STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510362	A. BUILDING: _____ B. WING _____	C 03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRA VISTA OF OAKBROOK TERRACE, LLC	1635 S ARDMORE AVENUE OAKBROOK TER, IL 60181

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A 000	Initial Comment Facility Reported Incident Investigation IL00200204- 295.4010 d) h)	A 000		
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) h) The service plan shall include all support services provided or arranged for by the establishment. These requirements were NOT met as evidenced by: Based on observation, interview and record review, the establishment failed to incorporate support services such as hospice care as stated on their policy and procedures for three (R2, R3) residents. The establishment also failed to revise and implement fall interventions that reflect the current resident needs including but not limited to resident supervision, affecting three (R2, R3) of four residents reviewed for falls. This failure resulting in multiple falls with or	A4010		

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A4010	Continued From page 1	A4010		

without injury.
This deficient practice has created the substantial probability to cause severe harm to residents who are cognitively impaired and has history of Dementia.

Findings include:

1. According to R2's Electronic Health Record (EHR), R2 is 81 years old. R2 moved to Memory care on 9/30/24. R2's diagnoses include but not limited to History of falling, Parkinson's disease, Type 2 diabetes mellitus without complications, and Orthostatic hypotension. R2's Fall Risk Assessment score dated 1/1/26 was 31, a score of >13 is a high risk for fall. R2's FAST (Functional Assessment Staging) dated 1/1/26 indicated (6e) Moderately severe Dementia. R2 is admitted on Hospice care.

On 3/3/26 at 10:31am, R2 was observed in the activity area with peers. R2 was seated on a specialized geriatric chair. According to E4 (Caregiver Mentor), R2 is unable to walk but able to stand. R2 was unable to answer questions appropriately.

R2's notes documented the following falls:
-4/24/25 9:50pm- fall inside apartment.
-5/19/25 3:36pm-fall inside apartment.
-7/4/25 7:33pm- fall hallway, walking too fast to catch up with wife, bleeding from bridge of nose and mouth...
-8/21/25 3:02pm- fall/ hallway
-10/13/25 11:00am - resident's room, no injury- At approximately 11 am, this writer was notified that the resident was sitting on the floor in his room.
-10/19/25 7:30am- resident room no injury.
-12/15/25 4:30pm- hallway, no injury.
-1/2/26 2:46pm- hallway, no injury

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A4010	Continued From page 2 -1/17/26 unwitnessed fall around 1630. Upon the way to dining area, the resident was observed laying on the supine position on the floor ...bump noted to the forehead, laceration to right corner of right eye, and right corner of right Lower Lip. The resident was unconscious, taken to hospital .... returned to the establishment with wound stitches. -1/27/26 11:17pm caregiver he was explaining an assignment to another caregiver when the resident fell backwards in his chair ...breathing but unresponsive to calling his name and sternal rub. The resident remained unresponsive but breathing even after paramedics arrived. -2/1/26 12:19pm- resident was found on the floor. Fall was unwitnessed. Per caregiver report, caregiver had stepped away to assist other residents. Another caregiver later found the resident lying on his back on the floor ... -2/19/26 9:34Pm resident had a fall and was found on the floor. Upon arrival to the scene, the resident was observed sitting in his Broda chair ...Upon inquiry, the assigned caregiver reported she was in the spa room assisting another resident at the time of the incident. A fellow caregiver found the resident lying on his left side on the floor. Per caregiver report, the resident got up from the floor independently ... -2/26/26 6:06am observed lying on the dining room floor. It appears resident ambulated independently from his room to the dining room prior to being found. R2's service plan dated 3/3/26, documented: Safety /Falls- Description of assistance: Remain in common areas during waking hours, round. Mobility- Description of assistance: Needs Broda chair. 2. According to R3's EHR, R3 is 80 years old.	A4010		

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A4010	Continued From page 3	A4010		

R3's diagnoses include but are not limited to Unspecified dementia with behavioral disturbance, Type 2 diabetes mellitus with hyperglycemia, Unspecified protein-calorie malnutrition, and Essential (primary) hypertension. R3's Fall risk assessment score dated 1/1/26 was 30 a score of >13 is a high risk for fall. R3's FAST (Functional Assessment Staging) dated 1/1/26 indicated (6e) Moderately severe Dementia. R3 is admitted to Hospice care on 5/28/25 with a diagnosis of cardiovascular disease.

R3's notes documented the following falls:
-5/19/25 3:16pm found on the floor with husband, stated helping husband in the bathroom, complained of knee pain.
-5/19/25 4:24pm found on the floor, hit head.
-5/20/25 12:45am found on the floor in apartment
-5/20/25 10:45am fall inside apartment.
-5/22/25 2:24pm fall inside apartment, pain to the back of head, swelling to the back of head.
-7/31/25 12:45pm, during lunch in the dining room, lost balance and fell.
-10/13/25 11:20am, observed on the floor in room
-12/15/25 at 4:30 pm observed on the floor next to the elevator. The staff member stated the resident was walking with a shuffling gait and fell before she could get to resident.
-12/15/26 at 5:30 witnessed fall in the dining area. The caregiver stated he observed the resident fall due to shuffling gait.
-12/16/25 7:39am notified by hospice CNA that resident was on the bathroom floor. Unwitnessed fall.
-12/21/25 witness fall around 1730. Per Staff, the resident tried to get up from the wheelchair, and her left leg got caught to the rest leg of the wheelchair and fell on the floor and hit the left side of her head to the floor, hitting lips to the

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A4010	Continued From page 4	A4010		

chair in the dining room.
-1/5/26 Writer alerted by Hospice CNA at 6: 49am that resident was on the floor ...observed resident on floor in between bathroom and apartment.
-1/12/26 At approximately 9:00 am, observed lying on the floor next to the bed. Fall was unwitnessed ...The resident did hit head, with bruising noted on the left side of the forehead. A skin tear was noted on the left forearm.
-1/12/26 at 4:25 pm, unwitnessed fall per caregiver ...writer came to the tv area and observed the resident sitting upright on the floor next to the recliner chair ...The caregiver was educated not to leave the resident unsupervised ...
-1/27/26 10:02pm- found supine in apartment's bathroom floor.
-1/31/26 5:18am- found by caregiver on floor with back to bed.
-2/4/26 3:10am- unwitnessed fall in room next to bed ... Last resident check was at 1:30 am.
-2/4/26 At 5:30 pm ...fell when trying to stand up from wheelchair. The resident was in the dining area...
-2/6/26 9:16pm- the resident was found in a sitting position on the floor...
-2/8/26 10:27pm- noted her to be lying on the floor in prone position next to the bed ...Small amount of dried blood noted on upper lip and fingers.

R3's Service Plan dated 12/23/25 indicated Safety/Falls Safety /Falls- Description of assistance: Remain in common area waking hours, keep door open at night, rounding Q2 hours, recline Broda, when not eating.

On 3/23/26 at 1:49pm, E2 (Director of Nursing) said R2 and R3 are related and both admitted on Hospice in May 2025. During that time, they were

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A4010	Continued From page 5 unable to walk, not safely. They cannot learn how to use a walker. They were trying to walk in the hallway, but they were not supposed to be walking. They recently got the (specialized) chair for that reason. R2 and R3 service plans did not incorporate interventions by Hospice. Establishment's Service Plan Policy and Procedure (revised 10.29.25) stated in part; " Each service plan shall address health-related or support services in place for the resident such as home health or hospice."	A4010		