STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510505	A. BUILDING: _____ B. WING _____	C 06/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAVERLY INN MEMORY CARE COMMUNITY	515 W RAND ROAD ARLINGTON HEIGHTS, IL 60004

(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 Report Incident Investigation #IL 190825- 295.6010a)1)c)	A 000		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr This Regulation is not met as evidenced by: 295.6010a)1)c) 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. c) Establishment employees and volunteers are obligated to report abuse, neglect, or financial exploitation of a resident to the establishment management and to the Department. This requirement was not met as evidenced by: Based on interview and record review the facility failed to report an allegation of abuse to Illinois Department of Public Health within 24 hours after	A6010		

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A6010	Continued From page 1	A6010		

receiving the allegation for 1 of 3 residents (R1) reviewed for abuse in the sample of 4.

The findings include:

The Incident Report dated 4/10/25 for R1 showed E6 Resident Assistant (RA) reported that E8 RA pulled the resident's hair. E8 was suspended pending investigation. An assessment was done by the nurse and the nurse practitioner. The family and physician were notified. The Incident Report showed it was faxed to the state on 4/21/25.

The Resident Incident and Accident Investigation form involving R1 showed the date of the incident was on 4/8/25. On 4/10/25, E6 RA reported that while providing incontinence care for R1 on 4/8/25 at approximately 11:00 PM, the resident became resistant to care, pushing away from staff. E6 noticed that E8 RA, who was also helping the resident, pulled the residents hair and then positioned herself in front of the resident. E6 said she was not 100% sure but she thought E8 hit R1 on the forehead, because he said, "ouch, you did not have to do that." E6 stated she was in shock from what she witnessed and did not know what to do. R1 was assessed upon report of the incident on 4/10/25. All staff members working the floor that night were interviewed. The medical doctor, power of attorney, and state were notified. The findings of E2 Director of Resident Services assessment showed a slight discoloration was noted on the left side of R1's neck on 4/10/25. Unable to determine if it was related to the report. Unable to rule out abuse. The investigation was unsubstantiated as a result of a lack of supporting evidence.

On 6/8/25 at 9:40 AM, E2 Director of Resident

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A6010	Continued From page 2	A6010		

Services (DRS) stated an abuse investigation was done for R1. E2 stated she and E1 Executive Director do the abuse investigations. E2 stated abuse is supposed to be reported in 24 hours to the state; that is what the regulation says. E2 stated the allegation of abuse for R1 was reported after the 24 hours. E2 stated the abuse was reported to her by E6 RA 2 days after it occurred. E2 stated the RA's receive education and training on abuse; E6 did not follow her training. E2 stated the nurse practitioner saw R1 on 4/14/25 reported to IDPH until it was determined as unsubstantiated (on 4/21/25).

On 6/8/25 at 10:59 AM, E6 RA stated that her and E8 RA were changing R1 because he was incontinent of bowel movement. R1 was agitated. E7 RA was in the room holding R1's hands like you do a friend. E6 stated R1 was moving around a lot and was agitated so the told E8 to help E7 with R1's hands. E6 stated E8 was frustrated with R1 and she saw E8 pull R1's hair. E6 stated she just looked at E8 and she knew E6 saw her do it. E6 stated she was in shock and did not know what to say. E6 stated she reported the incident a few days later because it was bothering her.

The Facility's Abuse, Neglect, and Exploitation policy (no date) showed, 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 provide notification to persons/agencies as described in this policy. All Resident Assistants will receive in-service training on elder abuse incidence, signs and symptoms of abuse, and reporting requirements during initial orientation. This training will be repeated per state regulations. Any community staff member or volunteer has

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A6010	Continued From page 3 observed, suspects, has knowledge of, or is told by 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 Resident Services, and Executive Director. Reporting of any suspected, alleged, or witnessed abuse will be completed according to the state reporting requirements. The Executive Director will notify the Illinois Department of Public Health Division of Assisted Living within 24 hours of notification.	A6010		