STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL5108201	A. BUILDING: _____ B. WING _____	C 05/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOTUS SENIOR LIVING LLC	4601 WEST YORKHOUSE ROAD WADSWORTH, IL 60083

(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 Investigation of Facility Reported Incident of 4/20/2025/IL192153 - 295.4010d)e) Investigation of Facility Reported Incident of 4/18/2025/IL191068 - 295.4010d)e) Investigation of Facility Reported Incident of 4/21/2025/IL190957 - 295.4010d)e)	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Section 295.4010 Service Plan General Violation 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). This REQUIREMENT was not met as evidenced by: Based on record review and interview, the establishment failed to review and revise a service plan following a residents fall, and failed to implement fall interventions which applies to 3 of 3 residents (R1 R2 R3) reviewed for falls in a sample of 3.	A4010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL5108201	A. BUILDING: _____ B. WING _____	C 05/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOTUS SENIOR LIVING LLC	4601 WEST YORKHOUSE ROAD WADSWORTH, IL 60083

(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
A4010	Continued From page 1 Findings include: 1. R1's Facesheet printed on 5/24/25 showed R1 is a ninety-two-year-old female resident who entered the facility on 3/11/24. R1's Observation notes showed R1 had a fall on 4/16/25 and on 4/20/25. On 5/24/25 at 2:45 PM, E3 Licensed Practical Nurse (LPN) stated during medication rounds they found R1 on the floor just inside the doorway to R1's room. R1 acquired a skin tear on their left elbow. R1 refused to go to the hospital to be evaluated at that time. E3 stated they made a progress note for the fall. On 5/24/25 at 3:00 PM, E7 Registered Nurse (RN) stated E8 Certified Nursing Assistant (CNA) reported to them R1 was found next to their bed approximately at 2:25 AM on 4/20/25. E7 stated they went to R1's room, R1 complained of multiple areas of soreness and agreed to be sent to the hospital for evaluation. R1's medical record showed no post fall assessments completed by E3 or E7 after R1's unwitnessed falls. This medical record showed no documentation of reviewing or revising R1's Service Plan after the 4/16/25 fall. On 5/24/25 at 3:05 PM, E2 Director of Health and Wellness stated R1's Service Plan was not revised after the 4/16/25 fall. Post fall assessments are the first step to determine if a Service Plan may need to be modified. A Service Plan should be reviewed in a reasonable time frame. At the most it would be 3-4 days after a fall.	A4010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL5108201	A. BUILDING: _____ B. WING _____	C 05/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOTUS SENIOR LIVING LLC	4601 WEST YORKHOUSE ROAD WADSWORTH, IL 60083

(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
A4010	Continued From page 2 2. On 5/24/2025 at 2:14PM, E3 Licensed Practical Nurse (LPN) said [R3] had a fall on the 4/21/2025 and she was working that day. E3 said she was called to respond to a fall and found [R3] in a resident room with a hematoma and swelling around his right eye. E3 said [R3] could not articulate what had occurred. E3 said [R3] was sent out to the hospital for evaluation. R3's Pre-Admission Clinical Assessment dated 2/10/2025 states. . . 2. Fall Risk Evalutation. . . resident has a history of falling in the past 6 months OR resident and/or residents family has expressed concern over resident's potential to fall - 10 points. . . (10+ High Risk), total score of 10. 3. On 5/24/2025 at 11:56AM, E4 Certified Nursing Assistant (CNA) said [R2] had a fall 4/18/2025. E4 said [R2] was found in her room on the floor. R2's progress notes dated 2/10/2025 and 4/18/2025 state R2 had a fall in the facility on those dates. On 5/24/2025 at 1:55PM, E1 Executive Director said she doesn't think the care plan or service plan was updated for [R2] or [R3]. E1 said she spoke with [the management company] and the charts for [R2] and [R3] had not been reviewed yet. On 5/24/2025 at 11:48AM and 2:47PM E2 Director of Health and Wellness said service plans are done upon admission, every 6 months, after a change in condition or after a fall. E2 said when a resident is deemed a high fall risk, purposeful rounding is done every 2 hours. E2 said the interventions in [R3's] care plan were not correct. E2 said the care plan or service plan	A4010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL5108201	A. BUILDING: _____ B. WING _____	C 05/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOTUS SENIOR LIVING LLC	4601 WEST YORKHOUSE ROAD WADSWORTH, IL 60083

(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
A4010	Continued From page 3 should direct staff on what interventions should be completed and this one does not. E2 said a service plan should be updated within a couple days following a fall. E2 said they do not have documentation of purposeful rounding being completed and that needs to be worked on. The facility failed to provide documentation showing a service plan or care plan was updated for R1 (4/16/2025), R2 (2/10/2025), and R3 following their falls or had interventions in place for the resident at the time of the fall. The facility provided Service Plan policy dated 12/13/2024 states. . . service plans are created/updated. . . whenever there is a significant change in resident status. . . The facility provided Falls policy dated 12/13/2024 states. . . a post - fall assessment is completed after any witnessed, reported, or suspected fall. . . the post fall assessment includes a list of possible interventions to be implemented	A4010		