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| A 000 | Initial Comment<br><br>Investigation of Facility Reported Incident 2/17/26 #IL200276.<br><br>Investigation of Complaints #2611865 - IL200236, #2613073 - IL200729, #2615307 - IL201216, #2614662 - IL201216.<br><br>Violations:<br><br>Section 295.2000 Residency Requirements a), c)3-4, c)9), c)12)<br><br>Section 295.2050 Incident and Accident Reporting a-c)<br><br>Section 295.4010 Service Plan a), b)1-3), c-e), g)1)A,C), g)2)h)<br><br>Section 295.5000 Medication Reminders, Supervision of Self-Medication, Medication Administration and Storage j)4-5)<br><br>Section 295.6000 Resident Rights a)1), a)5), a)13)<br>Section 389.110 Authorized Electronic Monitoring a-c)<br>Section 389.115 Consent of the Resident a)<br><br>Section 295.6010 Abuse, Neglect, and Financial Exploitation Prevention and Reporting<br><br>Section 295.9000 Physical Plant a-b)<br>Section 389.100 Definitions<br>Section 389.105 Incorporated and Referenced Materials a)1-3), c)1)I), c)2)G)<br>Section 389.110 Authorized Electronic Monitoring a-c) | A 000 | | |

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| A2000 | Continued From page 1 | A2000 | | |
| A2000 | Section 295.2000 Residency Requirements | A2000 | | |

This Regulation is not met as evidenced by:
Violation

Section 295.2000 Residency Requirements

a) No individual shall be accepted for residency or remain in residence if the establishment cannot provide or secure appropriate services, if the individual requires a level of service or type of service for which the establishment is not licensed or which the establishment does not provide, or if the establishment does not have the staff appropriate in numbers and with appropriate skill to provide such services. (Section 75(a) of the Act) ...

c) A person shall not be accepted for residency if: ...

3) The person requires total assistance with 2 or more activities of daily living;

4) The person requires the assistance of more than one paid caregiver at any given time with an activity of daily living; ...

9) The person requires insertion, sterile irrigation, and replacement of catheter, except for routine maintenance of urinary catheters, unless the catheter care is self-administered or administered by a licensed health care professional; ...

12) The person requires treatment of stage 3 or stage 4 decubitus ulcers

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| A2000 | Continued From page 2<br>or exfoliative dermatitis; ...<br><br>(Source: Amended at 48 Ill. Reg. 12026, effective July 29, 2024)<br><br>This requirement was not met, as evidenced by:<br><br>Based on record review and interview, the establishment remain in residence if the establishment cannot provide or secure appropriate services, if the individual requires a level of service or type of service for which the establishment is not licensed or which the establishment does not provide, or if the establishment does not have the staff appropriate in numbers and with appropriate skill to provide such services. This applies to 2 of 3 residents (R1, R3) reviewed for this requirement. This regulation was not met due to the conduct of the establishment or its staff, either by an improper action or the failure to take an action.<br><br>The findings include:<br><br>The establishment re-admitted or maintained the following residents that did not meet residency requirements:<br><br>1) R1's medical record showed R1 moved into the establishment on 1/3/25, resided in the assisted living unit, was on hospice, and expired on 3/29/26. The record showed R1 had multiple diagnoses, including acute systolic chronic heart failure, anemia, aneurysm of ascending aorta, coronary artery disease, cardiomegaly, transient ischemic attack and cerebral infarction without residual deficit. | A2000 | | |

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| A2000 | Continued From page 3<br><br>R1's Service Plan, dated 2/26/26, showed R1 required hospice assist for bathing, total assistance with dressing, oral care, toileting, and assistance with mobility and transfers, with use of cane and wheelchair. The service plan showed R1 needed occasional help due to forgetfulness and difficulty concentrating.<br><br>R1's Observations note, date/time 8/6/25 at 4:16 PM, written by E14 (Previous Director of Nursing), showed R1 was admitted to the hospital for a Urinary Tract Infection. The note, date/time 8/9/26 at 10:37 PM, written by E15 (Previous Licensed Practical Nurse - LPN), showed R1 was evaluated and confirmed for hospice services.<br><br>R1's Observations note, date/time 2/12/26 at 2:33 PM, written by E7 (LPN), showed R1 retained urine that required R1 to have a straight catheter inserted into the urinary tract to drain urine. The note showed hospice would manage urinary retention while at the establishment.<br><br>R1's Observations note, date/time 2/10/26 at 9:15 PM, written by E16 (Previous LPN), showed R1 was sent to the hospital per family's request. The note, date/time 2/12/26 at 7:36 PM, written by E17 (LPN), showed R1 returned to the facility around 5:30 PM that day with a diagnosis of acute abdominal pain suspect 2/2 metastatic malignancy, acute chronic urinary retention, acute constipation, acute kidney injury, and chronic kidney disease stage three. The note showed the hospice nurse was there to re-admit the resident to hospice.<br><br>2) R3 moved into the facility on 2/10/25 with following diagnoses atrial fibrillation, atherosclerotic heart disease, cirrhosis of liver, | A2000 | | |

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| A2000 | Continued From page 4<br>chronic obstructive pulmonary disease, gastroesophageal reflux disease, diverticulitis, anemia, lack of coordination, left foot drop, pleurodynia, peripheral vascular disease, with bilateral lower leg swelling.<br><br>Facility care plan dated 2/8/26 noted that R3 was independent of medications (diuretic). Totally dependent on staff for more than two areas of Activities of Daily Living (ADLs), maximum assistance for bathing usually refused showers and refused staff to remove elastic stocking from left leg, dressing moderate to total assistance, toileting max assisted with two to three staff. Transfer max full assistance expected three staff to lift R3 from wheelchair to R3's recliner.<br><br>Podiatry notes dated 3/12/26 ulcer to outer aspect of right calf. 100% full thickness beefy red. 13cm (centimeters) x 10cm x 0.1cm serosanguineous drainage with margins macerated treatment of debridement. Right toes one-five nails long painful. Toes to left foot one-five nails long painful thickened discolored and crumbly texture. Z11 (R3's Podiatrist) provided care to wound on leg and open wounds between toes. Open wound noted between great toe and second toe on bilateral feet. Home health provided care for wounds.<br><br>Progress notes date 3/7/26 noted wound covering left heel with discoloration from heel to inner aspect of ankle. Wound tunnels to bone, R3 admitted to hospital for wound debridement to the bone of left heel.<br><br>E7 (LPN) confirmed above and the need for a higher level of care for R3. | A2000 | | |

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| A2000 | Continued From page 5<br>During interviews with E2 (Director of Health and Wellness) on 4/16/26 at 3:38 PM and E1 (Executive Director) on 4/16/26 at 4:03 PM, they indicated E2 started employment in April and E1 in March. Both agreed staff should follow establishment policy and procedure, and the establishment should follow state regulation. | A2000 | | |
| A2050 | Section 295.2050 Incident and Accident Reporting<br><br>This Regulation is not met as evidenced by:<br>Type 3 Violation<br><br>Section 295.2050 Incident and Accident Reporting<br><br>a) An establishment shall report to the Department any serious incident or accident. For the purposes of this Section, "serious" means any incident or accident that causes physical or emotional harm or injury to a resident. A change in an individual's (resident's) condition that is due to health or medical decline is not a reportable incident or accident.<br><br>b) The report shall be made by contacting the Department of Public Health Division of Assisted Living via email at DPH.LTCAL@illinois.gov or as requested by the Department within 24 hours after the occurrence of the incident or accident.<br><br>c) A copy of the report shall be maintained by the establishment for one year after the date of the incident or accident. | A2050 | | |

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| A2050 | Continued From page 6<br>(Source: Amended at 47 Ill. Reg. 13264, effective August 30, 2023)<br><br>This requirement was not met as evidenced by:<br><br>Based on interview and record review, the establishment failed to report serious incidents/accidents to the Department. This applies to 2 of 3 residents (R1, R2) reviewed for this requirement.<br>This failure has the probability to affect a resident or residents.<br><br>The findings include:<br><br>On 4/15/26 an investigation of Facility Reported Incident IL200276, and Complaints IL200236, IL200729, IL201216, and IL201374.<br><br>The following incidents/accidents that caused physical harm or injury were not reported to the Department within 24 hours of the occurrence:<br><br>1) R1's Progress Note, date/time 2/24/26 at 10:30 PM, showed R1 had a fall that resulted in pain to the left hip with movement. The note showed hospice was called to assess R1.<br><br>2) R2's Incident and Accident Report, date/time 2/13/26 at 7:30 PM, showed R2 complained of arm pain after R2 fell on 2/12/26 with complaints of wrist pain, but refused to go to the hospital for evaluation. The report showed R2 was sent to the emergency room and returned with a splint and diagnosis of fracture to the right wrist.<br><br>Email confirmation showed the report was | A2050 | | |

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| A2050 | Continued From page 7<br>submitted to the Department past the 24 hour timeframe, on 2/16/26 at 4:38 PM.<br><br>During interviews with E2 (Director of Health and Wellness) on 4/16/26 at 3:38 PM and E1 (Executive Director) on 4/16/26 at 4:03 PM, they indicated E2 started employment in April and E1 in March. Both agreed the establishment should follow state regulation. | A2050 | | |
| A4010 | Section 295.4010 Service Plan<br><br>This Regulation is not met as evidenced by:<br>Type 1 Violation<br><br>Section 295.4010 Service Plan<br><br>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.<br><br>b) The service plan shall be developed by:<br><br>1) The resident, resident's representative or any individual requested by the resident;<br><br>2) The manager or manager's | A4010 | | |

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| A4010 | Continued From page 8<br>designee; and<br><br>3) A registered nurse, if the resident is receiving nursing services or medication administration, or is unable to direct self-care.<br><br>c) The service plan shall be signed and dated by all individuals involved in its development.<br><br>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)<br><br>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) ...<br><br>g) Service plans shall address:<br><br>1) The level of service the resident is receiving, including:<br><br>A) assistance with activities of daily living; ...<br><br>C) special accommodations for the resident;<br><br>2) The amount, type, and frequency of health-related services needed by the resident; ...<br><br>h) The service plan shall include all support services provided or arranged for by the | A4010 | | |

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| A4010 | Continued From page 9 | A4010 | | |

establishment.

This requirement was not met as evidenced by:

Based on interview and record review, the establishment failed to follow their policy and procedure and state regulation when they did not ensure service plans were individualized to the resident's needs and preferences. This applies to 3 of 3 residents (R1, R2, R3) reviewed for this requirement and has the probability to affect all residents that reside in the establishment.
This creates a substantial probability of severe harm or death to a resident or residents, in that it cannot be determined if the establishment is aware of or addressing the needs and safety concerns of the residents.

The findings include:

On 4/15/26 an investigation of Facility Reported Incident IL200276, and Complaints IL200236, IL200729, IL201216, and IL201374.

1) R1's medical record showed R1 moved into the establishment on 1/3/25, resided in the assisted living unit, was on hospice, and had multiple diagnoses, including acute systolic congestive heart failure, aneurysm of ascending aorta, coronary artery disease, cardiomegaly, cognitive communication deficit, lymphocytopenia, transient ischemic attack and cerebral infarction without residual deficit. R1 expired on 3/29/26.

R1's Service Plan, dated 2/26/26, was not signed by a registered nurse. R1's service plan showed

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| A4010 | Continued From page 10 | A4010 | | |

R1 had nurse administered medications.

R1's service plan did not address R1 had a court order to appoint Z9 (R1's Guardian) as Plenary Guardian for a Disabled Person (the authority of a plenary guardian is extensive, encompassing both life and healthcare decisions and the management of the ward's property), dated 4/23/25.

R1's service plan did not address amount, type, and frequency of health-related services for hospice. R1's medical record showed R1 was admitted to hospice on 8/9/25.

R1's service plan did not address the reason for and use of psychotropic medications and moods/behaviors to monitor for. R1's medication orders showed R1 had hospice comfort medications - as needed lorazepam (antianxiety) and morphine (analgesic opioid). These medication increase the risk of falls and R1 had a history of falls.

R1's service plan did not address R1 as a fall risk with interventions and was not updated for falls. R1's Progress Notes reviewed for April 2025-April 2026 showed R1 had falls on 8/24/25, 8/26/25, 12/6/25, 2/24/26, 2/27/26, 3/2/26, and 3/21/26.

R1's service plan did not address the special accommodation for the use of electronic monitoring. R1's establishment investigation of Facility Reported Incident (FRI) 2/13/26 - IL200276 that included a written timeline of events by E4 (Previous Executive Director - ED) showed R1 had an electronic monitoring device (Ring camera - A Ring camera is a smart home security device that provides video surveillance, motion detection, and two-way communication for

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| A4010 | Continued From page 11 | A4010 | | |

monitoring your property remotely.) During interviews with E3 (Previous Director of Health and Welfare - DHW) on 4/20/25 at 9:36 AM and E7 (Licensed Practical Nurse - LPN) on 4/16/26 at 12:15 PM, confirmed R1 had a camera outside the front door and one in the apartment. Email communication provided by E1 (ED) on 4/21/26 at 4:13 PM, showed email communication between E4 and Z9 (R1's Guardian) regarding electronic monitoring. In the email, Z9 indicated they had a camera installed since May 2025, with consent of the establishment.

R1's service plan did not address the special accommodation that R1 have only female caregivers overnight. R1's Observations note, date/time 6/17/25 at 10:36 PM, showed R1 made requested only females provide care overnight.

R1's service plan did not address the special accommodation that Z2 (R1's Son) resided in R1's apartment and assisted with R1's care. During interviews with E3 and E7, they indicated Z2 was around 24/7 for months, slept overnight, and many times assisted R1 with care, including incontinence care. E3 indicated, E4 (Previous ED), Z7 and Z8 (both Co-Owners) were aware of the situation. R1's Observations note, date/time 4/26/25 at 11:53 PM, showed Z9 (R1's Guardian) requested no visitation after 9:00 PM for all visitors and planned to obtain an order of protection against Z2 and to prevent Z2's visitation. Notes showed no further information on this.

R1's service plan was not updated with guidelines for contact with Z2, after R1 alleged sexual abuse by Z2, as reported in the FRI 2/13/26 - IL200276. During interview with E3, E3 indicated Z9 made the stipulations that Z2 not do personal care and

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| A4010 | Continued From page 12<br>not stay in the room when care was provided.<br><br>2) R2's medical record showed R2 moved into the establishment on 8/8/23 and has multiple diagnoses, including chronic obstructive pulmonary disease, diabetes mellitus type two, and hypertension.<br><br>R2's Service Plan, dated 2/24/26, was not signed by a registered nurse. R2's service plan showed R2 has nurse administered medications.<br><br>R2's service plan did not address the use of blood thinners, and reason for and use of psychotropic medication and any moods/behaviors to monitor for. R2's Physician's Order Sheet (POS) for April 2026 showed R2 takes scheduled clopidogrel (blood thinner). R2's POS showed R2 takes scheduled mirtazapine (antidepressant). These medications increase the risk of falls and injury with falls, and R2 has a history of falls.<br><br>R2's service plan did not address R2 as a fall risk with interventions and was not updated for falls with new interventions added, after multiple falls occurred. R2's Incident and Accident Report showed R2 had a fall on 2/12/26 that resulted in a right hand fracture. R2's Progress Notes, reviewed for 2/22/26 to 4/15/26 showed R2 had falls on 3/1, 3/11, 3/14, 3/26, 3/31, and 4/4.<br><br>3) Clinical records show R3 moved into the facility on 2/10/25 with following diagnoses atrial fibrillation, atherosclerotic heart disease, cirrhosis of liver, chronic obstructive pulmonary disease, gastroesophageal reflux disease, diverticulitis, anemia, left foot drop, chronic swelling of lower | A4010 | | |

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| A4010 | Continued From page 13<br>extremities.<br><br>R3's establishment service plan did not integrate outside services from a home health nurse visit for wound, Occupational Therapy (OT) and Physical Therapy (PT) treatments R3 received in February and Podiatry visits with wound care orders. E2 (DHW) did not realize that the above has to be integrated into facility service plan.<br><br>Podiatry notes dated 2/12/26, ulcer to outer aspect of right calf. 100% full thickness beefy red. 13cm (centimeters) x 10cm x 0.1cm serosanguineous drainage would margins macerated treatment of debridement. Right toes one-five nails long painful. Toes to left foot one-five nails long, painful thickened discolored and crumbly texture. Z11 (R3's Podiatrist) did care to wounds on leg and between toes and cut toe nails. Open wound noted between great toe and second toe on bilateral feet. Home health provided care for wounds.<br><br>Per notes from home health, R3 was received home health from nurse for wound care to right leg lateral aspect of calf. Home health came two times per week. Home health also provided PT/OT services in February for R3. R3 received podiatry care while at establishment.<br><br>4) R4's medical record showed R4 moved into the establishment on 4/25/24, moved out on 12/20/25, was on hospice, and had multiple diagnoses, including atherosclerotic heart disease, hypertension, heart failure, and dementia.<br><br>R4's Service Plan, dated 10/26/24, did not address the reason for and use of psychotropic | A4010 | | |

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| A4010 | Continued From page 14 | A4010 | | |

medications and related moods/behaviors to monitor for, and the use of opioids. R4's December Electronic Medication Administration Record (EMAR) showed R2 took scheduled and as needed quetiapine (antipsychotic), scheduled and as needed risperidone (antipsychotic), scheduled trazadone (antidepressant), as needed alprazolam (antianxiety), and as needed morphine (analgesic opioid). These medications increase the risk of falls and R4 is a fall risk.

R4's service plan did not address the level of assistance R4 received for toileting and bathing.

R4's service plan did not address the amount, type, and frequency of health-related services for hospice.

During interviews with E2 (Director of Health and Wellness) on 4/16/26 at 3:38 PM and E1 (Executive Director) on 4/16/26 at 4:03 PM, they indicated E2 started employment in April and E1 in March. Both agreed staff should follow establishment policy and procedure, and the establishment should follow state regulation.

The establishment policy titled CL15 - Falls (Date: 12/5/25) showed: Policy: All residents are evaluated for fall risk and their Service Plan will be developed/updated accordingly. Should a resident experience a fall, staff will provide immediate care and follow through with service planning. Procedure: ...1)b) Each resident's identified fall risks will be addressed with recommended interventions including in the resident's Service Plan ...c)ii)1) The Community Nurse or designee who completed the Post-Fall Evaluation may select interventions to be

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| A4010 | Continued From page 15<br>implemented and will communicate the implementations to care staff until a full Service Plan update can be completed ...<br><br>The establishment policy titled AS05 - Service Plans (Date 12/5/25) showed: Policy: Assessments and Service Plans will be developed and updated as frequently as necessary to ensure they reflect current resident care needs and preferences. Individualized Service Plans are used to plan for and meet resident needs using an interdisciplinary approach. Procedure: ...1)b) The Executive Director will ensure that each resident has a written service plan compliant with state regulations ...3)Service Plans are create/updated: ...d) Whenever there is significant change in resident status ...5) The Service Plan is to be individualized based on the resident's needs and preferences. 6) The Service Plan should be developed and updated using an interdisciplinary approach. A) The Service Plan should address any outside services received by the resident including home health, hospice, physical therapy, occupational therapy, etc ... | A4010 | | |
| A5000 | Section 295.5000 Medication Reminders, Supervision of Self Med<br><br>This Regulation is not met as evidenced by: Type 1 Violation<br><br>Section 295.5000 Medication Reminders, Supervision of Self-Medication, Medication Administration and Storage ...<br><br>j) A separate medication record shall be | A5000 | | |

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| A5000 | Continued From page 16<br>maintained for each resident receiving medication administration and shall include: ...<br><br>4) Date and time of actual medication administration; and<br><br>5) Signature or initials of the employee administering medication.<br><br>This requirement was not met as evidenced by:<br><br>Based on interview and record review, the establishment failed to follow their policy and procedure and state regulation when they did not document medication administration in the Electronic Medication Administration Record (EMAR) the reason the medication was not administered or complete a medication error for missed doses. This applies to 1 of 4 residents (R2) reviewed for this requirement.<br>This failure creates the substantial probability of severe harm or death to a resident or residents.<br><br>The findings include:<br><br>On 4/15/26 an investigation of Facility Reported Incident IL200276, and Complaints IL200236, IL200729, IL201216, and IL201374.<br><br>R2's medication was not recorded as administered and no reason was given:<br><br>R2's medical record showed R2 moved into the establishment on 8/8/23 and has multiple diagnoses, including chronic obstructive pulmonary disease, diabetes mellitus type two, and hypertension. | A5000 | | |

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| A5000 | Continued From page 17<br><br>R2's Service Plan, dated 2/24/26, showed R2 has nurse administered medications. The service plan showed, "Nurse will administer medications as prescribed by Physician."<br><br>R2's Physician's Order Sheet for 2/1/26-2/28/26 showed a 2/19/26 order from Z10 (R2's Physician) to start carbamide peroxide 6.5% ear drops - instill (five) drops into right ear (two times) a day for (four) days.<br><br>R2's February 2026 EMAR showed the drops scheduled at 8:00 AM and 8:00 PM, which started at 8:00 PM on 2/19/26. The drops were scheduled to be given through 8:00 PM on 2/23/26. The EMAR showed the dose "Not Recorded" for 8:00 AM on 2/21, 2/22, and 2/23, and 8:00 PM on 2/20, 2/21, 2/22, and 2/23.<br><br>There was no medication error completed for the missed doses:<br><br>On 4/15/26 Incident and Accident reports were reviewed and there was no documentation for a medication error for R2.<br><br>During email communication with E2 (Director of Health and Wellness) on 4/21/26 at 10:00 AM, E2 indicated nurses should document the reason for missed medication in the EMAR. E2 confirmed they could not find a medication error for R2.<br><br>During interviews with E2 (Director of Health and Wellness) on 4/16/26 at 3:38 PM and E1 (Executive Director) on 4/16/26 at 4:03 PM, they indicated E2 started employment in April and E1 in March. Both agreed the establishment should follow state regulation. | A5000 | | |

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| A5000 | Continued From page 18<br><br>The establishment policy titled MP16 - Administering and Supervision of Resident Self-Medication (Date: 12/5/25) showed: Policy: Residents will receive supervision of self-medication from unlicensed care staff or be offered medication administration from licensed healthcare professionals per (state) regulations. Procedure: ...5) General guidelines for staff who assist with or administer medications include: ...f) Document on the resident's MAR.<br><br>The establishment policy titled MP19 - Medication Pass (Date: 12/5/25) showed: Policy Community med Techs will follow a consistent workflow to document all medications provided during a medication pass. Procedure: 1) Assistance with Mediation Administration a) All medications are administered per physician orders. 2) The EMAR is signed/initialed at the time the medication is poured ...7) Community Nurse and Med Techs will document the following exceptions in the EMAR system being used; ...c) Medication Unavailable - make notation entry. d) Out of community - make notation entry. e) Out of Community, Given to Family to Give Later ...g) Resident Refused. h) Withheld per Prescriber Orders.<br><br>The establishment policy titled MP25 - Missed or Refused Medications (Date: 12/5/25) showed: Policy: Residents cannot be forced to take any medication ...Procedure: 1) Any missed or refused medications are documented in the resident's medication record in the narrative notes.<br><br>The establishment policy titled MP37 - Medication Errors (Date: 12/5/25) showed: Policy: Medications are handled in a manner that | A5000 | | |

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| A5000 | Continued From page 19<br>minimizes risk of mediation errors. Procedure: 1) A medication error is defined as: ...f) Missed dose. | A5000 | | |
| A6000 | Section 295.6000 Resident Rights<br><br>This Regulation is not met as evidenced by:<br>Type 1 Violation<br><br>Section 295.6000 Resident Rights<br><br>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:<br><br>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; ...<br><br>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; ...<br><br>13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; ...<br><br>Section 389.110 Authorized Electronic Monitoring | A6000 | | |

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| A6000 | Continued From page 20<br><br>a) A resident shall be permitted to conduct authorized electronic monitoring of the resident's room through the use of electronic monitoring devices placed in the room pursuant to the Act and this Part. (Section 10(a) of the Act)<br><br>b) A facility that houses dementia residents may allow electronic monitoring devices only in rooms that are located in a building that is entirely dedicated to dementia care; or that are located in a building wing that is solely dedicated to dementia care. (Section 10(c) of the Act)<br><br>c) Authorized electronic monitoring may begin only after a notification and consent form prescribed by the Department has been completed and submitted to the facility. (Section 20(a) of the Act)<br><br>Section 389.115 Consent of the Resident<br><br>a) A resident, a resident's plenary guardian of the person, or the parent of a resident under the age of 18 must consent in writing on a notification and consent form prescribed by the Department to the authorized electronic monitoring in the resident's room.<br><br>This requirement was not met as evidenced by:<br><br>Based on interview and record review, the establishment failed to ensure residents' dignity, independence, and privacy was protected when they permitted a resident who did not reside in memory care, or their representative, to install an electronic monitoring device outside the apartment door in the hallway. The resident's | A6000 | | |

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| A6000 | Continued From page 21<br>family was able to see, hear, and record other residents and staff, without their knowledge and consent.<br><br>They failed to provide medication administration and showers as specified in the service plan.<br><br>Nursing was aware and neglected to transfer or assist staff with a resident or their higher level of care.<br><br>This applies to 3 of 3 residents (R1, R2, R3) reviewed for this requirement. These requirements were not met due to the conduct of the establishment or its staff, either by an improper action or the failure to take an action. This failure creates the substantial probability of severe harm or death to a resident or residents.<br><br>The findings include:<br><br>On 4/15/26 an investigation of Facility Reported Incident IL200276, and Complaints IL200236, IL200729, IL201216, and IL201374 was initiated.<br><br>1) R1 had an electronic monitoring device installed in the hallway which infringed on other residents' right to privacy:<br><br>During the investigation, it was discovered the establishment permitted a resident, or their representative, who did not reside in rooms that are located in a building that is entirely dedicated to dementia care, or that are located in a building wing that is solely dedicated to dementia care, to install an electronic monitoring device in their room and outside the apartment door in the hallway, without proper consent. | A6000 | | |

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| A6000 | Continued From page 22 | A6000 | | |

R1's establishment investigation of Facility Reported Incident 2/13/26 - IL200276, that included a written timeline of events from E4 (Previous Executive Director - ED), showed R1 had set up an electronic monitoring device (Ring camera - A Ring camera is a smart home security device that provides video surveillance, motion detection, and two-way communication for monitoring your property remotely.)

R1's medical record showed R1 moved into the establishment on 1/3/25, resided in the assisted living unit, and expired on 3/29/26.

R1's medical record showed R1 had a court appointed guardian, Z9 (R1's Guardian).

During interviews with E3 (Previous Director of Health and Welfare - DHW) on 4/20/26 at 9:36 AM and E7 (Licensed Practical Nurse - LPN) on 4/16/26 at 12:15 PM, they confirmed R1 had a camera outside the front door and one in the apartment. E3 indicated, privacy concerns were brought to management because with the camera posted outside the front door, R1's family could see other residents, visitors, and staff, and hear any conversations or patient information discussed. E3 indicated the camera remained outside the front door until the 2/13/26 incident occurred.

R1's Observations note, dated 6/30/25 at 10:07 PM, written by E13 (LPN), showed Z9 (R1's Guardian) voiced concern because Z9 heard on (R1's) ring camera that a resident was wandering down the street.

Email communication with E1 (ED), on 4/21/26 at 4:13 PM, provided email communication between

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| A6000 | Continued From page 23<br><br>E4 (Previous ED) and Z9 regarding electronic monitoring. In the email, E4 requested Z9 sign a consent for use of electronic monitoring, according to policy put in place in June 2025. The communication with Z9 showed the camera was installed in the hall. In the email, Z9 indicated they had a camera installed since May 2025, with consent of the establishment. Z9 indicated they had video footage where staff assisted R1 down the hallway, R1 fell, and Z9 demanded a caregiver be disciplined for negligence. Z9 implied there was no issue with the camera until after a complaint was made but offered to move the camera three or four inches closer to R1's door.<br><br>The establishment policy titled GP-02 Personal Rights (Date: 10/1/23) showed: Policy: All (establishment) staff will observe and respect the personal rights of all residents residing in the community ...Procedure: 3) Community Management ensures that: ...4) Residents have the following rights: 4)a) 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; ...4)n) The right to confidentiality of the resident's medical, financial, or other records ...4)q) The right to privacy with regard to mail, phone calls, and visitors; ...<br><br>2) R2's medication was not administered per physician's orders, as instructed in the service plan:<br><br>R2's medical record showed R2 moved into the establishment on 8/8/23 and has multiple | A6000 | | |

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| A6000 | Continued From page 24 | A6000 | | |

diagnoses, including chronic obstructive pulmonary disease, diabetes mellitus type two, and hypertension.

R2's Service Plan, dated 2/24/26, showed R2 has nurse administered medications. The service plan showed, "Nurse will administer medications as prescribed by Physician."

R2's Physician's Order Sheet for 2/1/26-2/28/26 showed a 2/19/26 order from Z10 (R2's Physician) to start carbamide peroxide 6.5% ear drops - instill (five) drops into right ear (two times) a day for (four) days.

R2's February 2026 Electronic Medication Administration Record (EMAR) showed the drops scheduled at 8:00 AM and 8:00 PM, which started at 8:00 PM on 2/19/26. The drops were scheduled to be given through 8:00 PM on 2/23/26. The EMAR showed the dose "Not Recorded" for 8:00 AM on 2/21, 2/22, and 2/23, and 8:00 PM on 2/20, 2/21, 2/22, and 2/23.

During email communication with E2 (DHW) on 4/21/26 at 10:00 AM, E2 indicated nurses should document the reason for missed medication in the EMAR.

The establishment policy titled GP-02 Personal Rights (Date: 10/1/23) showed: Policy: All (establishment) staff will observe and respect the personal rights of all residents residing in the community ...Procedure: 3) Community Management ensures that: ...4)e) The right to receive the services specified in the service plan ...

The establishment policy titled MP19 - Medication

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| A6000 | Continued From page 25<br><br>Pass (Date: 12/5/25) showed: Policy Community med Techs will follow a consistent workflow to document all medications provided during a medication pass. Procedure: 1) Assistance with Mediation Administration a) All medications are administered per physician orders. 2) The EMAR is signed/initialed at the time the medication is poured ...7) Community Nurse and Med Techs will document the following exceptions in the EMAR system being used; ...c) Medication Unavailable - make notation entry. d) Out of community - make notation entry. e) Out of Community, Given to Family to Give Later ...g) Resident Refused. h) Withheld per Prescriber Orders.<br><br>The establishment policy titled MP25 - Missed or Refused Medications (Date: 12/5/25) showed: Policy: Residents cannot be forced to take any medication ...Procedure: 1) Any missed or refused medications are documented in the resident's medication record in the narrative notes.<br><br>R2 did not receive showers as instructed in the service plan:<br><br>R2's Service Plan, dated 2/24/26, showed R2 was one person assist with showers (two times) per week.<br><br>R2's Shower Sheets were requested and reviewed for January through April 2026 showed the following showers:<br><br>January<br>Refused - none<br>Given - 1/31/26 | A6000 | | |

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| A6000 | Continued From page 26<br><br>February<br>Refused - 2/4/26, 2/7/26, 2/25/26<br>Given - 2/21/26<br><br>March<br>Refused - none<br>Given - 3/4/26, 3/18/26<br><br>April<br>Refused - none<br>Given - 4/1/26<br><br>For January through April 15th, R2 should have been offered at least 32 showers, but only eight were documented as given or refused.<br><br>During interviews on 4/15/26 at 1:35 PM E5 (Certified Nursing Assistant - CNA); E6 (CNA) on 4/15/26 at 2:05 PM; and E7 (LPN) on 4/16/26 at 12:15 PM, they indicated R2 often refused showers. They indicated shower sheets are completed for each shower and should document if the shower was given or refused.<br><br>The establishment policy titled GP-02 Personal Rights (Date: 10/1/23) showed: Policy: All (establishment) staff will observe and respect the personal rights of all residents residing in the community ...Procedure: 3) Community Management ensures that: ...4)e) The right to receive the services specified in the service plan ...<br><br>The establishment policy titled CP01 - Basic Care (Date: 6/1/25) showed: Policy: Basic care will be provided to all residents on an individual basis according to findings from the admission appraisal and subsequent re-appraisals. Procedure: ...7) Residents will be | A6000 | | |

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| A6000 | Continued From page 27<br>showered/bathed as outlined in their individualized Service Plan.<br><br>3) Nursing was aware and neglected to transfer or assist staff for R3's higher level of care:<br><br>R3 moved into the facility on 2/10/25 with following diagnoses atrial fibrillation, atherosclerotic heart disease, cirrhosis of liver, chronic obstructive pulmonary disease, gastroesophageal reflux disease, diverticulitis, anemia, left foot drop, chronic swelling of lower extremities.<br><br>Facility care plan dated 2/8/26 noted that R3 was independent of medications (diuretic). Totally dependent on staff for more than two areas of Activities of Daily Living (ADLs), max assist for bathing - usually refused showers and refused staff to remove elastic stocking from left leg, dressing moderate assistance, toileting max assisted with two to three staff. Transfer max full assistance expected - three staff to lift him from wheelchair to his recliner.<br><br>Podiatry notes dated 2/12/26 ulcer to outer aspect of right calf. 100% full thickness beefy red. 13cm (centimeters) x 10cm x 0.1cm serosanguineous drainage with margins macerated treatment of debridement. Right toes one-five, nails long painful. Toes to left foot one-five, nails long, painful thickened discolored and crumbly texture. Z11 (Podiatrist) provided care to wounds on leg and between toes and cut toenails. Open wound noted between great toe and second toe on bilateral feet. Home health provided care for wounds.<br><br>Progress notes, dated 3/7/26, noted wound | A6000 | | |

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| A6000 | Continued From page 28 | A6000 | | |

covering left heel with discoloration from heel to inner aspect of ankle. Wound tunnels to bone, R3 admitted to hospital for wound debridement to the bone of left heel.

Confidential interview with E5 and E6 (both CNAs) disclosed that R3 was difficult to care for due to his size six foot two inches, over 235 pounds, required two to three staff to toilet and clean him. Since R3 was in wheelchair all day, and at night expected three to four staff members to lift him from wheelchair to recliner. R3 was unable to bear much weight on legs due to swelling. Staff told nursing that R3's feet smelled bad and R3 would not let us take off R3's elastic hose on left leg and would not let staff bath R3. Nursing was aware and neglected to transfer or assist staff for R3's higher level of care.

On 4/15/26, E7 (LPN) did confirm that R3 was difficult to take care of and needed a higher level of service.

The establishment policy titled GP-02 Personal Rights (Date: 10/1/23) showed: Policy: All (establishment) staff will observe and respect the personal rights of all residents residing in the community ...Procedure: 3) Community Management ensures that: ...3)b)Residents are not subject to: 3)b)ii) Neglect ...4)e) The right to receive the services specified in the service plan ...4)m) The right to be free of abuse or neglect ...

During interviews with E2 (DHW) on 4/16/26 at 3:38 PM and E1 (ED) on 4/16/26 at 4:03 PM, they indicated E2 started employment in April and E1 in March. Both agreed staff should follow establishment policy and procedure, and the

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| A6000 | Continued From page 29<br>establishment should follow state regulation. | A6000 | | |
| A6010 | Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr<br><br>This Regulation is not met as evidenced by:<br>Type 1 Violation<br><br>Section 295.6010 Abuse, Neglect, and Financial Exploitation Prevention and Reporting<br><br>a) When the establishment has a reasonable belief that a resident has been the victim of abuse, neglect, or financial exploitation, the establishment shall:<br><br>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.<br><br>2) Investigate and develop a written report within 14 days after the initial report. The establishment shall send the written report to the Department within 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.<br><br>b) A written report of the investigation conducted pursuant to subsection (a)(2) shall contain at least the following:<br><br>1) Dates, times, and description of | A6010 | | |

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| A6010 | Continued From page 30<br>the alleged abuse, neglect or financial exploitation;<br><br>2) Description of any injury to the resident;<br><br>3) Description of any change in the resident's physical, cognitive, functional, or emotional condition;<br><br>4) Any actions taken by the licensee;<br><br>5) A list of individuals and agencies interviewed or notified by the establishment;<br><br>6) Names of witnesses to the alleged abuse, neglect, or financial exploitation; and<br><br>7) If the abuse, neglect, or financial exploitation is substantial, a description of the action to be taken by the establishment to prevent the abuse, neglect or financial exploitation from occurring in the future.<br><br>c) Establishment employees and volunteers are obligated to report abuse, neglect, or financial exploitation of a resident to the establishment management and to the Department.<br><br>d) When the establishment has a reasonable belief that abuse, neglect or financial exploitation occurred, the perpetrator, if an employee or volunteer, shall be removed from direct contact with residents.<br><br>This requirement was not met as evidenced by: | A6010 | | |

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Based on interview and record review, the establishment failed to follow their policy and procedure and state regulation when staff failed to report an allegation of sexual abuse to management in a timely manner. They failed to take immediate steps to protect the resident from further abuse and remove them from direct contact with the perpetrator. They failed to conduct a thorough investigation. They failed to develop a written report of the investigation that included all the required elements. This applies to 1 of 3 residents (R1) reviewed for this requirement and has the probability to affect all residents in the establishment. These failures create a substantial probability of severe harm or death to a resident or residents, in that they do not protect the residents' right to be free of abuse.

The findings include:

On 4/15/26 an investigation of Facility Reported Incident IL200276, and Complaints IL200236, IL200729, IL201216, and IL201374.

R1's medical record showed R1 moved into the establishment on 1/3/25, resided in the assisted living unit, was on hospice, and expired on 3/29/26. The record showed R1 had multiple diagnoses, including acute systolic chronic heart failure, anemia, aneurysm of ascending aorta, coronary artery disease, cardiomegaly, transient ischemic attack and cerebral infarction without residual deficit.

R1 had a court order appointing Z9 (R1's Guardian) as Plenary Guardian for a Disabled Person (the authority of a plenary guardian is extensive, encompassing both life and healthcare

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decisions and the management of the ward's property), dated 4/23/25.

R1's Service Plan, dated 2/26/26, showed R1 required hospice assist for bathing, total assistance with dressing, oral care, toileting, and assistance with mobility and transfers, with use of cane and wheelchair. The service plan showed R1 needed occasional help due to forgetfulness and difficulty concentrating.

Staff failed to report an allegation of sexual abuse to management in a timely manner:

R1's Incident and Accident Report, date/time 2/13/26 at 9:00 AM, showed a caregiver was called to (R1's) apartment to assist with bathroom cleanup and (R1) stated (Z2 - R1's Son) touched (R1) inappropriately. Review of the establishment investigation of the incident showed R1 alleged to E9 (Certified Nursing Assistant - CNA) that Z2 stuck Z2's finger in R1's vagina.

The establishment abuse policy (see below) showed staff should immediately report allegations to the Director of Health and Wellness and Executive Director.

The investigation showed E9 finished providing care to R1 around 6:30 AM and since there was no nurse scheduled overnight, waited until E7 (Licensed Practical Nurse) arrived at 7:00 AM to report the allegation to E7.

The investigation showed E7 collected statements but did not report the allegation to E3 (Previous Director of Health and Wellness - DHW) until E3 arrived at 8:30 AM.

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Email communication provided, on 4/22/26 at 10:00 AM, by E12 (Human Resources Director), showed, on 2/19/26, E7 was disciplined because when E7 arrived at 6:59 AM (on 2/13/26) and was informed of the allegation, E7 failed to notify (E3) and (E4 - Previous Executive Director - ED).

They failed to take immediate steps to protect the resident from further abuse and remove them from direct contact with the perpetrator:

The establishment abuse policy (see below) showed immediate steps should be taken to ensure the resident is protected from potential future abuse and neglect while the investigation is conducted, and the alleged perpetrator will have no contact with any residents during the investigation.

The investigation showed Z2 (R1's) son remained in the apartment with R1 from the time the allegation was made, around 6:30 AM, until after E4 alerted corporate staff of the situation on a conference call, then E4 removed Z2 from the apartment at 9:30 AM.

They failed to conduct a thorough investigation:

During interview with the staff whom R1 made the allegation, E9 (CNA), on 4/16/26 at 2:46 PM, E9 indicated E3 and E4 did not interview E9 until a couple of days after the incident. There was no documentation for the interview.

During interview with E7 (LPN), on 4/16/26 at 12:15 PM, when asked if management interviewed E7, E7 indicated she provided a written statement. There was no documentation

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for a verbal interview with E7.

There was no documentation additional staff were interviewed to see if there were concerns with Z2, if R1 made any previous allegations, if there was any change in R1's condition or behavior after the incident.

The investigation showed staff failed to include pertinent details in their written statements and in the Incident and Accident Report provided to the Department. During interview on 4/16/26 at 2:46 PM, E9 stated R1 called for assistance, which was unusual. E9 indicated R1 was upset and asked if the rules still applied that no men were allowed in R1's room. E9 stated R1 made the allegation at least four times, while E9 assisted R1 with toileting, that Z2 stuck Z2's finger in R1's vagina. E9 stated R1 had blood in the private area when E9 wiped R1. The information about the man in the room, being upset, the number of times R1 made the statement, or R1 had blood when wiped was not included in E9's written statement, dated 2/13/26. It is unclear if the information was relayed to E3 and E4 since there was no documentation of the interview. E9 indicated E7 reported the same information to E7 (LPN) as reported to this surveyor.

During interview with E7, on 4/16/26 at 12:15 PM, E7 indicated E9 reported R1 alleged Z2 stuck Z2's finger in R1's vagina but did report about the man in the room, the number of times R1 made the statement, or R1 had blood when wiped. E7's written statement, dated 2/13/26 did not include that information.

E4's (Previous ED) timeline of events showed Z9 (R1's Guardian) refused for R1 to be interviewed by E3 and the staff nurse, unless it was in front of

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the ring camera. E4 indicated E4 reached out to (corporate) for direction and waited for police to arrive. There was no documentation that establishment staff interviewed the victim R1.

There was no documentation the establishment interviewed the perpetrator Z2.

Because pertinent information was not included in written statements, and the establishment did not conduct interviews, information relayed to the police officer by management lacked important and/or inaccurate information, to which the officer could compare information provided by interviewees.

R1's police report was received and reviewed on 4/22/26. The report, dated 2/13/26, written by Z6 (City Police Officer) showed Z6 spoke with E3 (Previous DHW) and E4 (Previous ED), who relayed the allegation. There was no documentation that Z6 interviewed E4 or E9. The report showed the establishment told Z6 that R1 had dementia, but this surveyor could not find documentation of a diagnosis of dementia in R1's medical record.

The report showed Z6 interviewed Z2 on 2/13/26. The report showed conflicting information to what E9 reported. The report showed Z2 indicated Z2 assisted R1 to the toilet and stepped away. Z2 indicated, R1 reported blood on the toilet paper. Z2 indicated R1 normally self-cleaned, but Z2 called for assistance and let them know why. Z2 indicated R1 got verbally aggressive with staff when they did not do as R1 wished. Z2 indicated Z2 knew R1 would get mad when Z2 contacted staff to clean R1 but Z2 wanted R1 cleaned.

The report showed Z6 interviewed R1, while Z9

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| A6010 | Continued From page 36<br><br>(R1's Guardian) and another daughter listened to the conversation on Z6's phone. It was unclear if Z6 disclosed to R1 that they were listening. The report showed R1 did not know why Z6 wanted to talk with R1, reported no concerns, and indicated Z2 took good care of R1. The report showed Z6 determined there was no criminal matter.<br><br>E4's (Previous ED) timeline report showed, Z6 stated, because of R1's confusion and after speaking with the family, Z6 did not feel the incident occurred.<br><br>They failed to develop a written report of the investigation that included all the required elements:<br><br>The E4's email confirmation showed the 2/13/26 Incident/Accident Report submitted to the Department on 2/13/26 at 3:49 PM. The Department cases log showed the report was submitted as the first and final report. The written report submitted with the Incident/Accident Report was brief and included the police department report card.<br><br>The documentation submitted did not include:<br><br>-Description of the alleged abuse: The description noted, "Caregiver was called to resident apartment to assist with bathroom cleanup. Resident stated to caregiver her son touched her inappropriately." The information about the man in the room, R1 was upset, the number of times R1 made the statement, what R1 actually alleged, or R1 had blood when wiped was not included in the description.<br><br>-Description of any injury to the resident: The | A6010 | | |

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| A6010 | Continued From page 37<br>report indicated (R1) and (Z9) refused care, but did not indicate assessment for injury was refused.<br><br>-Description of any change in the resident's physical, cognitive, functional, or emotional condition: The report did not indicate R1 was upset when R1 reported the allegation. There was no documentation to note R1 was assessed for any change for a period of time after the allegation.<br><br>-Any actions taken by the licensee: The report did not indicate if and when the perpetrator was removed from contact with the resident.<br><br>-A list of individuals and agencies interviewed or notified by the establishment: The report did not list the name of the physician, guardian, police department, and hospice agency notified.<br><br>-Names of witnesses to the alleged abuse: The report did not list the name of the caregiver R1 reported the allegation to.<br><br>-If the abuse, neglect, or financial exploitation is substantial, a description of the action to be taken by the establishment to prevent the abuse, neglect or financial exploitation from occurring in the future: The report did not indicate E7 was disciplined because the allegation was not reported immediately to management. The report did not indicate an in-service was held on 2/17/26 to review resident rights and resident safety. The report did not indicate measures taken with Z2 prevent future incidents.<br><br>During interviews with E2 (DHW) on 4/16/26 at 3:38 PM and E1 (ED) on 4/16/26 at 4:03 PM, they | A6010 | | |

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| A6010 | Continued From page 38 | A6010 | | |

indicated E2 started employment in April and E1 in March. Both agreed the establishment should follow state regulation.

The establishment policy titled GP03 - Abuse, Neglect, and Exploitation (Date: 6/1/25) showed:

Policy: Resident abuse, neglect, and exploitation are prohibited. Should any resident experience abuse (by staff, residents, family, or others) or when abuse is suspected, staff and volunteers are required to immediately provide notification to persons/agencies as described in this policy ...The term abuse as used in this policy also includes, but is not limited to, neglect, abandonment, exploitation, and any other form of abuse.

Procedure: ...2) All staff and volunteers at (the establishment) are "mandated reporters". 3) Any community staff member or volunteer has observed, suspects, has knowledge of, or is told by a resident or other staff member, of an incident which appears to be any form of abuse, the incident will be immediately reported to the Director of Health and Wellness, and Executive Director ...4) Upon the notice of reported, observed, suspected, or at imminent risk of any form of abuse: 4)a) Immediate steps will be taken to ensure the resident is protected from potential future abuse and neglect while the investigation is conducted. 4)b) The alleged perpetrator will have NO CONTACT with any residents during the investigation. 4)c) A thorough investigation will be conducted by the Director of Health and Wellness or Executive Director. 4)c)i) A written report will be submitted to licensing within fourteen days of the initial report ...4)e) Witnesses or other persons will be interviewed as part of the investigation, as necessary ...4)i) Reporting of

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| A6010 | Continued From page 39<br>any suspected, alleged, or witnessed abuse will be completed according to state reporting requirements. 4)i)i) The Executive Director will notify the (Department) within twenty-four hours of notification ... | A6010 | | |
| A9000 | Section 295.9000 Physical Plant<br><br>This Regulation is not met as evidenced by:<br>Violation<br><br>Section 295.9000 Physical Plant<br><br>a) The establishment shall comply with the residential board and care occupancies chapter of the National Fire Protection Association's (NFPA) Life Safety Code (Life Safety Code) 101, Chapter 32 for new establishments and Chapter 33 for existing establishments.<br><br>b) The establishment shall comply with local and State building codes for the building type and local ordinances, fire codes, and zoning requirements. In the case of a conflict between a local requirement and this Part, the more stringent requirement shall apply. The establishment may petition the Department for a determination as to which requirement is applicable. The Department shall respond within 30 days after receipt of the petition ...<br><br>(Source: Amended at 47 Ill. Reg. 13264, effective August 30, 2023) | A9000 | | |

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| A9000 | Continued From page 40<br>Section 389.100 Definitions ...<br><br>"Electronic monitoring device" means a surveillance instrument with a fixed position video camera or an audio recording device, or a combination thereof, that is installed in a resident's room under the provisions of this Act and broadcasts or records activity or sounds occurring in the room.<br><br>"Facility" means an intermediate care facility for the developmentally disabled licensed under the ID/DD Community Care Act that has 30 beds or more, a facility licensed under the MC/DD Act, a long-term care facility licensed under the Nursing Home Care Act, or<br><br>A facility that provides housing to individuals with dementia, as dementia is defined in Section 3 of the Alzheimer's Disease Assistance Act (Section 5 of the Act), including: ...<br><br>An Alzheimer's unit in an assisted living establishment licensed under the Assisted Living and Shared Housing Act, and as provided for in 77 Ill. Adm. Code 295.4060.<br><br>"Resident" means a person residing in a facility.<br><br>"Resident's representative" has the meaning given to that term in: ...<br><br>Section 10 of the Assisted Living and Shared Housing Act if the resident resides in an Alzheimer's unit in an establishment licensed under the Assisted Living and Shared Housing Act; ... | A9000 | | |

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| A9000 | Continued From page 41<br><br>Section 389.105 Incorporated and Referenced Materials<br><br>a) The following standards are incorporated in this Part:<br><br>1) National Fire Protection Association (NFPA) 101 Life Safety Code (2012), which may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, Massachusetts 02169<br><br>2) National Fire Protection Association (NFPA) 70, National Electric Code, (2011), which may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, Massachusetts 02169<br><br>3) International Building Code (2012), which may be obtained from the International Code Council, 4051 Flossmoor Road, Country Club Hills, Illinois 60477-5795 ...<br><br>c) The following statutes and State administrative rules are referenced in this Part:<br><br>1) State of Illinois statutes: ...<br><br>I) Assisted Living and Shared Housing Act [210 ILCS 9]<br><br>2) State of Illinois administrative rules: ...<br><br>G) Assisted Living and Shared Housing Establishment Code (77 Ill. Adm. Code 295)<br><br>Section 389.110 Authorized Electronic | A9000 | | |

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| A9000 | Continued From page 42<br>Monitoring<br><br>a) A resident shall be permitted to conduct authorized electronic monitoring of the resident's room through the use of electronic monitoring devices placed in the room pursuant to the Act and this Part. (Section 10(a) of the Act)<br><br>b) A facility that houses dementia residents may allow electronic monitoring devices only in rooms that are located in a building that is entirely dedicated to dementia care; or that are located in a building wing that is solely dedicated to dementia care. (Section 10(c) of the Act)<br><br>c) Authorized electronic monitoring may begin only after a notification and consent form prescribed by the Department has been completed and submitted to the facility. (Section 20(a) of the Act)<br><br>This requirement was not met, as evidenced by:<br><br>Based interview and record review, the establishment failed to ensure they followed Life Safety Code, local and state building code, and Part 389 Authorized Electronic monitoring in long-term care facilities code, when they permitted residents who were not located in a building that is entirely dedicated to dementia care, or that are located in a building wing that is solely dedicated to dementia care, to install an electronic monitoring device outside their apartment door in the hallway and in their apartment, without proper consent. This applies to 1 of 3 residents (R1) reviewed for this requirement. This requirement was not met due to the conduct of the establishment or its staff, either by an improper action or the failure to take | A9000 | | |

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| A9000 | Continued From page 43 | A9000 | | |

an action.
This failure has the probability to affect all residents.

The findings include:

On 4/15/26 an investigation of Facility Reported Incident IL200276, and Complaints IL200236, IL200729, IL201216, and IL201374.

During the investigation, it was discovered the establishment permitted a resident, or their representative, who did not reside in rooms that are located in a building that is entirely dedicated to dementia care, or that are located in a building wing that is solely dedicated to dementia care, to install electronic monitoring in their room and outside the apartment door in the hallway, without proper consent:

R1's establishment investigation of Facility Reported Incident 2/13/26 - IL200276 that included a written timeline of events from E4 (Previous Executive Director - ED) showed R1 had an electronic monitoring device (Ring camera - A Ring camera is a smart home security device that provides video surveillance, motion detection, and two-way communication for monitoring your property remotely.)

R1's medical record showed R1 moved into the establishment on 1/3/25, resided in the assisted living unit, and expired on 3/29/26.

During interviews with E3 (Previous Director of Health and Welfare - DHW) on 4/20/26 at 9:36 AM and E7 (Licensed Practical Nurse - LPN) on 4/16/26 at 12:15 PM, confirmed R1 had a camera

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| A9000 | Continued From page 44 | A9000 | | |

outside the front door and one in the apartment. E3 indicated, privacy concerns were brought to management because with the camera posted outside the front door, R1's family could see other residents, visitors, and staff, and hear any conversations or patient information discussed. E3 indicated the camera remained outside the front door until the 2/13/26 incident occurred.

Email communication with E1 (ED), on 4/21/26 at 4:13 PM, provided email communication between E4 (Previous ED) and Z9 (R1's Guardian) regarding electronic monitoring. In the email, E4 requested Z9 sign a consent for use of electronic monitoring, according to policy put in place in June 2025. The communication with Z9 showed the camera was installed in the hall. In the email, Z9 indicated they had a camera installed since May 2025, with consent of the establishment. Z9 indicated they had video footage where staff assisted R1 down the hallway, R1 fell, and Z9 demanded a caregiver be disciplined for negligence. Z9 implied there was no issue with the camera until after a complaint was made but offered to move the camera three or four inches closer to R1's door.

The email communication attached an establishment Electronic Monitoring Roommate Consent form. The Department Electronic Monitoring Notification and Consent Form was not attached. There was no documentation to show Z9 ever signed a Department consent.

During interviews with E2 (DHW) on 4/16/26 at 3:38 PM and E1 (ED) on 4/16/26 at 4:03 PM, they indicated E2 started employment in April and E1 in March. Both agreed the establishment should follow state regulation.

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| A9000 | Continued From page 45<br><br>The establishment policy titled GP18 - Electronic Communication and Monitoring Devices (Policy Date: 6/1/25) showed:<br><br>Policy: The (establishment) will allow Electronic Monitoring, in accordance with state regulations. Electronic monitoring devices include cameras ...and video monitoring devices. To respect the right to privacy, devices that capture video shall not be pointed in the direction of resident care areas (bathrooms, etc.) ...Video devices may not be used to record video without written consent and only used in accordance with state regulations ...<br><br>Procedure: 1) Residents and/or their representative have the right to electronic monitoring use in accordance with a resident's rights and state regulations ...c) Consent for electronic monitoring must be obtained by all parties before electronic monitoring can be conducted ...ii) The Electronic Monitoring Consent form will be used. 1) Completed consent forms will be retained in the resident's record ....4) The Executive Director and Director of Health and Wellness will ensure the Community: a) Meets residents' requests to have a video camera obstructed to protect their dignity ....i) Electronic monitoring devices are for recording video only; these devices cannot capture or record audio. d) The Community may: i) Require an electronic monitoring device to be installed in a manner that is safe for residents, employees, or visitors who may be moving about the room, and meets all local and state regulations ... | A9000 | | |