STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510103	A. BUILDING: _____ B. WING _____	C 02/25/2026

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A 000	Initial Comment Facility Reported Incident Investigation to Incident Report dated 1/20/26 / IL199729 Violation cited 295.4010 d) g) 1) A) (Repeat Violation) 295.4060) h) 6) 9) 295.6000) a) 5) (Repeat Violation) Complaint # 2640910 / IL199776 Violations already cited during Complaint Investigation IL199681, IL199683 completed 1/21/26 Complaint # 2641393 / IL199955 Violations cited: 295.5000 a) d) 295.6000 a) 5) Complaint # 2641437 / IL199960 Violations cited: 295.5000 a) d) 295.6000 a) 5) Complaint # 2641375 / IL199994 Violation cited: 295.6000 a) 1) 3) Complaint # 2641488 / IL199999 Violation cited: 295.6000 a) 1) 3) Complaint # 2641509 / IL200056 No violation cited. Complaint # 2641833 / IL200156 Violation cited: 295.4010 d) g) 1) A) 295.6000 a) 1) 2) 5) Complaint # 2641834 / IL200157	A 000		

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A 000	Continued From page 1 Violation cited: 295.6000 a) 1) 3) 5) 295.7000 b) 9)	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: REPEAT TYPE 2 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. 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) g) Service plans shall address: 1) The level of service the resident is receiving, including: A) assistance with activities of daily living;	A4010		

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A4010	Continued From page 2 Based on interview and record review the facility failed to ensure interventions are formulated and put in place to prevent resident to resident physical assault (R1); to prevent future falls for residents (R4) identified as at risk for falls and with actual fall incident; and R4 needing physical assist with dressing.These failures resulted in: R1 being physically aggressive to R2; and an unwitnessed fall (R4) with inadequate monitoring which was unreported and undocumented. These failures create a substantial probability of harm to residents. Findings include: a. R1 to R2 Physical Assault R1's record documents R1 moved into the Memory Care Unit of the facility on 3/12/25 with multiple diagnoses significant for Dementia and a cognitive assessment score dated 7/30/25 of stage 6 -Severe Cognitive Decline on the GDS or Global Deterioration Scale. R1's Service Plan documents," BEHAVIORS - AGGRESSION/ANXIOUSNESS. 08/7/25 - Present. Behaviors - Aggression/Anxiousness. Directions: Resident has present and past behaviors of physical aggression, anxiousness, uses foul language, belligerent or destructive. Use calm and gentle approach. Provide safe environment. Redirect without agitating as needed to protect the rights of other residents. Schedule: Daily @ as needed. Service Needs/Preferences: Resident has present and past behaviors of physical aggression, anxiousness, uses foul language, belligerent or destructive. Use calm and gentle approach.	A4010		

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A4010	Continued From page 3	A4010		

Provide safe environment. Redirect without agitating as needed to protect the rights of other residents. VISUAL CHECKS MC (Memory Care) General/other: 8/25/25 - PRESENT. Directions: Lay eyes on resident to ensure safety. Schedule: Daily @ 12:00 AM, 1:00 AM, 2:00 AM, 3:00 AM, 4:00 AM, 5:00 AM, 6:00 AM, 7:00 AM, 8:00 AM, 9:00 AM, 10:00 AM, 11:00 AM, 12:00 PM, 1:00 PM, 2:00 PM, 3:00 PM, 4:00 PM, 5:00 PM, 6:00 PM, 6:00 PM, 7:00 PM, 8:00 PM, 9:00 PM, 10:00 PM, 11:00 PM, As Needed."

R1's Incident Report dated 1/16/26 documents, "1/16/25 7:14 PM. Location: Dining Room. Description of Incident: (R2) was sitting in dining room socializing with other residents when (R1) walked up to him and started striking him in the back of his head with his fist. Witnesses: Visitor. Describe Action Taken/measure initiated to reduce the possibility of future incidents: Increased behavior monitoring, medication review and monitoring residents while in common areas."

R1's Service Plan, "FOLLOW UP TO ALTERCATION 01/17/26 - 01/27/26. Directions: Describe residents behavior. Schedule: Daily @ 7:00 AM - 3:00 PM, 3:00 PM - 11:00 PM, 11:00 PM - 7:00 PM. Service Need/Preferences: (Specify any needs/support with condition, and schedule appropriately if needed).

On 2/19/26 at 1:10 PM, E3/Licensed Practical Nurse stated she was still in the unit when she heard the commotion and ran towards the dining room and saw R1 standing next to R2 holding R2's cane and immediately separated them for safety. E3 stated there were other residents in the dining room and one visitor who reported seeing R1 approaching R2 from behind and suddenly hit

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A4010	Continued From page 4	A4010		

him on the back of the head with his fist. E3 added that R1 exhibited aggressive behavior towards staff in the past but no reports of being aggressive towards other residents. E3 stated both R1 and R2 were sent out for evaluation and returned from the ER with no findings and no new orders. E3 stated she noted no staff present in the dining room when the incident happened. E3 stated a staff member should have been present monitoring when residents are present in the common area.

b. R4 Dressing assist not completed, inadequate safety monitoring, unwitnessed fall

R4's record documents R4 moved to the Memory Care unit of the facility on 10/23/25 with multiple diagnoses to include Dementia with Behavioral Disturbances.

R4's Service Plan documents, "DRESSING/GROOMING - PHYSICAL ASSIST (ADLS/DRESSING & GROOMING) 11/25/25 - Present. Directions:Requires physical assist with dressing and grooming. Gather grooming and dressing supplies, encouraging resident to select clothing. Assist resident with dressing and grooming while encouraging resident to complete as much of the task as possible. Report increasing difficulty with dressing tasks and/or safety concerns. MOBILITY- INDEPENDENT (Mobility and Transfers). Directions: Resident is independent with mobility and transfers. "

R4's Service Plan documents, " MORSE FALL SCREEN LEVEL 2. 01/30/26 - Present. Directions: Level 2 indicates the need to implement standard fall risk reduction interventions. Service Needs/Preferences: Level

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	ASL510103	A. BUILDING: _____ B. WING _____	C 02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF SHILOH	429 S MAIN ST SHILOH, IL 62269

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A4010	Continued From page 5 2 indicates the need to implement standard fall risk reduction interventions. VISUAL CHECKS MC (Memory Care) General/other: 8/25/25 - PRESENT. Directions: Lay eyes on resident to ensure safety. Schedule: Daily @ 12:00 AM, 1:00 AM, 2:00 AM, 3:00 AM, 4:00 AM, 5:00 AM, 6:00 AM, 7:00 AM, 8:00 AM, 9:00 AM, 10:00 AM, 11:00 AM, 12:00 PM, 1:00 PM, 2:00 PM, 3:00 PM, 4:00 PM, 5:00 PM, 6:00 PM, 6:00 PM, 7:00 PM, 8:00 PM, 9:00 PM, 10:00 PM, 11:00 PM, As Needed." A series of Video Clips from a surveillance camera installed by Z4 (R4's Power of Attorney for Healthcare/POA) inside R4's room and time stamped 2/7/26 at 7:23 AM, 7:24 AM, 7:29 AM show E4 (Care Manager) entering and changing R4's incontinent brief and inserting pants on R4's feet, and at 8:10 AM showing R4 by herself in the room lying on the bed with both legs dangling on the side of the bed wearing a top and adult incontinent briefs and pants by her ankles. The next footage time stamped 2/7/26 at 9:37 AM shows E4 and E7 (Care staff) entering the room with R4 in the same position on the previous footage and starting to assist R4 to sit up. The video footages show R4 was left unattended from approximately 8:10 AM until 9:37 AM, halfway lying in bed with legs hanging on one side of the bed and pants down her lower legs providing entrapment if R4 attempted to get up and walk. A video clip time stamped 2/8/26 at 5:03 PM, shows R4 being brought in by E6/Care Manager wearing a grey sweatshirt and pants and left sitting in bed and a second footage time stamped 2/8/26 at 10:19 PM showing R4 lying on the floor on her left side next to the bed now wearing blue top and pants and E10 and E11, both Care Managers entering the apartment to assist R4.	A4010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A4010	Continued From page 6 No video footage were presented to provide information what happened between those two clips. The facility failed to provide evidence that safety monitoring was provided for R4 as stated in the service plan. On 2/19/26 at 2:20 PM, when asked for any documentation on the fall incident captured on the video footage on 2/8/26 at 10:19 PM, E1/Executive Director stated nobody reported it to her and E1 only learned about it when the video was sent to her. E1 stated they do not have documentation on the fall incident capture on the 2/8/26 video footage.	A4010		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Type 2 Violation Section 295.4060 Alzheimer's and Dementia Programs a) In addition to this Section, Alzheimer and dementia programs shall comply with all of the other provisions of the Act. (Section 150(a) of the Act) h) An establishment that offers to provide a special program for persons with Alzheimer's disease and related disorders shall: 6) Provide an appropriate number of staff for its resident population. The establishment shall provide staff sufficient in number, with qualifications, adequate skills, education, and	A4060		

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A4060	Continued From page 7	A4060		

experience to meet the 24-hour scheduled and unscheduled needs of the residents and who participate in ongoing training, to serve the resident population. At a minimum, at least one staff member shall be awake and on duty at all times;

9) Develop emergency procedures and staffing patterns to respond to the needs of residents; (Section 150(f) of the Act)

Based on interview and record review the facility failed to ensure appropriate number of staff is provided to fulfill the need for increased close monitoring for a resident at fall risk (R4) and a resident (R1) with physically aggressive behaviors resulting in R4 with an unwitnessed fall and R1 hitting R2 on the back of the head in the common area without any staff present. These failures create a substantial probability of harm to residents in the Memory Care unit in the facility.

Findings include:

R1-R2 physical assault:

R1's record documents R1 moved into the Memory Care Unit of the facility on 3/12/25 with multiple diagnoses significant for Dementia.

R1's Incident Report dated 1/16/26 documents, "1/16/25 7:14 PM. Location: Dining Room. Description of Incident: (R2) was sitting in dining room socializing with other residents when (R1) walked up to him and started striking him in the back of his head with his fist. Witnesses: Visitor.

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A4060	Continued From page 8 Describe Action Taken/measure initiated to reduce the possibility of future incidents: Increased behavior monitoring, medication review and monitoring residents while in common areas." R1's Service Plan, "FOLLOW UP TO ALTERCATION 01/17/26 - 01/27/26. Directions: Describe residents behavior. Schedule: Daily @ 7:00 AM - 3:00 PM, 3:00 PM - 11:00 PM, 11:00 PM - 7:00 PM. Service Need/Preferences: (Specify any needs/support with condition, and schedule appropriately if needed). On 2/19/26 at 1:10 PM, E3/Licensed Practical Nurse stated she was still in the unit when she heard the commotion and ran towards the dining room and saw R1 standing next to R2 holding R2's cane and immediately separated them for safety. E3 stated there were other residents in the dining room and one visitor who reported seeing R1 approaching R2 from behind and suddenly hit him at the back of the head with his fist. E3 added that R1 exhibited aggressive behavior towards staff in the past but no reports of being aggressive towards other residents. E3 stated both R1 and R2 were sent out for evaluation and returned from the ER with no findings and no new orders. E3 stated she noted no staff present in the dining room when the incident happened. E3 stated a staff member should have been present monitoring when residents are around in the common area. R4 need for completed dressing assist, adequate safety monitoring and unwitnessed, unreported/undocumented fall: R4's record documents R4 moved to the Memory	A4060		

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A4060	Continued From page 9	A4060		

Care unit of the facility on 10/23/25 with multiple diagnoses to include Dementia with Behavioral Disturbances.

R4's Service Plan documents, "DRESSING/GROOMING - PHYSICAL ASSIST (ADLS/DRESSING & GROOMING) 11/25/25 - Present. Directions:Requires physical assist with dressing and grooming. Gather grooming and dressing supplies, encouraging resident to select clothing. Assist resident with dressing and grooming while encouraging resident to complete as much of the task as possible. Report increasing difficulty with dressing tasks and/or safety concerns. MOBILITY- INDEPENDENT (Mobility and Transfers). Directions: Resident is independent with mobility and transfers. "

A series of Video Clips from a surveillance camera installed by Z4 (R4's Power of Attorney for Healthcare/POA) inside R4's room and time stamped 2/7/26 at 7:23 AM, 7:24 AM, 7:29 AM show E4 (Care Manager) entering and changing R4's incontinent brief and inserting pants on R4's feet, and at 8:10 AM showing R4 by herself in the room lying on the bed with both legs dangling on the side of the bed wearing a top and adult incontinent briefs and pants by her ankles. The next footage time stamped 2/7/26 at 9:37 AM shows E4 and E7 (Care staff) entering the room with R4 in the same position on the previous footage and starting to assist R4 to sit up. The video footages show R4 was left unattended from 8:10 AM until 9:37 AM,halfway lying in bed with legs hanging on one side of the bed and pants down her lower legs providing entrapment if R4 attempted to get up and walk.

A video clip time stamped 2/8/26 at 5:03 PM, shows R4 being brought in by E6/Care Manager

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A4060	Continued From page 10	A4060		

wearing a grey sweatshirt and pants and left sitting in bed and a second footage time stamped 2/8/26 at 10:19 PM showing R4 lying on the floor on her left side next to the bed now wearing blue top and pants and E10 and E11, both Care Managers entering the apartment to assist R4. No video footage were presented to provide information what happened between those two clips and the facility failed to provide evidence that safety monitoring was provided for R4 as stated in the service plan.

On 2/19/26 at 1:10 PM, E4/Care Manager stated that on 2/7/26 which was a Saturday on the dayshift there were only 2 Care Managers on the dayshift and she left R4's room to help E12/Care Manager serve breakfast since R4 did not want to get up yet. E4 stated that R4 was assigned a staff as one on one sitter from Mondays thru Fridays due to her past aggressive behaviors but there's none on weekends so whoever works on the floor has to do close monitoring on R4 as well. E4 stated she should have finished dressing R4 and not leave her with her pants down which could have made her trip if she tried to get up since she was able to get up from bed and walk around by herself inside her apartment.

On 2/19/26 at 3:00 PM, E2/RN/Regional Nurse stated the Memory Care unit census is 19 with daily staffing of one nurse on day shift, two direct care staff on each shift and 1 direct care staff assigned as sitter for R4 from Mondays-Fridays on day shift only.

On 2/24/26 at 1:45 PM, E1/Executive Director was requested to present a working schedule for nurses and direct care staff for the Memory Care unit for January-February 2026 for the duration of the investigation but failed to do so.

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ADDINGTON PLACE OF SHILOH	429 S MAIN ST SHILOH, IL 62269

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A5000	Section 295.5000 Medication Reminders, Supervision of Self Med This Regulation is not met as evidenced by: TYPE 2 VIOLATION Section 295.5000 Medication Reminders, Supervision of Self-Medication, Medication Administration and Storage a) An establishment may provide medication reminders, supervision of self-administered medication, and medication administration as an optional service. Based on interview and record review the facility failed to prevent a Memory Care resident from being given any substance without physician order that resulted in screen positive cannabis urine drug test. This failure create a substantial probability of harm to residents in the facility. Findings include: R4's record documents R4 moved to the Memory Care unit of the facility on 10/23/25 with multiple diagnoses to include Dementia with Behavioral Disturbances and a cognitive assessment score dated 11/5/25 of stage 6 -Severe Cognitive Decline on the GDS or Global Deterioration Scale. R4's Service Plan documents Medication Administration. 8/7/25 - Present. Directions: Resident requires assist/administration	A5000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A5000	Continued From page 12	A5000		

medication more than 3x per day with 4 or fewer medications per pass.

A review of R4's Medication Administration Record for the months of January and first week of February 2026 show R4 have no physician order for any cannabinoid or related substance/s.

R4's Reportable Incident Report dated 2/4/26 documents, "5:00 PM. Description of Incident. Around 5:00 PM on 2/4/26, this community was notified by our legal counsel that per resident's family, Resident had allegedly tested positive for cannabis while in the hospital for Altered Mental Status from 2/1/26 to 2/4/26. Description of Action Taken: Internal Investigation is being conducted to determine validity of allegation. Discharge paperwork received upon return to community but there was no confirmation of positive drug screen (cannabis) noted.

R4's Hospital Drug of Abuse Screen, Urine Without Confirmation Result dated 2/1/26 1338, Final Result documents, "Component: Cannabinoids, ur Screen Positive, Presumptive CutOff 50 ng/ml Flag A.
Comment: Interpretive Data - Cannabinoids: Samples containing greater than 50 ng/mL delta-9 TCH - COOH or other cross-reactingcompounds are reported as positive. False positive and false negative results are possible. Confirmatory testing required for definitive results." (Note:A presumptive positive is a "screen positive" that requires confirmatory test to be validated as a "true positive".

On 2/19/26 at 10:45 AM, E2/Registered Nurse/Regional Nurse stated the facility requested Z5/R4's Primary Physician for a repeat Urine drug screen for R4 but has yet to receive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510103	A. BUILDING: _____ B. WING _____	C 02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF SHILOH	429 S MAIN ST SHILOH, IL 62269

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A5000	Continued From page 13 the order requested . E2 stated that it is possible for R4 to have a false positive screen result because she was receiving a combination of medications that were prescribed while R4 was at the hospital on 1/26-1/28 due to COVID. The facility was unable to provide supporting evidence to their claim of false positive result at the time of the investigation. On 2/19/26 at 11:30 AM, E1/Executive Director stated she immediately conducted an investigation into the allegation of R4's cannabis use with no conclusive evidence that R4 was given anything that would come up as positive for cannabinoid on the drug screen at the ER.	A5000		
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: 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; 2) The right to respect for bodily privacy and dignity at all times, especially during care and treatment;	A6000		

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	ASL510103	A. BUILDING: _____ B. WING _____	C 02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF SHILOH	429 S MAIN ST SHILOH, IL 62269

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A6000	Continued From page 14 3) The right to retain and use personal property, unless such use infringes on the health, safety, or welfare of other individuals, and a place to store personal items that is locked and secure; 5) The right to receive the services specified in the service plan, to review and renegotiate the service plan at any time; and to be informed of the cost of the changes; Based on interview and record review the facility failed to prevent a resident from being given any substance without physician order that resulted in screen positive cannabis urine drug test (R4) in the ER; are not left half dressed in an uncomfortable and unsafe position unsupervised; failed to ensure residents receive the services specified in the service plan for safety monitoring to prevent resident physical assault (R1) and falls (R4); failed to ensure resident property is used appropriately and the choice to have the use of resident video camera for safety is respected and upheld. These failures create a substantial probability of harm to residents in the facility. Findings include: a. R4's presumptive positive screen test for Cannabinoid. R4's Reportable Incident Report dated 2/4/26 documents, "5:00 PM. Description of Incident. Around 5:00 PM on 2/4/26, this community was notified by our legal counsel that per resident's family, Resident had allegedly tested positive for cannabis while in the hospital for Altered Mental	A6000		

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A6000	Continued From page 15	A6000		

Status from 2/1/26 to 2/4/26. Description of Action Taken: Internal Investigation is being conducted to determine validity of allegation. Discharge paperwork received upon return to community but there was no confirmation of positive drug screen (cannabis) noted.

R4's Hospital Drug of Abuse Screen, Urine Without Confirmation Result dated 2/1/26 1338, Final Result documents, "Component: Cannabinoids, ur Screen Positive, Presumptive CutOff 50 ng/ml Flag A.
Comment: Interpretive Data - Cannabinoids: Samples containing greater than 50 ng/mL delta-9 TCH - COOH or other cross-reacting compounds are reported as positive. False positive and false negative results are possible. Confirmatory testing required for definitive results." (Note:A presumptive positive is a "screen positive" that requires confirmatory test to be validated as a "true positive".

On 2/19/26 at 10:45 AM, E2/Registered Nurse/Regional Nurse stated the facility requested Z5/R4's Primary Physician for a repeat Urine drug screen for R4 but has yet to receive the order requested . E2 stated that it is possible for R4 to have a false positive screen result because she was receiving a combination of medications that were prescribed while R4 was at the hospital on 1/26-1/28 due to COVID. The facility was unable to provide supporting evidence to their claim of false positive result during the duration of the investigation.

On 2/19/26 at 11:30 AM, E1/Executive Director stated she immediately conducted an investigation into the allegation of R4's cannabis use with no conclusive evidence that R4 was given anything that would come up as positive for

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A6000	Continued From page 16	A6000		

cannabinoid on the drug screen at the ER.

b. R1 to R2 physical assault/lack of safety monitoring.

R1's record documents R1 moved into the Memory Care Unit of the facility on 3/12/25 with multiple diagnoses significant for Dementia.

R1's Service Plan documents," BEHAVIORS - AGGRESSION/ANXIOUSNESS. 08/7/25 - Present. Behaviors - Aggression/Anxiousness. Directions: Resident has present and past behaviors of physical aggression, anxiousness, uses foul language, belligerent or destructive. Use calm and gentle approach. Provide safe environment. Redirect without agitating as needed to protect the rights of other residents. Schedule: Daily @ as needed. Service Needs/Preferences: Resident has present and past behaviors of physical aggression, anxiousness, uses foul language, belligerent or destructive. Use calm and gentle approach. Provide safe environment. Redirect without agitating as needed to protect the rights of other residents. VISUAL CHECKS MC (Memory Care) General/other: 8/25/25 - PRESENT. Directions: Lay eyes on resident to ensure safety. Schedule: Daily @ 12:00 AM, 1:00 AM, 2:00 AM, 3:00 AM, 4:00 AM, 5:00 AM, 6:00 AM, 7:00 AM, 8:00 AM, 9:00 AM, 10:00 AM, 11:00 AM, 12:00 PM, 1:00 PM, 2:00 PM, 3:00 PM, 4:00 PM, 5:00 PM, 6:00 PM, 6:00 PM, 7:00 PM, 8:00 PM, 9:00 PM, 10:00 PM, 11:00 PM, As Needed."

R1's Incident Report dated 1/16/26 documents, "1/16/25 7:14 PM. Location: Dining Room. Description of Incident: (R2) was sitting in dining room socializing with other residents when (R1) walked up to him and started striking him in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510103	A. BUILDING: _____ B. WING _____	C 02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A6000	Continued From page 17 back of his head with his fist. Witnesses: Visitor. Describe Action Taken/measure initiated to reduce the possibility of future incidents: Increased behavior monitoring, medication review and monitoring residents while in common areas." R1's Service Plan, "FOLLOW UP TO ALTERCATION 01/17/26 - 01/27/26. Directions: Describe residents behavior. Schedule: Daily @ 7:00 AM - 3:00 PM, 3:00 PM - 11:00 PM, 11:00 PM - 7:00 PM. Service Need/Preferences: (Specify any needs/support with condition, and schedule appropriately if needed). On 2/19/26 at 1:10 PM, E3/Licensed Practical Nurse stated she was still in the unit when she heard the commotion and ran towards the dining room and saw R1 standing next to R2 holding R2's cane and immediately separated them for safety. E3 stated there were other residents in the dining room and one visitor who reported seeing R1 approaching R2 from behind and suddenly hit him at the back of the head with his fist. E3 added that R1 exhibited aggressive behavior towards staff in the past but no reports of being aggressive towards other residents. E3 stated both R1 and R2 were sent out for evaluation and returned from the ER with no findings and no new orders. E3 stated she noted no staff present in the dining room when the incident happened. E3 stated a staff member should have been present monitoring when residents are around in the common area. c. R4 right to be treated with dignity, right to receive services stated in service plan on safety monitoring to prevent falls, unattended, unwitnessed fall, failed to provide completed	A6000		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A6000	Continued From page 18	A6000		

dressing assist and personal property mishandling

R4's record documents R4 moved to the Memory Care unit of the facility on 10/23/25 with multiple diagnoses to include Dementia with Behavioral Disturbances.

R4's Service Plan documents, "DRESSING/GROOMING - PHYSICAL ASSIST (ADLS/DRESSING & GROOMING) 11/25/25 - Present. Directions:Requires physical assist with dressing and grooming. Gather grooming and dressing supplies, encouraging resident to select clothing. Assist resident with dressing and grooming while encouraging resident to complete as much of the task as possible. Report increasing difficulty with dressing tasks and/or safety concerns. MOBILITY- INDEPENDENT (Mobility and Transfers). Directions: Resident is independent with mobility and transfers. "

R4's Service Plan documents, " MORSE FALL SCREEN LEVEL 2. 01/30/26 - Present. Directions: Level 2 indicates the need to implement standard fall risk reduction interventions. Service Needs/Preferences: Level 2 indicates the need to implement standard fall risk reduction interventions. VISUAL CHECKS MC (Memory Care) General/other: 8/25/25 - PRESENT. Directions: Lay eyes on resident to ensure safety. Schedule: Daily @ 12:00 AM, 1:00 AM, 2:00 AM, 3:00 AM, 4:00 AM, 5:00 AM, 6:00 AM, 7:00 AM, 8:00 AM, 9:00 AM, 10:00 AM, 11:00 AM, 12:00 PM, 1:00 PM, 2:00 PM, 3:00 PM, 4:00 PM, 5:00 PM, 6:00 PM, 6:00 PM, 7:00 PM, 8:00 PM, 9:00 PM, 10:00 PM, 11:00 PM, As Needed."

A series of Video Clips from a surveillance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A6000	Continued From page 19	A6000		

camera installed by Z4 (R4's Power of Attorney for Healthcare/POA) inside R4's room and time stamped 2/7/26 at 7:23 AM, 7:24 AM, 7:29 AM show E4 (Care Manager) entering and changing R4's incontinent brief and inserting pants on R4's feet, and at 8:10 AM showing R4 by herself in the room lying on the bed with both legs dangling on the side of the bed wearing a top and adult incontinent briefs and pants by her ankles. The next footage time stamped 2/7/26 at 9:37 AM shows E4 and E7 (Care staff) entering the room with R4 in the same position on the previous footage and starting to assist R4 to sit up. The video footages show R4 was left unattended from 8:10 AM until 9:37 AM,halfway lying in bed with legs hanging on one side of the bed and pants down her lower legs providing entrapment if R4 attempted to get up and walk.

A video clip time stamped 2/8/26 at 5:03 PM, shows R4 being brought in by E6/Care Manager wearing a grey sweatshirt and pants and left sitting in bed and a second footage time stamped 2/8/26 at 10:19 PM showing R4 lying on the floor on her left side next to the bed now wearing blue top and pants and E10 and E11, both Care Managers entering the apartment to assist R4. No video footage were presented to provide information what happened between those two clips. The facility failed to provide evidence that safety monitoring was provided for R4 as stated in the service plan.

The following time stamped video clips show the video camera's position in R4's room was either moved or was blocked preventing an unobstructed view of R4's bed:

1/29/26 11:03 AM. Camera initially was facing the bed with R4 in it and E7/Care Manager entered

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510103	A. BUILDING: _____ B. WING _____	C 02/25/2026

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ADDINGTON PLACE OF SHILOH	429 S MAIN ST SHILOH, IL 62269

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A6000	Continued From page 20 and turned camera towards the wall now focused on a framed photo of 2 boys 2/1/26 5:47 AM. A bottle of drink is placed right in front of the camera blocking the view of the upper half of the bed with R4 in bed. 2/8/26 22:19 Camera view is blocked by bedsheets, at 22:18 R4 is seen lying on the floor on her left side. On 2/19/26 at 11:32 AM, E1/Executive Director stated all staff in Memory Care were reeducated to not touch the video camera in R4's room as soon as she was made aware of the issue that the camera was moved or obstructed.	A6000		
A7000	Secton 295.7000 Resident Records This Regulation is not met as evidenced by: TYPE 2 VIOLATION Section 295.7000 Resident Records a) Service delivery contracts and related documents executed by each resident or resident's representative shall be maintained by the establishment from the date of execution until three years after the date the contract is terminated. (Section 105 of the Act) b) An establishment shall maintain a resident's record that contains at least the following: 9) Notation of known accidents, incidents or injuries; Based on interview and record review the facility	A7000		

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A7000	Continued From page 21 failed to document, assess, investigate a fall incident. This failure creates a substantial probability of harm to residents in the facility. Findings include: R4's record documents R4 moved to the Memory Care unit of the facility on 10/23/25 with multiple diagnoses to include Dementia with Behavioral Disturbances. R4's Service Plan documents, "DRESSING/GROOMING - PHYSICAL ASSIST (ADLS/DRESSING & GROOMING) 11/25/25 - Present. Directions:Requires physical assist with dressing and grooming. Gather grooming and dressing supplies, encouraging resident to select clothing. Assist resident with dressing and grooming while encouraging resident to complete as much of the task as possible. Report increasing difficulty with dressing tasks and/or safety concerns. R4's Service Plan documents, " MORSE FALL SCREEN LEVEL 2. 01/30/26 - Present. Directions: Level 2 indicates the need to implement standard fall risk reduction interventions. Service Needs/Preferences: Level 2 indicates the need to implement standard fall risk reduction interventions. VISUAL CHECKS MC (Memory Care) General/other: 8/25/25 - PRESENT. Directions: Lay eyes on resident to ensure safety. Schedule: Daily @ 12:00 AM, 1:00 AM, 2:00 AM, 3:00 AM, 4:00 AM, 5:00 AM, 6:00 AM, 7:00 AM, 8:00 AM, 9:00 AM, 10:00 AM, 11:00 AM, 12:00 PM, 1:00 PM, 2:00 PM, 3:00 PM, 4:00 PM, 5:00 PM, 6:00 PM, 6:00 PM, 7:00 PM, 8:00 PM, 9:00 PM, 10:00 PM, 11:00 PM, As	A7000		

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	ASL510103	A. BUILDING: _____ B. WING _____	C 02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A7000	Continued From page 22	A7000		

Needed."

A series of Video Clips from a surveillance camera installed by Z4 (R4's Power of Attorney for Healthcare/POA) inside R4's room and time stamped 2/7/26 at 7:23 AM, 7:24 AM, 7:29 AM show E4 (Care Manager) entering and changing R4's incontinent brief and inserting pants on R4's feet, and at 8:10 AM showing R4 by herself in the room lying on the bed with both legs dangling on the side of the bed wearing a top and adult incontinent briefs and pants by her ankles. The next footage time stamped 2/7/26 at 9:37 AM shows E4 and E7 (Care staff) entering the room with R4 in the same position on the previous footage and starting to assist R4 to sit up. The video footages show R4 was left unattended from 8:10 AM until 9:37 AM,halfway lying in bed with legs hanging on one side of the bed and pants down her lower legs providing entrapment if R4 attempted to get up and walk.

A video clip time stamped 2/8/26 at 5:03 PM, shows R4 being brought in by E6/Care Manager wearing a grey sweatshirt and pants and left sitting in bed and a second footage time stamped 2/8/26 at 10:19 PM showing R4 lying on the floor on her left side next to the bed now wearing blue top and pants and E10 and E11, both Care Managers entering the apartment to assist R4. No video footage were presented to provide information what happened between those two clips. The facility failed to provide evidence that safety monitoring was provided for R4 as stated in the service plan.

On 2/19/26 at 2:20 PM, when asked for any documentation on the fall incident captured on the video footage on 2/8/26 at 10:19 PM, E1/Executive Director stated nobody reported it to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510103	A. BUILDING: _____ B. WING _____	C 02/25/2026

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ADDINGTON PLACE OF SHILOH	429 S MAIN ST SHILOH, IL 62269

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A7000	Continued From page 23 her and E1 only learned about it when the video was sent to her. E1 stated they do not have documentation on the fall incident captured on the 2/8/26 video footage.	A7000		