STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL5106155	A. BUILDING: _____ B. WING _____	C 03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIGO AT ELMHURST (THE)	123 WEST BRUSH HILL ROAD ELMHURST, IL 60126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comment Facility Reported Incident Survey IL00200511 - 295.6000 a) 1)	A 000		
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, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 1) The right to live in an environment that promotes and supports each resident's dignity, individuality, independence, self-determination, privacy, and choice and to be treated with consideration and respect; This requirement was not met as evidence by: Based on document review and interview, the Establishment failed to ensure a resident was free of verbal abuse for 1 of 3 residents (R1) reviewed for abuse in the sample of 3. This failure resulted in R1 being violently yelled at by an employee (E7). This failure creates the substantial probability of severe harm to R1 and other residents. Findings include:	A6000		

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A6000	Continued From page 1 The record of R1 (the resident) was reviewed on 03/10/26 at 11:55 AM. The nursing note dated 02/20/26 included, " Incident - While in health center, writer (E6) overheard very loud yelling. Writer exited the health center to follow the sound of the voices, eventually observing resident and resident assistant (E7) in a heated verbal exchange ... Writer immediately separated the two, escorting resident back to his room. Resident could not provide any detail regarding the interaction with the staff member ... Incident reported to administrator and DON. The resident assistant was asked to leave the community immediately and informed not to return until receiving notice from upper management with next steps. Family ... made aware of incident and assured of resident's safety. MD also made aware." This nursing note was completed by E6 (LPN). The Service Plan dated 10/08/25 was reviewed and included, "Goal - Resident will be assisted to have optimal functioning and comfort around managing verbal aggression behavior. Action... Do not approach if resident upset while aggressive. If resident becomes upset when you approach while he or she is aggressive, stop and notify the nurse/administrator. Respond calmly and do not raise your voice..." On 03/10/26 at 1:41 PM, interview with E6 (LPN), stated she witnessed the incident on 02/20/26. Early around 5:00 AM, (E6) was sitting in the nursing office, when (E6) heard yelling. Saw R1 and E7 (CNA) in a loud verbal altercation, mostly coming from the E7. E6 stated, " ...(E7) said a lot of "F bombs, she was doing most of the yelling and cursing ..." E6 stated, E7 reported to E6 she saw R1 in the kitchen and tried to walk around R1, but couldn't and that E7 said, "get the ... out	A6000		

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A6000	Continued From page 2 of the way". E6 stated, she spoke with E7 regarding anger and stress management, called E1 (Executive Director) and E2 (RN, Healthcare Coordinator). E1 and E2 gave E6 instructions for E7 to leave the facility immediately. E7 failed to utilize resident assistant/CNA instructions indicated in R1's Service Plan, "Do not approach if resident upset while aggressive. If resident becomes upset when you approach while he or she is aggressive, stop and notify the nurse/administrator. Respond calmly and do not raise your voice..." E7 failed to treat the R1 with respect. On 03/10/26 at 1:45 PM, the above findings were reviewed and confirmed with E1 (Executive Director) and E2 (RN, Healthcare Coordinator).	A6000		