness director)	A6000		

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A6000	Continued From page 5	A6000		

stated, "R1 informed E1 (resident care supervisor) about the incident. R1 felt E2 (CNA, certified nurse aide) was being unnecessarily rough with her. R1 is a little hard of hearing but she is alert and oriented. E2 was suspended pending investigation. We did terminate E2 due to other past care issues. We couldn't substantiate abuse actually happened."

The progress note dated 12/26/25 shows Writer E7 (LPN) was informed by R1 that at approximately 2:00am. E2 was assisting during overnight shift, was grabbing R1 by her toes to transfer her legs into the bed and that E2 had punched R1 on the back of her left leg. R1 was assessed for any bruising. Nothing observed on either leg. E3 (wellness director) made aware.

On 3/2/26 the establishment presented a hand written statement by R1 detailing what happened on 12/26/25. This hand written statement was given to E1 by R1.

R1 wrote: "the CNA (E2) at about 2am answered on my call door not knowing how to do her job. I commented lift my legs up so they could be lifted into the bed after she (R1) went to the bathroom. E2 took my legs by my toes and which I have gotten over an infection and when I yelled she dropped them at the edge of the bed and they were sliding off it. I asked E2 to put my legs up. E2 punched the back of my left leg which left a black and blue mark. E 2 also left my walker in the middle of the room instead of by my bed."

The incident report mirrors what is documented in the progress notes. The establishment did not present a statement from E2 concerning this incident.

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Review of Corrective Action Forms for E2 show the following:
-10/10/25: first warning: not delivering a resident's laundry until 6 hours later

-10/20/35: 2nd warning: not responding to a resident's call light for 54 minutes

-12/26/25: final warning, suspended for 2 days. E2 violated code of conduct and unsatisfactory performance.

E2 was terminated after 3 corrections and violating the code of conduct.

2. R2 was a 81 year old resident who moved into the establishment 8/6/24. R2 has several diagnoses including Major depressive disorder recurrent, Adjustment disorder with mixed anxiety and depressed mood, type 2 Diabetes Mellitus, Chronic kidney disease, Hypoxemia and Hypertensive heart disease with heart failure. R2 resided in the assisted living building.

The progress note dated 1/23/26 shows R1 stated to the nurse that the nurse was "interrupting the conversation she was having with Mel". When nurse asked R2 if she knew that Mel had passed, R2 stated, "I know that he's dead. He died in September, but I can still see his spirit and talk to him. He's a lot happier now than when he was here". R2 also said she saw Mel's brother (who is also deceased), and that "I see Mel and his brother playing golf, and they ' re having so much fun. I hope to join them soon."

1/25/26 12:43, Incident Note: Care partner called this writer to resident's apartment. Upon arrival observed R2 on the bathroom floor naked in a

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sitting position facing the door. Per CP resident did not push her call light for assistance. Also care partner stated R2 informed her that she was seeing little kids in her apartment earlier. No kids present in resident's apartment. R2 said she fell in the living room and was waiting for help for one hour. R2 also said she hit her head but unable to give more details. No visible injuries noted, no bumps or open area to head observed. R2 alert and oriented x 2, able to verbalize needs. 911 called. R2 refused to go to ER (emergency room) to be further evaluated. Z1 on the phone with paramedics, aware of R2's refusal.

-1/25/2026 4:50pm, Behavior Expression Note: R2 eloped and was found in memory care without her jacket and shoes. R2 was brought back safety into her apartment. R2 is really confused and talking about seeing cats and dogs in her apartment. Z1 and E3 (wellness director) heve been informed. The Z1 has agreed that R2 should be sent to the local hospital for further evaluation.

According to NOAA (national oceanic and atmospheric administration) website, the outside daytime temperature on 1/25/26 in Romeoville, IL was between 12 and 18 degrees Fahrenheit with wind chills of 10 degrees to 15 degrees below zero.

1/26/26: Resident admitted to local hospital with a diagnosis of UTI (urinary tract infection).

On 3/6/26 at 9:40am via telephone, E3 (wellness director) stated, "R2 was able to go over to memory care across the street. R2 did have a jacket on. The caregivers brought R2 back. R2 made it across the street to memory care. R2 was started on ABT (antibiotic therapy) on 1/24.

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A6000	Continued From page 8 We sent R2 out. R2 was declining and R2 was having more infections. R2 was admitted to the hospital. The hospital diagnosed R2 with a UTI (urinary tract infection). We did have a conversation with the family about considering hospice. R2 came back to us on hospice and passed a few days later." On 3/9/26 at 3:25pm via telephone, E6 (LPN) stated, "I was coming in to work that morning. The receptionist called to say the memory care staff found R2. The memory care staff brought R2 back to assisted living. R2 had a coat on but I don't think she had on shoes but socks. R2 was very confused. R2 said her husband was calling her. Prior to this R2 would say she was seeing things in her room like animals that weren't there. R2 was showing signs of confusion prior to this incident. R2 was hospitalized for a UTI before."	A6000		