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	ASL5105850	A. BUILDING: _____ B. WING _____	C 04/20/2026

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SUNRISE OF WESTMONT	407 W 63RD ST WESTMONT, IL 60559

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A 000	Initial Comment Complaint Investigation IL00201024/ 2673799 295.3020 b) 4) IL00201031/ 2673809 295.4010 d) e) 295.6000 a) 13) IL00200185/ 2671879 295.4060 h) 4) 6) 295.6000 a) 13) 295.6010 a) 1) Entity Reported Incident Investigation IL00200563- No deficiency cited. IL00200521 295.4010 d) e) 295.6000 a) 13) IL00201241- No deficiency cited.	A 000		
A3020	Section 295.3020 Employee Orientation and Ongoing Training This Regulation is not met as evidenced by: VIOLATION Section 295.3020 Employee Orientation and Ongoing Training b) Each employee shall also complete orientation within 30 days after the starting date of employment that includes: 4) The employee's job responsibilities and limitations; This requirement is not met as evidenced by:	A3020		

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A3020	Continued From page 1 Based on interview and record review, the establishment failed to ensure employee follow employee responsibility as stated on the employees' Essential Duties affecting three (R2, R3, R10) of seven residents reviewed. This deficient practice has the probability of affecting all residents. Findings include: On 4/13/26 at 2:28pm, R3 stated, generally all the aides are excellent except for one staff that she had an issue. R3 did not elaborate what exactly happened. R3 identified the staff as E9 (Care Manager). On 4/13/26 at 4:16pm E2 (Resident Care Coordinator) said, R3 had concern with E9. E9 was late and R3 became aggravated when E9 did not get the exact clothes R3 wanted to wear. E9 was counselled to provide choices to resident and will no longer be assigned to R3. E9 called another coworker to work with R3 so as not to upset the resident more. On 4/13/26 at 4:27pm, E9 (Care Manager) said, R3 was upset because E9 was late. E9 gave the reason for being late however, R3 said "I do not care", and will no longer need shower". R3 demanded to have night gown, and when E9 gave the wrong one, R3 became more upset and said, "Are you stupid?" E9 said R3 was verbally abusive and combative, so E9 called for co-worker to come in and relieve her. E9 said, "I said, that was not how you talk to people who care for you, she started crying. That was not nice." E9 said R3 answered, "No care manager has ever treated me this way." E9 said, "It was not my intention to make her upset, she was crying and loud...."	A3020		

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A3020	Continued From page 2 On 4/14/26 at 11:05am, E12 (Care Manager) said she did not witness the incident between E9 (Care Manager) and R3. E12 said E9 kept on calling, so E12 went to R3's apartment. E12 said, "R3 and E9 were yelling at each other, R3 told E12 "We are being nasty to each other. E12 said, if a resident is refusing, do not engage and call for another staff to help. She did that but it was too late." E12 said, she sent E9 out and helped R3. E12 said, "In my training, if you and a resident have issue, ask another staff to step in let them take over. Do not yell, do not engage. Deescalate the situation." E9's documents titled "Job Responsibilities" stated in part; Essential Duties: Resident Care -Strive to understand and respond to each resident with empathy, always remaining mindful of the resident's unique communication patterns or history, and basic human needs -Maintain an atmosphere of warmth, personal interest and positive emphasis as well as calm environment. On 4/13/26 at 10:47am, R2 indicated E18 (Care Manager) takes a long time, an hour to respond to pendant call. Review of E18's employee file documented, E18 was given verbal warning. "It was reported that (R10's apartment number) pendant was reset while sitting in the hallway and TM (Team Member) told resident she would be right back after she got the sit to stand. Resident was still sitting in the hall when overnight came due to TM never returning to the resident. On 4/15/26 at 12:55pm, R10 was observed in	A3020		

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A3020	Continued From page 3 room. R10 uses wheelchair and requires assistance from staff. R10 said call lights response getting better. E18's documents titled "Job Responsibilities" stated in part; Essential Duties: Resident Care -Respond to security system and resident call bells promptly and immediately. Takes appropriate actions including resetting call bells.	A3020		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: TYPE 1 VIOLATION Section 295.4010 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) 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). These requirements are not met as evidenced by:	A4010		

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A4010	Continued From page 4 Based on interview and record review, the establishment failed to follow resident's fall service plan, as well as failed to assess, revise and implement intervention for mobility and transfer requirements to prevent fall resulting to fall with major injury for one (R4) of three residents reviewed. This deficient practice has created the substantial probability of causing severe harm or death to 1 or all residents. Findings include: According to R4's documents, R4 moved to the community on 7/3/25. R4's diagnoses include but are not limited to Major Depressive Disorder, Low back pain, Thalassemia and Unspecified Weakness. R4's cognitive assessment completed on 9/11/25, - FAST (Functional Assessment Staging of Alzheimer's Disease) score was 4 which indicate Mild Dementia. R4 was admitted to hospice care on 1/20/26 with primary diagnosis of End Stage anemia. R4's nursing note dated 2/17/26 documented," Writer was requested by Care Manager to come to resident's suite. Upon arrival at the suite, resident was observed lying on the floor, on (R4) left side. Resident's left arm at the wrist, was noted with actively bleeding, with the bone/tendons, exposed and the wrist at a backward facing 90degree angle. Resident noted fully dressed, with socks on. Resident states (R4) had finished using the bathroom and reached for the door handle when she fell. Resident's wrist was supported with towels stacked underneath it for support. While writer telephoned 911 (2/17 @ 1245a.m.) & (Hospice RN), 2/17/26 @ 12:44a.m.), resident remained on the floor under direct supervision of the Care manager. ..." On 4/15/26 at 9:14am, E8 (Care Manager) whose	A4010		

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A4010	Continued From page 5	A4010		

shift starts at 10pm, said on the day of incident E8 noticed R4's pendant call was on through the staff work phone. As R4 was not assigned to E8, and another staff was assigned to care for R4, E8 continued to round and attend to assigned residents. As timed passed by and R4's pendant call remained on, E8 was concern for R4, because R4 was a known fall risk, and the pendant call has been "on for hours". E8 said on (E8's) way back to the office, E8 heard banging on R4's apartment's wall. E8 went inside R4's apartment, R4 was found in the bathroom, fell from wheelchair, lying on the floor bleeding, arm was broken, R4 was screaming and asking for help. E8 said, unknown how long R4 has been on the floor. E8 was unable to determine the exact time E8 found R4 on the floor, E8 said, "after 11:30pm". E8 said, when R4 pressed the pendant it means, R4 had fallen. E8 said, "They told us to check (R4) every 1-2 hours. (R4) is x1 person assist to the toilet, and to transfer. (R4) cannot propel own wheelchair. "That is why I was wondering how (R4) got into bathroom. I think (R4) transferred self to wheelchair to go the bathroom because if someone was with (R4), they would have cleared the call light." E8 said, when a resident pendant is on, resident's apartment and name will appear on the work phone. Staff were also instructed to answer pendant calls, whoever staff is available.

On 4/15/26 at 4:08pm, E17 (Care Manager) was the staff assigned to R4 on 2/17/26. E17 said E17 checked R4 around 10:30pm-11:00pm. R4 was on the wheelchair and pm staff were supposed to put R4 on the bed, or if they did, R4 could have transferred self to the wheelchair. After putting R4 to bed, E17 went upstairs and assisted another resident. E17 said a call was on for apartment 215, when E17 checked the apartment, it was

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A4010	Continued From page 6	A4010		

empty. E17 later learned from the manager that resident's name will also appear on the phone together with the resident apartment. E17 said, she did not see R4's name on the phone. E17 was asked if there were more (R4's name) on her assigned list, E17 claimed she was not familiar with residents' names, more familiar with apartment numbers. Per E17, while E17 was attending to another resident, E8 paged for her to go to R4's apartment. In the apartment, R4 was noted on the floor with broken hand. On a previous interview with E17 on 4/15/26 at 9:00am, E17 said R4 was full assistance for toileting, does not push pendant to call, wakes in the middle of the night roaming, unbeknownst to staff. E17 said R4 required staff assistance to push R4's wheelchair.

E17's employee documents titled "Job Description" stated in part:
Essential Duties
Resident Care:
-Respond to security system and resident call bells promptly and immediately. Take immediate action including resetting call bells.

According to R4's Nurses notes, (2/17/26) R4 was evaluated and diagnosed at the Emergency Department with Non acute C3 Fracture and open hand fracture. R4 returned to the community on 2/18/26. On 2/20/26 R4 expired.

On 4/15/26 at approximately 1:35pm, E1 (Executive Director) said R4's pendant call log requires go signal for release from Corporate. E1 said there was no policy and procedure for pendant call/call light.

Establishment's Incident investigation documented:

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A4010	Continued From page 7 "Timeline of Events: o 10:30 PM (2/16/26): Resident reported leg pain in hallway; assisted back to bed by care staff (E17); nursing notified. (statement from staff member) ~10:30 PM: Resident activated pendant requesting pain medication. (visible on call log) 10:42 PM: Nursing responded and administered Norco; pendant not cleared. (PCC documentation) o 10:45 PM - 12:00 AM: Staff continued resident care duties; pendant remained active and not cleared. (visible on call log shows not cleared) ~12:00AM (2/17/26): Staff heard resident calling out from apartment. (statements from staff members) ~12:29 AM: Resident found on bathroom floor following fall; nursing notified. (PCC documentation) 12:45 AM Emergency services (911) contacted. (PCC documentation) 1:00 AM: Pendant cleared. (visible on call log)" While R4's pendant call was on from 10:42pm when the nurse administered the medication to the time of fall 12:29am, the pendant call was not answered and cleared, for a total close to two hours. During this time R4 would have had no means of asking for assistance, as the pendant call was already on and remained unanswered by staff. E1 was asked about this concern. On 4/15/26 at 3:48pm, E1 was asked, if the pendant call was not cleared, how would staff know and respond if the resident needed assistance, E1 answered, they wouldn't know, since the pendant call once it is pressed, it will be on, and resident will not be able to press it again. There is no way of knowing that in between the time the nurse went to administer the medication, up to time of discovering the resident on the floor, if resident required any assistance, as the call light remained on, and no one had responded or cleared the pendant call.	A4010		

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A4010	Continued From page 8 There was discrepancy on R4's Service plan and the interview of E8 and E17. These staff indicated R4 was full assist with toileting and uses wheelchair. R4's Service Plan (undated) documented: Focus- Mobility/Transferring Needs Interventions: I am independent with mobility (Date initiated: 7/3/25) I am independent with transferring (Date initiated: 7/3/25) I need walker to assist with mobility/transferring (Date initiated: 7/3/25). Service plan also indicated: Focus: Toileting Assistance/ Incontinence care needs Interventions: I need physical assist of 1 person with toileting assistance and incontinence care (Date initiated 9/25/25) Focus: I have an actual fall Interventions (not limited to the following): -Check on me at frequent intervals to see if I need any assistance and to offer me reassurance -Encourage me to press my pendant or pull cord for assistance prior to attempting to get out of bed on my own. R4 had several documented fall incidents on 8/14/25 12:00pm (unwitnessed), 8/18/25 12:00am, 1/1/26 3:00pm, 1/8/26 12:20am (unwitnessed) complained of shoulder pain ,1/28/26 2:55pm, 2/14/26 4:45am (unwitnessed), 2/15/26 1:40am (unwitnessed).	A4010		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs	A4060		

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A4060	Continued From page 9 This Regulation is not met as evidenced by: TYPE 1 VIOLATION Section 295.4060 Alzheimer's and Dementia Programs h) An establishment that offers to provide a special program for persons with Alzheimer's disease and related disorders shall: 4) Provide coordination of communications with each resident, resident's representative, relatives and other persons identified in the resident's service plan; 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 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; These requirements are not met as evidenced by: Based on interview and record review, the establishment failed to report, assess and provide intervention for one resident's (R5) injury (forehead contusion) resulting to delay in care. The establishment also failed to notify resident representative of the injury. This deficient practice	A4060		

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has created the substantial probability of severe harm or death to 1 or all residents.

Findings include:

According to R5's Face sheet. R5 is 85 years old. R5's diagnoses include but are not limited to Unspecified Dementia, Generalized Osteoarthritis and Unspecified Depression. R5 moved to the community on 11/4/24. Nurse's notes indicated R5 moved out on 2/10/26.

On 4/14/26 at 9:12am and at 11:23am, Z1 (Family Member) was interviewed. According to Z1, on 2/6/26 R5's other daughter went to visit R5 in memory care and observed contusion to R5's forehead. When R5's daughter asked the staff what caused R5's injury, no staff was able to provide an answer. As there was a Ring camera installed inside R5's apartment, Z1 went back to view video footages. According to Z1, on 2/4/26 at 6:36pm an aid of Indian American (From India) descent was seen wheeling R5 to the bathroom, at that time there was no bruise on R5's forehead. The aid took R5 to the bathroom to shower. At 6:52pm, R5 was heard from the camera audio saying, "That looks really bad, I hit my head". The Aid said, "That looks really bad." At 6:57pm, R5 and the Aid came out of bathroom, this time a bruise on R5's forehead was noted. Z1 described the bruise as "about 4 inches long about one-inch wide, right smack in the middle of forehead." The aid was seen assisting R5 from wheelchair to easy chair and left the room. Z1 said, no one checked R5 for the rest of the night. The next morning on 2/5/26 at about 8am, staff assisted R5 up for breakfast, they got R5 dressed "and they did not do anything" they did not report about the bruise not until 2/6/26 at 11am, when R5's other daughter brought R5 to the nursing

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A4060	Continued From page 11	A4060		

station. Z1 said, Z2 (Power of Attorney) was not aware of the bruise, the daughter who discovered the bruise called the family after which, the family called establishment to ask about the bruise. Z1 said it was only this time that the establishment notified Z2.

There was no documentation pertaining to the bruise until 2/6/26 12:15pm. This nursing note documented "Staff noted a dark purplish discoloration on the resident's forehead. When asked what happened, the resident stated in front of her (daughter) that she went to the bathroom overnight and hit her head on the edge. When asked if she's in pain, the resident stated, "No, I'm fine." RCD, (POA) and (Nurse Practitioner-NP) were notified. NP ordered to do neuro checks for the next 72 hours and monitor unless family wants her to go out for scan. POA made aware of new order." Succeeding notes documented R5 went to Emergency Room for evaluation.
Z1 said, R5 was a poor historian. Z1 also said the ER physician indicated R5 could have had concussion but due to the time passed and R5's dementia, it was difficult to diagnose.

On 4/14/26 at 10:31am, E2 (Resident Care Coordinator) said on Friday 2/6/26 around 11-11:30 E2 received a call from Memory Care about R5's bruise. R5's family questioned it. E2 said, "I went to see R5 and observed visible bruise, "clearly see the bruise". E2 then talked to nurse and Care Managers. Nurse was aware of the bruise but has not done anything yet. E2 called R5's family to look at the camera to figure out the origin of bruise because there was no documentation about it. The doctor advised R5's family to bring R5 to ER for evaluation, while R5 was there, the family said they went back and watched the footage. They discovered E25

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A4060	Continued From page 12 (Terminated Care Manager) went in to bring resident to shower when they went into the bathroom, R5 had no bruise, when resident came out with Care Manager, R5 had a noticeable bruise on the forehead, "you can see on the camera clearly there is no question". E2 said, at that point, E25 was put on leave immediately. Staff were in-serviced for reporting injury. E25 denied seeing any bruise, denied anything happened while they were in the bathroom. E2 said R5 did not remember what happened. R5 was easy going but could not really say. E25 was terminated. On 4/14/26 at 12:47pm, E2 said from 2/4 to 2/6 no one reported bruise and no one assed R5. Staff who worked on 2/5/26 were aware of the bruise. E2 said, "They should call the nurse and report it, so the nurse can assess and follow protocol. E25's employee documents titled "Job Description" stated in part: Essential Duties Resident Care: -Observes, reports, and documents, symptoms and conditions of residents for changes in condition such as skin, behavior, alertness	A4060		
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,	A6000		

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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 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: 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; This requirement is not met as evidenced by: Based on interview and record review, the establishment failed to provide a safe environment resulting in a fall with major injury (Hand Fracture) for one (R4) resident. The establishment also failed to report injury causing delay in resident assessment and intervention for one (R5) resident's head injury. This failure creates the substantial probability of severe harm or death to 1 or all residents. Findings include: An onsite visit was conducted on 4/13, 4/14 and 4/15/26. According to R4's documents, R4 moved to the community on 7/3/25. R4's diagnoses include but are not limited to Major Depressive Disorder, Low back pain, Thalassemia and Unspecified Weakness. R4's FAST (Functional Assessment Staging of Alzheimer's Disease) completed on 9/11/ score was 4 which indicate Mild Dementia. R4 was admitted to hospice care on 1/20/26 with primary diagnosis of End Stage anemia. R4 expired on 2/20/26.	A6000		

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	ASL5105850	A. BUILDING: _____ B. WING _____	C 04/20/2026

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A6000	Continued From page 14 R4's nursing note dated 2/17/26 documented," Writer was requested by Care Manager to come to resident's suite. Upon arrival at the suite, resident was observed lying on the floor, on (R4) left side. Resident's left arm at the wrist, was noted with actively bleeding, with the bone/tendons, exposed and the wrist at a backward facing 90degree angle. Resident noted fully dressed, with socks on. Resident states (R4) had finished using the bathroom and reached for the door handle when she fell. Resident's wrist was supported with towels stacked underneath it for support. While writer telephoned 911 (2/17 @ 1245a.m.) & (Hospice RN), 2/17/26 @ 12:44a.m.), resident remained on the floor under direct supervision of the Care manager. ..." On 4/15/26 at 9:14am, E8 (Care Manager) whose shift starts at 10pm said on the day of incident E8 noticed R4's pendant call was on through the staff work phone. As R4 was not assigned to E8, E8 continued to round assigned residents. E8 said, at that time, E8 was concern of R4 because R4 was a known fall risk, and the pendant call has been "on for hours". As E8 was going back to the office, E8 heard banging on R4's apartment's wall. E8 went inside R4's apartment, R4 was found in the bathroom, fell from wheelchair, lying on the floor bleeding. Arm was broken, R4 was screaming and asking for help. E8 said, unknown how long R4 has been on the floor. E8 was unable to determine the exact time R4 was found on the floor, E8 said, "after 11:30pm". E8 said, when R4 pressed the pendant it means, R4 had fallen .... "They told us to check (R4) every 1-2 hours. (R4) is x1 person assist for toilet, and transfer. (R4) cannot propel own wheelchair. "That is why I was wondering how (R4) got into bathroom. I think (R4) transferred self to wheelchair to go the bathroom because if	A6000		

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A6000	Continued From page 15	A6000		

someone was with (R4), they would have cleared the call light." E8 said, when a resident pendant is on, the resident's apartment number and name will appear on the staff work phone. Whoever staff was available must answer pendant call.

On 4/15/26 at 4:08pm, E17 (Care Manager) was interviewed. E17 was the staff member assigned to R4 on 2/17/26. E17 said E17 checked on R4 around 10:30pm-11:00pm. R4 was on the wheelchair and pm staff were supposed to put R4 to bed, or if they did, R4 could have transferred self to the wheelchair. After putting R4 to bed, E17 went upstairs and attended to another resident. E14 said a pendant call was on for apartment 215, when E17 went to check the apartment, it was empty. E17 later learned from the manager that resident's name will also appear on the phone together with the resident apartment number when pendant call was pressed. E17 said, she did not see R4's name on the phone. E17 was asked if there were more residents with the same name as R4 on her assigned list, E17 claimed she was not familiar with residents' names, more familiar with apartment numbers. E17 said, while attending to another resident, E8 paged for her to go to R4's apartment. In the apartment R4 was noted on the floor with broken hand. On a previous interview with E17 on 4/15/26 at 9:00am, E17 said R4 was full assistance for toileting, does not push pendant to call, wakes in the middle of the night roaming without staff's knowledge. E17 said R4 needs assistance to push R4's wheelchair.

E8 said, if it appeared on the work phone pendant call as 215- which was not R4's apartment number, R4's name will still be on the phone screen.

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A6000	Continued From page 16 According to R4's Nurses notes dated 2/17/26 R4 was evaluated and diagnosed at the Emergency Department with Non acute C3 Fracture and open hand fracture. R4 returned to the community on 2/18/26. On 2/20/26, R4 expired. On 4/14/26 at 12:47pm, E2 (Resident Care Coordinator) said, R4 started to decline by the end of December 2025 and middle of January 2026. R4 started to get more confused, needing more care. E2 also confirmed that R4 required x1 assist for transfer for safety reason. "If you leave (R4) in the chair, (R4) could transfer but not stable, so it meant it was not safe that was why (R4) needed x1 for safety. Mobility- right before the fall happened (R4) was on a wheelchair most of the time. For toileting needs, (R4) needed one person assist, however R4 was not consistent in using call button to call for assistance. On 4/15/26 at approximately 1:35pm, E1 (Executive Director) said R4's pendant call log requires go signal for release from Corporate. E1 said there was no policy and procedure for pendant call/call light. Establishment's Incident investigation documented: "Timeline of Events: o 10:30 PM (2/16/26): Resident reported leg pain in hallway; assisted back to bed by care staff (E17); nursing notified. (statement from staff member) ~10:30 PM: Resident activated pendant requesting pain medication. (visible on call log) 10:42 PM: Nursing responded and administered Norco; pendant not cleared. (PCC documentation) o 10:45 PM - 12:00 AM: Staff continued resident care duties; pendant remained active and not cleared. (visible on call log shows not cleared) ~12:00AM (2/17/26): Staff heard resident calling	A6000		

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A6000	Continued From page 17 out from apartment. (statements from staff members) ~12:29 AM: Resident found on bathroom floor following fall; nursing notified. (PCC documentation) 12:45 AM Emergency services (911) contacted. (PCC documentation) 1:00 AM: Pendant cleared. (visible on call log)" While R4's pendant call was on/ active from 10:42pm, when the nurse administered the medication to the time of fall at 12:29am, the pendant call was not answered and cleared, for a total close to two hours. As pendant call is used by residents to request assistance, R4 would have had no means of asking for assistance, as the pendant call was already on/active and remained unanswered by staff. During this time, R4's condition inside the apartment was also unknown, since no one checked on R4. E1 was asked about this concern. On 4/15/26 at 3:48pm, E1 was asked, if the pendant call was not cleared, how would staff know and respond if the resident needed assistance, E1 answered, they wouldn't know, since the pendant call once it is pressed, it will be on, and resident will not be able to press it again. There is no way of knowing that in between the time the nurse went to administer the medication, up to time of discovering the resident on the floor, if resident required any assistance, as the call light remained on, and no one had responded or cleared the pendant call. E17's employee documents titled "Job Description" stated in part: Essential Duties Resident Care: -Respond to security system and resident call bells promptly and immediately. Take immediate action including resetting call bells.	A6000		

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A6000	Continued From page 18 R4's undated Service plan documented Focus: Toileting Assistance/ Incontinence care needs Interventions: I need physical assist of 1 person with toileting assistance and incontinence care (Date initiated 9/25/25). Focus: I have an actual fall Interventions (not limited to the following): -Check on me at frequent intervals to see if I need any assistance and to offer me reassurance -Encourage me to press my pendant or pull cord for assistance prior to attempting to get out of bed on my own. Both interventions were not followed. R4 had several documented fall incidents: 8/14/25 12:00pm (unwitnessed), 8/18/25 12:00am, 1/1/26 3:00pm, 1/8/26 12:20am (unwitnessed) complained of shoulder pain 1/28/26 2:55pm, 2/14/26 4:45am (unwitnessed), 2/15/26 1:40am (unwitnessed). Establishment's document titled "Abuse, Neglect, &Exploitation- Prevention, Reporting, and Investigation stated in part "Neglect: the failure to provide goods and services necessary to protect the resident from health and safety hazards." According to R5's Face sheet. R5 is 85 years old. R5's diagnoses include but are not limited to Unspecified Dementia, Generalized Osteoarthritis and Unspecified Depression. R5 moved to the community on 11/4/24. Nurse's notes indicated R5 moved out on 2/10/26. On 4/14/26 at 9:12am and at 11:23am, Z1 (Family Member) was interviewed. According to Z1, on 2/6/26 R5's other daughter went to visit R5 in memory care and observed contusion to R5's forehead. When R5's daughter asked the staff what caused R5's injury, no staff was able to	A6000		

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A6000	Continued From page 19	A6000		

provide an answer. As there was a Ring camera installed inside R5's apartment, Z1 went back to view video footages. According to Z1, on 2/4/26 at 6:36pm an aid of Indian American (From India) descent was seen wheeling R5 to the bathroom, at that time there was no bruise on R5's forehead. The aid took R5 to the bathroom to shower. At 6:52pm, R5 was heard from the camera audio saying, "That looks really bad, I hit my head". The Aid said, "That looks really bad." At 6:57pm, R5 and the Aid came out of bathroom, this time a bruise on R5's forehead was noted. Z1 described the bruise as "about 4 inches long about one-inch wide, right smack in the middle of forehead." The aid was seen assisting R5 from wheelchair to easy chair and left the room. Z1 said, no one checked R5 for the rest of the night. The next morning on 2/5/26 at about 8am, staff get R5 up for breakfast, they got R5 dressed "and they did not do anything" they did not report about the bruise not until 2/6/26 at 11am, when R5's other daughter brought R5 to the nursing station. Z1 said, Z2 (Power of Attorney) was not aware of the bruise, the daughter who discovered the bruise called the family after which, the family called establishment to ask about the bruise. Z1 said it was only this time that the establishment notified Z2.

There was no documentation pertaining to the bruise until 2/6/26 12:15pm on R5's nursing notes, this nursing note documented "Staff noted a dark purplish discoloration on the resident's forehead. When asked what happened, the resident stated in front of her (daughter) that she went to the bathroom overnight and hit her head on the edge. When asked if she's in pain, the resident stated, "No, I'm fine." RCD, (POA) and (Nurse Practitioner- NP) were notified. NP ordered to do neuro checks for the next 72 hours

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A6000	Continued From page 20	A6000		

and monitor unless family wants her to go out for scan. POA made aware of new order." Succeeding notes documented R5 went to Emergency Room for evaluation.

Z1 said, R5 was a poor historian. Z1 also said the ER physician said that R5 could have had concussion but due to the time passed and R5's dementia, it was difficult to diagnose.

On 4/14/26 at 10:31am, E2 (Resident Care Coordinator) said on Friday 2/6/26 around 11-11:30 E2 received a call from Memory Care about R5's bruise. R5's family questioned it. E2 said, "I went to see R5 and observed visible bruise, "clearly see the bruise". E2 then talked to nurse and Care Managers. Nurse was aware of the bruise but has not done anything yet. E2 called R5's family to look at the camera to figure out the origin of bruise because there was no documentation about it. The doctor advised R5's family to bring R5 to ER for evaluation, while R5 was there, the family said they went back and watched the footage. They discovered E25 (Terminated Care Manager) went in to bring resident to shower when they went into the bathroom, R5 had no bruise, when resident came out with Care Manager, R5 had a noticeable bruise on the forehead, "you can see on the camera clearly there is no question". E2 said, at that point, E25 was put on leave immediately. Staff were in-serviced for reporting injury. E25 denied seeing any bruise, denied anything happened while they were in the bathroom. E2 said R5 did not remember what happened. R5 was easy going but could not really say. E25 was terminated.

On 4/14/26 at 12:47pm, E2 said from 2/4 to 2/6 no one reported bruise and no one assed R5.E2

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A6000	Continued From page 21 said, staff who worked on 2/5/26 were aware of the bruise. E2 said, "They should call the nurse and report it, so the nurse can assess and follow protocol.	A6000		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr This Regulation is not met as evidenced by: TYPE 1 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. 2) Investigate and develop a written report within 14 days after the initial report. The establishment shall send the written report to the Department 24 hours after it is completed and shall maintain a copy of the written report on the premises for 12 months after the date of the report. c) Establishment employees and volunteers	A6010		

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A6010	Continued From page 22 are obligated to report abuse, neglect, or financial exploitation of a resident to the establishment management and to the Department. These requirements were not met as evidenced by: Based on interview and record review the establishment failed to report and investigate in a timely manner one (R5) resident's bruise on the forehead. This failure creates the substantial probability of severe harm or death to 1 or all residents. Findings include: According to R5's Face sheet. R5 is 85 years old with diagnoses of but not limited to Unspecified Dementia, Generalized Osteoarthritis and Unspecified Depression. R5 moved to the community on 11/4/24. Nurse's notes indicated R5 moved out on 2/10/26. On 4/14/26 at 9:12am and at 11:23am, Z1 (Family Member) was interviewed. According to Z1, on 2/6/26 R5's other daughter went to visit R5 in memory care and observed contusion to R5's forehead. When R5's daughter asked what happened to R5, no staff were able to provide an answer. No documentation pertaining to R5's bruise until 2/6/26 12:15pm nursing notes. It documented "Staff noted a dark purplish discoloration on the resident's forehead. When asked what happened, the resident stated in front of her (daughter) that she went to the bathroom overnight and hit her head on the edge. When asked if she's in pain, the resident stated, "No, I'm fine." RCD, (POA) and (Nurse Practitioner- NP) were notified. NP	A6010		

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A6010	Continued From page 23 ordered to do neuro checks for the next 72 hours and monitor unless family wants her to go out for scan. POA made aware of new order." Succeeding notes documented R5 went to Emergency Room for evaluation. On 4/14/26 at 12:47pm, E2 (Resident Care Coordinator) said from 2/4 to 2/6 no one reported bruise and no one assed R5. Staff who worked on 2/5/26 were aware of the bruise. E2 said, "They should call the nurse and report it, so the nurse can assess and follow protocol. This incident was only investigated and reported to state agency after R5's family discovered the bruise on 2/6/26. According to Z1 a camera with audio was installed in R5's apartment. On 2/4/26 a staff member was seen bringing R5 to bathroom to shower. There was no visible bruise on R5's forehead as seen on the footage. When staff and R5 returned to where the camera was located, there was a noticeable bruise on R5's forehead. The whole day of 2/5/26 and morning of 2/6/26, not one of the staff members reported and checked what caused the bruise on R5's forehead, to rule out resident abuse. Initial Report of this incident was sent to state agency on 2/6/26.	A6010		