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A 000	Initial Comment Violations cited Complaint # 2642823/IL200594- 295.3000 a)h)1)2)3) Facility Reported Incident IL200874- 295.5000 d)j)1)2)3)4)5) Facility Reported Incident IL200934- 295.4060 a)b)	A 000		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: Type 1 violation Section 295.3000 Personnel Requirements, Qualifications and Training a) The establishment shall have staff sufficient in number with qualifications, adequate skills, education and experience to meet the 24 hour scheduled and unscheduled needs of residents and who participate in ongoing training to serve the resident population. (Section 35(a)(3) of the Act) h) The establishment shall have sufficient personnel to provide the following for its current resident population 1) All mandatory services; 2) Services established in each resident's service plan; 3) Service to meet the needs of each resident, including 24 hour scheduled and unscheduled needs, general supervision, and the ability to intervene in a crisis;	A3000		

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Based on interview and record review, the establishment failed to ensure staff were following physician's orders regarding a catheter flush, as well as complete timely assessment and intervention for a resident experiencing a change in condition. This failure has the significant negative impact on the delivery of services to the residents. This failure creates a substantial probability of severe harm to a resident or residents.

Findings include:
1. On 3/18/2026, Z7, R1's daughter in law stated she has concerns about R1's catheter because of "things I've heard".

On 3/18/2026 at 11:17 PM E4, Care Giver, stated R1's catheter was leaking and E4 witnessed E6 flush it with "sink tap water". E4 stated she relayed this information to Z2, Former Registered Nurse.
R1's Progress Notes do not include this notification.

An untitled document provided by Z2 documents, "Summary of Event: Caregiving staff reported that a resident's suprapubic catheter was flushed with tap water, this caregiver did not realize this was not the proper procedure. This was directly violating physician orders and standard sterile technique requirements. This action poses a significant infection control risk and is considered a serious clinical error."

R1's Physician's Orders document, "Irrigate supra-pubic catheter once daily using saline or sterile water".

2. On 3/19/2026 Z2 stated, "You should also look into the resident who got sent out for RSV

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(Respiratory Syncytial Virus) the other day."

Z2 provided a document stating, "Summary of Events- 3/1/26 - Initial Report of Respiratory Distress:
On 3/4/26, a caregiver reported in a facility owned group chat that resident (R10) was having trouble breathing and "would benefit from oxygen".
The caregiver stated that the resident "could benefit from oxygen," despite the resident not having oxygen ordered and no assessment being documented.
No follow up assessment, vital signs, lung sounds, or escalation to a nurse or physician were documented or communicated."

The Facility provided a screen shot of the Group Chat referred to above and it documents on 3/4/2026 at 10:06 PM, E10, Care Giver, reported R10 "could benefit from oxygen". It continues to document on 3/5/2025 at 5:23 AM, E2, Caregiver agreed. At 10:44 on 3/5/2026, Z2 stated R10 would need a doctor's order.

R10's Progress Notes dated 3/6/2026 at 5:26 PM document Z2 heard R10 wheezing, assessed R10's "wet lung sounds", obtained a oxygen saturation of 85% (normal is 90-100) and respirations of 22 a minute (normal is 12-20). Z2 contacted family and they agreed to send to the local ER for evaluation.

There is no documentation in R10's Progress Notes of an assessment performed/completed prior, an update to R10's Physician regarding his condition, nor a notification to R10's doctor to obtain orders for supplemental oxygen.

R10's Service Plan dated 12/4/25 documents R10 is a total assist for oxygen needs and the

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A3000	Continued From page 3 nurse is responsible for set up. The establishment's "Emergency Plans" Policy documents, "Medical Emergencies- any situation that has, or is likely to have a significant effect on the health, safety or welfare of a resident or residents". It continues to document, "a. The RA/Nurse/CAN assigned to care for the resident during his/her shift is responsible for follow through of all the notification and treatment, unless relieved of said responsibility by his/her supervisor. B. The RA/Nurse/CAN makes immediate and through assessment of the condition of residents and the situation. Emergency treatment should be carried out when necessary." On 3/23/2026 at 9:00 AM, E1, Regional Director, stated R10 passed away at the hospital from RSV. On 3/24/2026 at 11:23 AM, E7,Executive Director, stated, "On 3/4/26 there was a message from (E10) stating #27 (R10) would benefit from O2 (oxygen). On 3/5/2026, the nurse (Z2) replied that they would need an order for O2. (Z2) did not call the physician to request an order for his oxygen. He was sent to the hospital on 3/6/2026 due to O2 levels lower than the accepted rate. " On 3/24/2026 at 1:51 PM, E7, stated "She (Z2) should have contacted the physician for evaluation prior to when she did. He (R10) could have used some oxygen." E7 added that R10 passed away at the hospital on 3/18/2026.	A3000		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs	A4060		

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A4060	Continued From page 4	A4060		

This Regulation is not met as evidenced by:
Type 2 Violation.
Section 295.4060 Alzheimer's and Dementia Programs

a) In addition to this Section, Alzheimer and dementia programs shall comply with all of the other provisions of the Act. (Section 150(a) of the Act)

b) No person shall be admitted or retained in an assisted living or shared housing establishment if the establishment cannot provide or secure appropriate care, if the resident 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 150(b) of the Act)

Based on interview and record review, the establishment failed to ensure a resident (R7) was prevented from exiting the locked building without staff present; as well as did not follow to establishment's reporting or elopement policy. R7 was located outside the establishment, by herself, in the parking lot. This failure has the substantial probability of harm to a resident (or residents).

Findings include:

On 3/24/2026, Z9, R7's daughter, stated, "On 3/9 (2026) the cook found her in the parking lot by the dumpster, on the left of the parking lot, going towards the highway. I would have thought they would have heard the alarm. She said she thought she was going to a town event in her

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A4060	Continued From page 5	A4060		

hometown. The sign says, 'Hold the door for 15 seconds' . She read that and told me, 'I had to do it three times'. Those doors aren't supervised a lot of the time because no one is at the front desk. It was about 5:20 in the evening when she got out. They didn't even tell me until the next day. (E1) told me, 'By the way, your mom got out yesterday." In the meantime, they told staff 'Keep a closer eye on everyone'. (Date unspecified) My niece rang the buzzer (outside doorbell to alert staff to let guests/visitors in) and no one answered. She then called the facility, and no one answered. She didn't end up going in and mom (R7) was expecting her".

On 3/24/2026 at 2:52 PM, E7 stated R7's elopement was not reported nor was there an incident report turned in. E7 stated "they" looked on the cameras and didn't see where she got out. The lady in the kitchen found her, but she's been off. No one said anything about it. Nothing was documented about what happened. The family just told us she got out."

The Facility's IDPH (Illinois Department of Public Health) Report documents the time and date of the event was 3/9/2026 from 6:00 PM-6:30 PM. An agency nurse found R7 walking outside on the sidewalk with her walker. It continues to document the agency nurse did not notify management or the family at the time of event. There was no documentation of the incident. It also states the nurse did not remember if the alarms were going off or not.

On 3/24/2026 at 5:06 PM, "I filled out an incident report. The agency nurse did not know the policies on Elopement policies. We are reviewing the training protocols tomorrow and the fact that I need it to be reported to me within immediately

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A4060	Continued From page 6 because I have to report it within 24 hours. I will make all staff aware of this." E7 stated an Elopement Risk Assessment should have been filled out as well. On 3/25/2026 at 1:07 PM, Z11, Hospice Nurse, stated she knew R7 had gotten out of the building by pushing on the door for 15 seconds and was found in the parking lot by a staff member. Z11 stated she does not know why staff didn't respond to the door alarm. Z11 stated R7's dementia has gotten worse since she has been at the facility. Z11 stated R7 thought she was going to a festival in her hometown. The establishment's Incident and Accident Reporting Policy documents elopements are State Reportable Incidents; Incident Reports should be completed by the staff member who witnesses an incident or is the first to see it/hear it. The Establishment's Policy Guidelines: "The facility strives to promote and protect the rights and dignity of the residents the facility maintains a process to asses all residents for risk for elopement, implement risk reduction strategies for those identified as a an elopement risk, institute measures for resident identification at the time of admission and conduct a coordinated resident search in the event of a missing resident. Definitions: Elopement is the ability of a cognitively impaired resident, who is not capable of protecting himself or herself from harm, to successfully leave the facility unsupervised and unnoticed and who may enter into harms way."	A4060		
A5000	Section 295.5000 Medication Reminders, Supervision of Self Med	A5000		

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A5000	Continued From page 7	A5000		

This Regulation is not met as evidenced by:
Type 2 Violation (repeat)
Section 295.5000 Medication Reminders, Supervision of Self-Medication, Medication Administration and Storage-

d) Medication administration refers to a licensed health care professional employed by an establishment engaging in administering routine insulin and vitamin B-12 injections, oral medications, topical treatments, eye and ear drops, or nitroglycerin patches. Non-licensed staff may not administer any medication. (Section 70 of the Act)
j) A separate medication record shall be maintained for each resident receiving medication administration and shall include:

1) Name of resident;

2) Name of medication, dosage, directions, and route of administration;

3) Date and time medication is scheduled to be administered;

4) Date and time of actual medication administration; and

5) Signature or initials of the employee administering medication.

Based on interview and record review, the Establishment failed to ensure medications were administered using the most current physicians orders and were documented in the Medication Administration Record (MAR). This failure has the

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A5000	Continued From page 8 substantial probability of harm to a resident (or residents) Findings include: On 3/24/26 at 9:30 AM, E7, Executive Director, stated, "(Z9) and (R7's other daughter) were upset because (R7) was 'so out of it' the other night (3/18/26). They went home and looked at their camera and said they heard the nurse say 'Here's your Morphine. One more dose to go'. Hospice had discontinued the routine Morphine on 3/3/26 and made it PRN (as needed). The Agency nurse (E8) didn't even chart anywhere that she had given any. She was not giving meds (medication) correctly. She should have been looking at the MAR. It was a medication error. On 3/24/2026 at 11:23 AM, E7 stated, "It (Morphine/MS) it is PRN, but had been scheduled three times a day. She didn't need it. She wasn't having any issues that day (pain). She (E8) should not have been giving it three times a day anymore. She didn't even mark that she gave it. Hospice was upset too because she didn't need it. She had already had 2 doses by 2 (pm) and (E8) was going to give her another. She (R7) was out of it. The next day, she didn't have any of it and was ok." On 3/24/26 at 1:57 PM, Z9, R7's daughter stated, "My brother called that evening (3/18/26) and said mom (R7) was mumbling and he couldn't understand her. He said she kept falling asleep. My sister left crying because she had never seen mom like that. Mom was complaining about her stomach hurting. I looked on the camera and saw the nurse give her something and I heard her say, 'I wonder why your stomach is hurting, it may be the medicine. You're getting Morphine (MS) 3	A5000		

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times a day'. We have been weaning mom off the MS for a month. She does have an allergy to it, but she tolerates it in small doses. She has it PRN IF she needs it (for pain). I asked mom if she got the medication in the mouth with the syringe and she said yes. I talked to the nurse, and she said she had given it twice and was getting ready to give her a third dose. She showed me a piece of paper- it was old orders, not from the computer. The nurse the next day said she wasn't supposed to be getting it like that. I talked to the hospice nurse about it and she was upset because she knew we were trying to wean her off it. Mom was good the next day since she didn't get any of it.

On 3/25/26, at 1:07 PM, E11, Hospice Nurse, stated, "(R7's) family had informed me an agency nurse gave (R7) MS 3 times in one day. It had been scheduled that way about a month ago because she was having pain from a fracture. It was then changed to nightly, then as needed. The nurse did not go by the MAR. She used a notebook- like a report book. She didn't even sign off any of the meds. The family said she was groggy, mumbling and it was above and beyond her dementia. She was back to baseline the next day. Their order transcription process is not user-friendly."

The Establishment's Illinois Department of Public Health (IDPH) Incident Report documents on 3/18/26, R7 was "out of sorts" when family came to visit. Family reviewed camera footage and heard the nurse tell R7 she had already given her two doses of morphine and was due for her third. It continues to document the medication that had been discontinued on 3/3/26 by R7's hospice doctor was now PRN. It documents, "This is a medication error on the nurse's part".

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A5000	Continued From page 10 R7's Service Plan documents 2/3/26- Change Morphine from 3 times a day to bedtime only. R7's hospice orders dated 3/3/26 document R7's Morphine at bedtime was discontinued and changed to PRN. The Facility's Medication Errors Policy documents, "1. The nurse will report any medication errors to the manager upon finding. 2. The nurse will report any medication errors to the resident's primary/ordering practitioner and power of attorney. 3. The nurse will monitor the resident for any adverse effects and report any adverse effects to the manager, resident's primary physician/ordering practitioner and power of attorney."	A5000		