STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5108235	A. BUILDING: _____ B. WING _____	C 02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARHURST OF WOODSTOCK	10511 ROUTH 14 WOODSTOCK, IL 60098

(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 Facility Reported Incident IL199784 Violations cited 295.2000a)e), 295.4010 a)b)1)2)3)d)e)g)1)A)C)3) 295.6000a)1)	A 000		
A2000	Section 295.2000 Residency Requirements This Regulation is not met as evidenced by: TYPE 1 VIOLATION Section 295.2000 Residency Requirements 295.2000a)e) 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) e) Residency shall be terminated in accordance with Section 295.2010 when services available to the resident in the establishment are no longer adequate to meet the needs of the resident. This provision shall not be interpreted as limiting the authority of the Department to require the residency termination of individuals. (Section 75(e) of the Act) This regulation is NOT MET as evidenced by:	A2000		

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A2000	Continued From page 1 Based on observation, interview and record review, the establishment failed to discharge a cognitively impaired resident that requires extensive supervision to prevent accidents and/or risk of serious injury and that requires staff assistance for transfers. This failure applies to one (R2) of three residents reviewed for this requirement. This failure resulted in R2 experiencing repeated falls that occurred in areas supervised by staff. This failure creates a substantial probability of severe harm to R2 and other residents. Findings include: Review of R2's medical record showed a move-in date of 08/25/2025 with a past medical history not limited to anxiety disorder, Alzheimer's disease, hypertension, osteoarthritis, overactive bladder and ataxic (unsteady) gait. R2 is documented as being at risk for falls. R2 does not receive hospice services. Incident log from 11/01/2025 through 02/16/2026 provided by establishment documented that R2 was found on her bedroom floor on 12/06/2025 at 08:26 AM; fell out of her wheelchair in the activity area on 12/20/2025 at 05:10 PM; fell out of her wheelchair onto the floor in the back lounge area on 01/09/2026 at 05:45 PM; was witnessed by staff standing up from her wheelchair then falling to the floor in the common area on 01/10/2026 at 06:20 PM; was found on the floor in another resident's room on 01/15/2026 at 06:20 PM; and was found sitting on the floor in the hallway on 01/19/2026 at 05:10 PM. R2's care plan dated 02/24/2026 (date of survey entrance) documented that resident requires staff assistance with toileting and transfers, requires	A2000		

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A2000	Continued From page 2	A2000		

frequent reassurance and redirection with activities of daily living (ADLs) by staff, is at high risk for falls and elopement. Undated fall interventions included: staff to encourage use of wheelchair to propel self, non-slip socks at night, toileting at night as needed, therapy referral per physician's orders, and safety checks throughout the day which are scheduled every two hours by staff. (No documentation was provided by establishment that indicted R2 received or is currently receiving therapy services)

On 02/24/2026 at 01:40 PM, E3 (Registered Nurse) escorted surveyor to R2's room. Upon entering room, R2 was observed lying in bed. Wheelchair was next to bed. R2 sat up in bed and placed legs over side of bed. R2 then reached for the wheelchair and attempted to stand up from the bed. E3 instructed R2 to stay in bed then turned to surveyor and said, "I'm going to get an RA" (resident assistant) then E3 left the room. R2 was alert to self and was not interviewable. From 01:42 PM through 01:50 PM, surveyor observed R2 attempt to transfer herself into the wheelchair. R2 was unable to stand for long periods of time and after multiple attempts, was able to transfer herself from the bed to the wheelchair. Surveyor and R2 then exited the room. No staff member returned to R2's room during this observation to assist with the transfer.

On 02/24/2026 at 01:52 PM, E3 and several other staff members were observed at the nursing desk area. R2 was observed propelling self in wheelchair throughout the unit. No staff were observed interacting with R2 at this time.

On 02/24/2026 at 3:25 PM, E2 (Director of Nursing) said verbatim regarding R2 falls: most occurred in the common areas, she likes to roam

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A2000	Continued From page 3 in her wheelchair and sometimes she leans forward too far and falls or tries to stand at times by the nurse's station. She is a high fall risk. On 02/25/2026 at 10:07 AM, E1 (Executive Director) said R2 was moved from assisted living to memory care last fall because she was "a significant risk alone and we recommended 1:1" to the family. E1 said that R2 received 1:1 for a week to ten days prior to moving to the memory care unit. E1 then said a family member stay with R2 for approximately one week during this transition period into memory care. R2 did not continue 1:1 when she was moved into the memory care unit. On 02/25/2026 at 01:09 PM, during exit conference with E1 and E2 (Director of Nursing), when asked if staff are present in common areas to ensure residents stay in these areas for increased supervision, E2 said "yes". When asked about R2's numerous falls that occurred in common areas, E1 said the residents "are spontaneous, that's why we always have staff in common areas". He added that from 6:00 AM to 10:00 PM, there are three resident assistants on the memory care unit for supervision. E1 then said that R2 can transfer herself but E3 should not have left the room previously, and E1 was unsure as to why E3 did not assist R2 transfer into the wheelchair.	A2000		
A4010	Section 295.4010 Service Plan	A4010		

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A4010	Continued From page 4 This Regulation is not met as evidenced by: TYPE 1 VIOLATION Section 295.4010 Service Plan 295.4010 a)b)1)2)3)d)e)g)1)A)C)3) 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. 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). 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). g) Service plans shall address: 1) The level of service the resident is receiving, including: A) assistance with activities of daily living. C) special accommodations for the resident. 3) Staff responsible for the provisions of the service plan. This regulation is NOT MET as evidenced by:	A4010		

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A4010	Continued From page 5 Based on interview and record review, the establishment failed to implement interventions and identify new measures to provide adequate supervision and protect residents' safety to prevent accidents and/or injury. This failure applies to two (R1, R2) of three residents reviewed for this requirement. This failure resulted in R1 experiencing repeated falls and subsequently a left hip fracture. This failure resulted in R2 experiencing repeated falls while in areas supervised by staff. This failure creates a substantial probability of severe harm for R1,R2 and other residents. Findings include: 1. Review of R1's medical record showed a move-in date of 08/03/2024 and a discharge date of 01/27/2026. Past medical history includes (but not limited to) congestive heart failure, dizziness and giddiness, fracture of left acetabulum and left pubis. R1 is documented as being at risk for falls. R1 did not receive hospice services while at establishment. Incident reports (IDPH and establishment) with incident date of 01/09/2026 indicated that at approximately 09:54 AM, staff found resident on the floor laying on left side in fetal position between bed and hvac system. Floor mat was on the floor by the bed, but resident not found on the mat. Resident complained of right sided hip and thigh pain and left sided hip pain. Resident was noted to be more lethargic. 911 was initiated and resident was transferred to the emergency room for further evaluation.	A4010		

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A4010	Continued From page 6 R1's hospital paperwork dated 01/12/2026 reads in part, Emergency Medical Services (EMS) reports nursing home stated patient experienced "multiple falls through the night" and was "found on the floor this morning" ... Per EMS, facility staff states patient is "more confused". Admitting diagnosis is pelvic fracture. X-ray of pelvis showed findings of "healing but not fully healed left-sided pubic rami fracture" and "subacute appearing left inferior pubic ramus and left acetabular fractures which are new since 01/14/2025". Incident reports (IDPH and establishment) with incident date of 01/18/2026 indicated that at approximately 10:30 PM, resident was found lying on bedroom floor on her right side and off the floor mats. Resident has dementia and was unable to explain what happened. Complained of left hip pain when touched. Unable to perform range of motion due to resident "screaming in pain". 911 was called and resident sent to local emergency room and was admitted for left closed hip fracture. Per E1 (Executive Director) and E2 (Director of Nursing) on 02/24/2026, R1 did not return to the establishment after the fall incident on 01/18. Resident discharged from the hospital to home with hospice services and has since expired. R1's care plan care plan dated 02/24/2026 (date of survey entrance) documented that resident requires staff assistance with toileting and transfers by staff, requires daily reminders and redirection with activities of daily living (ADLs) by staff, is at high risk for falls and had multiple falls. Undated interventions included staff to remind to lock wheelchair; wear non-slip shoes and call for	A4010		

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A4010	Continued From page 7	A4010		

assistance; safety checks hourly during the day and every two hours during the night by staff, therapy referral per physician's orders and floor mats while in bed.

R1's undated interventions for "safety check" on same care plan documented a discrepancy with scheduled safety checks and indicated for staff to check on R1 hourly during the night and every two hours during the day.

2. Review of R2's medical record showed a move-in date of 08/25/2025 with a past medical history not limited to anxiety disorder, Alzheimer's disease, hypertension, osteoarthritis, overactive bladder and ataxic (unsteady) gait. R2 is documented as being at risk for falls. R2 does not receive hospice services.

Incident log from 11/01/2025 through 02/16/2026 provided by establishment documented that R2 was found on her bedroom floor on 12/06/2025 at 08:26 AM; fell out of her wheelchair in the activity area on 12/20/2025 at 05:10 PM; fell out of her wheelchair onto the floor in the back lounge area on 01/09/2026 at 05:45 PM; was witnessed by staff standing up from her wheelchair then falling to the floor in the common area on 01/10/2026 at 06:20 PM; was found on the floor in another resident's room on 01/15/2026 at 06:20 PM; and was found sitting on the floor in the hallway on 01/19/2026 at 05:10 PM.

R2's care plan dated 02/24/2026 (date of survey entrance) documented that resident requires staff assistance with toileting and transfers, requires frequent reassurance and redirection with activities of daily living (ADLs) by staff, is at high risk for falls and elopement. Undated fall interventions included: staff to encourage use of

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A4010	Continued From page 8	A4010		

wheelchair to propel self, non-slip socks at night, toileting at night as needed, therapy referral per physician's orders, and safety checks throughout the day which are scheduled every two hours by staff.

On 02/24/2026 at 01:40 PM, E3 (Registered Nurse) escorted surveyor to R2's room. Upon entering room, R2 was observed lying in bed. Wheelchair was next to bed. R2 sat up in bed and placed legs over side of bed. R2 then reached for the wheelchair and attempted to stand up from the bed. E3 instructed R2 to stay in bed then turned to surveyor and said, "I'm going to get an RA" (resident assistant) then E3 left the room. R2 was alert to self and was not interviewable.

On 02/24/2026 from 01:42 PM through 01:50 PM, surveyor observed R2 attempt to transfer herself into the wheelchair while in her room with no staff present. R2 was unable to stand for long periods of time and after multiple attempts, was able to transfer herself from the bed to the wheelchair. Surveyor and R2 then exited the room. No staff member returned to R2's room during this observation to assist with the transfer.

On 02/24/2026 at 01:52 PM, E3 and several other staff members were observed at the nursing desk area. R2 was observed propelling self in wheelchair throughout the unit. No staff were observed interacting with R2 at this time.

On 02/24/2026 at 03:10 PM, E2 (Director of Nursing) said verbatim regarding R1 falls: was sent out for evaluation after fall on 01/09/2026 and returned on 01/12/2026. Was found to have an "old fracture". At 3:12 PM, E2 said a second, thicker floor mat was implemented; R1 already

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A4010	Continued From page 9	A4010		

had one mat in place previously. The first mat was placed by the head of bed and the second was placed towards the middle and foot of bed. With fall on 01/18/2026, R1 was found on the floor, past the mat. Was sent out for evaluation after this fall and was found to have a new fracture to the left hip. At 03:18 PM, E2 then said she updates interventions after a resident returns from the hospital, but if not sent out, will do that day or the following day depending on time of fall. E2 added with multiple falls, she will talk with their physician for a referral to therapy. She added that safety checks for all residents are done every two hours in memory care but with more falls, can be more frequent like every hour. At 3:21 PM, E2 said R1 was on every hour checks as of 05/02/2025 per her service plan. She added that resident care managers, who work on first and second shifts, check to ensure that staff rounding and safety checks are being done, and that fall interventions are in place.

On 02/24/2026 at 3:25 PM, E2 (Director of Nursing) said verbatim regarding R2 falls: most occurred in the common areas, she likes to roam in her wheelchair and sometimes she leans forward too far and falls or tries to stand at times by the nurse's station. She is a high fall risk.

On 02/25/2026 at 01:09 PM, during exit conference with E1 and E2 (Director of Nursing), when asked if staff are present in common areas to ensure residents stay in these areas for increased supervision, E2 said "yes". When asked about R2's numerous falls that occurred in common areas, E1 said the residents "are spontaneous, that's why we always have staff in common areas". He added that from 6:00 AM to 10:00 PM, there are three resident assistants on the memory care unit for supervision. E2 also

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A4010	Continued From page 10 said "there's no place to put dates for falls or interventions on care plan or which intervention is specific post fall. It's a glitch in the system". Undated Individualized Service Plans & Plan of Care Meetings policy provided by facility on 02/24/2026 reads in part: it is the policy of the community to assure all community staff understand the importance of the plan of care and the care plan meeting. All plans of care must reflect the resident's needs, as identified in the initial evaluation and the on-going evaluations. All evaluations will be in conjunction with a plan of care meeting scheduled as directed by the regulatory guidelines specific to your state, unless there is a significant change of condition, which will prompt an earlier plan of care meeting. All plans of care will be developed using your community's plan of care tool. All plans of care will be readily available for staff to view. The plan of care will be developed based on all the information gathered during the evaluation. The plan of care will include who will provide the services and how often. Changes and entries made may be handwritten directly on the plan of care tool, but all must be dated ...The plans of care must be developed by members of the team and include the resident and the resident's authorized signer.	A4010		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: TYPE 1 VIOLATION Section 295.6000 Resident Rights 295.6000a)1)	A6000		

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A6000	Continued From page 11 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 consideration and respect; This regulation is NOT MET as evidenced by: Based on observation, interview and record review, the establishment failed to provide a safe environment and adequate supervision or monitoring to avoid an accident or serious injury. This failure applies to two (R1, R2) of three residents reviewed for this requirement. This failure resulted in R1 experiencing repeated unwitnessed falls and subsequently a left hip fracture. This failure resulted in R2 experiencing repeated unwitnessed falls, several that occurred in areas supervised by staff. This failure creates a substantial probability of severe harm for R1,R2 and other residents. Findings include: 1. Review of R1's medical record showed a move-in date of 08/03/2024 and a discharge date of 01/27/2026. Past medical history includes (but not limited to) congestive heart failure, dizziness	A6000		

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A6000	Continued From page 12	A6000		

and giddiness, fracture of left acetabulum and left pubis. R1 is documented as being at risk for falls. R1 did not receive hospice services while at establishment.

Incident reports (IDPH and establishment) with incident date of 01/09/2026 indicated that at approximately 09:54 AM, staff found resident on the floor laying on left side in fetal position between bed and hvac system. Floor mat was on the floor by the bed, but resident not found on the mat. Resident complained of right sided hip and thigh pain and left sided hip pain. Resident was noted to be more lethargic. 911 was initiated and resident was transferred to the emergency room for further evaluation.

R1's hospital paperwork dated 01/12/2026 reads in part, Emergency Medical Services (EMS) reports nursing home stated patient experienced "multiple falls through the night" and was "found on the floor this morning" ... Per EMS, facility staff states patient is "more confused". Admitting diagnosis is pelvic fracture. X-ray of pelvis showed findings of "healing but not fully healed left-sided pubic rami fracture" and "subacute appearing left inferior pubic ramus and left acetabular fractures which are new since 01/14/2025".

Incident reports (IDPH and establishment) with incident date of 01/18/2026 indicated that at approximately 10:30 PM, resident was found lying on bedroom floor on her right side and off the floor mats. Resident has dementia and was unable to explain what happened. Complained of left hip pain when touched. Unable to perform range of motion due to resident "screaming in pain". 911 was called and resident sent to local emergency room and was admitted for left closed

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(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
A6000	Continued From page 13 hip fracture. Per E1 (Executive Director) and E2 (Director of Nursing) on 02/24/2026, R1 did not return to the establishment after the fall incident on 01/18. Resident discharged from the hospital to home with hospice services and has since expired. R1's care plan care plan dated 02/24/2026 (date of survey entrance) documented that resident requires staff assistance with toileting and transfers by staff, requires daily reminders and redirection with activities of daily living (ADLs) by staff, is at high risk for falls and had multiple falls. Undated interventions included staff to remind to lock wheelchair; wear non-slip shoes and call for assistance; safety checks hourly during the day and every two hours during the night by staff, therapy referral per physician's orders and floor mats while in bed. R1's undated interventions for "safety check" on same care plan documented a discrepancy with scheduled safety checks and indicated for staff to check on R1 hourly during the night and every two hours during the day. On 02/24/2026 at 12:30 PM, E4 (Resident Assistant) said verbatim during interview: fall interventions for residents on memory care include to stay with them, escort them to bathroom, and try to keep residents in common areas to keep eyes on them. When in room, we check on all residents every two hours. R1 was usually always in the common area, did some activities but not all. When in wheelchair, she was not anxious but tried to stand up at times. E4 added that staff document safety checks on electronically every two hours but if safety check times are more frequent, they would be noted on the resident's electronic charting.	A6000		

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A6000	Continued From page 14 On 02/24/2026 at 02:13 PM, E5 (Registered Nurse) said verbatim regarding R1's 01/09/2026 fall incident: we were checking on her frequently, like every 5-10 minutes. Told caregivers to get her up by 10:00 AM if she was not already up. We had just checked on her and a few minutes later, heard a loud noise. When we went into her room, she was in a fetal position between the bed and hvac unit. She was complaining of hip pain; think it was her right side. I called 911 immediately and she was sent out to emergency room for evaluation. They said she had a left pubic fracture that was old and healing. At 2:19 PM, E5 said R1 was a fall risk. She would get up spontaneously to get things off the floor. R1 used a wheelchair and could stand and pivot for transfers. E5 then said staff checked on her (R1) frequently and kept her in common areas. On 02/24/2026 at 2:27 PM, E7 (Resident Assistant) said verbatim regarding R1's 01/18/2026 fall incident: we were doing rounds with night shift at around 10:30 PM on day of incident. When we opened the door, she (R1) was on the floor in the middle of the room and the floor mats were by the foot bed and not next to the bed where they should have been. Bed was in a higher position, about hip level. At 02:38 PM, E7 said high fall risks residents are checked on every hour. On 02/24/2026 at 02:42 PM, E6 (Resident Assistant) said verbatim regarding R1's 01/18/2026 fall incident: She had bruising to her face from a previous fall. Around 8:30-09:00 PM on day of incident, I put her into bed and placed the fall mat next to her bed. She didn't have a hospital bed, so the bed height was approximately knee level. Last checked on her at	A6000		

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around 09:30 PM, was in bed and was awake. She is confused. I checked her brief, and it was dry. Started doing rounds with third shift about 10:15-10:20 PM. Upon entering her room, we found her on the floor in the middle of the room. The mat was away from the bed. Her brief was wet when we found her but we couldn't move her legs because she was in pain; urine leaked through to her pants. We called for the nurse who assessed her then called 911. Paramedics got her up from the floor when they arrived. E6 then said R1's fall interventions included to place floor mats, position her in the middle of the bed, and safety checks every two hours. At 2:56 PM, said prior to fall on 01/18, R1 complained of pain from the previous fall. Her legs were weak. After her falls, her legs got weak, and she had a decline. She complained of pain with movement.

On 02/24/2026 at 03:10 PM, E2 (Director of Nursing) said verbatim regarding R1 falls: was sent out for evaluation after fall on 01/09/2026 and returned on 01/12/2026. Was found to have an "old fracture". At 3:12 PM, E2 said a second, thicker floor mat was implemented; R1 already had one mat in place previously. The first mat was placed by the head of bed and the second was placed towards the middle and foot of bed. With fall on 01/18/2026, R1 was found on the floor, past the mat. Was sent out for evaluation after this fall and was found to have a new fracture to the left hip. At 03:18 PM, E2 then said she updates interventions after a resident returns from the hospital, but if not sent out, will do that day or the following day depending on time of fall. E2 added with multiple falls, she will talk with their physician for a referral to therapy. She added that safety checks for all residents are done every two hours in memory care but with more falls, can be more frequent like every hour. At 3:21 PM, E2

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said R1 was on every hour checks as of 05/02/2025 per her service plan. She added that resident care managers, who work on first and second shifts, check to ensure that staff rounding and safety checks are being done, and that fall interventions are in place.

2. Review of R2's medical record showed a move-in date of 08/25/2025 with a past medical history not limited to anxiety disorder, Alzheimer's disease, hypertension, osteoarthritis, overactive bladder and ataxic (unsteady) gait. R2 is documented as being at risk for falls. R2 does not receive hospice services.

Incident log from 11/01/2025 through 02/16/2026 provided by establishment documented that R2 was found on her bedroom floor on 12/06/2025 at 08:26 AM; fell out of her wheelchair in the activity area on 12/20/2025 at 05:10 PM; fell out of her wheelchair onto the floor in the back lounge area on 01/09/2026 at 05:45 PM; was witnessed by staff standing up from her wheelchair then falling to the floor in the common area on 01/10/2026 at 06:20 PM; was found on the floor in another resident's room on 01/15/2026 at 06:20 PM; and was found sitting on the floor in the hallway on 01/19/2026 at 05:10 PM.

R2's care plan dated 02/24/2026 (date of survey entrance) documented that resident requires staff assistance with toileting and transfers, requires frequent reassurance and redirection with activities of daily living (ADLs) by staff, is at high risk for falls and elopement. Undated fall interventions included: staff to encourage use of wheelchair to propel self, non-slip socks at night, toileting at night as needed, therapy referral per physician's orders, and safety checks throughout the day which are scheduled every two hours by

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staff.

On 02/24/2026 at 01:40 PM, E3 (Registered Nurse) escorted surveyor to R2's room. Upon entering room, R2 was observed lying in bed. Wheelchair was next to bed. R2 sat up in bed and placed legs over side of bed. R2 then reached for the wheelchair and attempted to stand up from the bed. E3 instructed R2 to stay in bed then turned to surveyor and said, "I'm going to get an RA" (resident assistant) then E3 left the room. R2 was alert to self and was not interviewable.

On 02/24/2026 from 01:42 PM through 01:50 PM, surveyor observed R2 attempt to transfer herself into the wheelchair while in her room with no staff present. R2 was unable to stand for long periods of time and after multiple attempts, was able to transfer herself from the bed to the wheelchair. Surveyor and R2 then exited the room. No staff member returned to R2's room during this observation to assist with the transfer.

On 02/24/2026 at 01:52 PM, E3 and several other staff members were observed at the nursing desk area. R2 was observed propelling self in wheelchair throughout the unit. No staff were observed interacting with R2 at this time.

On 02/24/2026 at 3:25 PM, E2 (Director of Nursing) said verbatim regarding R2 falls: most occurred in the common areas, she likes to roam in her wheelchair and sometimes she leans forward too far and falls or tries to stand at times by the nurse's station. She is a high fall risk.

On 02/25/2026 at 01:09 PM, during exit conference with E1 and E2 (Director of Nursing), when asked if staff are present in common areas

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to ensure residents stay in these areas for increased supervision, E2 said "yes". When asked about R2's numerous falls that occurred in common areas, E1 said the residents "are spontaneous, that's why we always have staff in common areas". He added that from 6:00 AM to 10:00 PM, there are three resident assistants on the memory care unit for supervision. E2 also said "there's no place to put dates for falls or interventions on care plan or which intervention is specific post fall. It's a glitch in the system".

No safety check logs were provided by establishment for review upon survey exit.

Undated Resident Rights Employee Acknowledgment (IL) provided by facility on 02/24/2026 reads in part: 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 (including but not limited to) 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 consideration and respect ...

Undated Fall Risk Policy & Procedures policy provided by facility on 02/24/2026 reads in part: upon move into the assisted living community and routinely according to state regulations and assessment policy and Procedures, each resident will be assessed for their fall risk. The fall risk assessment will be completed by the director of nursing or licensed nurse. All residents moving into memory care communities are identified at risk for fall. Interventions or a plan needs to be

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A6000	Continued From page 19 established and added to their care plan ...Procedures (included but not limited to) conduct fall risk assessment and add interventions to the individualized service plan ...When a resident falls ...initiate a fall risk assessment if one has not been completed within the past 90 days, or if resident has a change of condition that may place him/her at risk for falls. Implement fall prevention interventions and consider if resident needs a physical therapy evaluation or medication regime evaluation by the medical doctor ...Note interventions on individualized service plan.	A6000		