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	ASL5106296	A. BUILDING: _____ B. WING _____	07/17/2025

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ALTO-GRAYSLAKE	1865 EAST BELVIDERE ROAD GRAYSLAKE, IL 60030

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A 000	Initial Comment Annual Licensure Survey Conducted Section 295.2050 Incident and Accident Reporting Section 295.4010 a) b) 2) 3) c) d) e) Service Plan	A 000		
A2050	Section 295.2050 Incident and Accident Reporting This Regulation is not met as evidenced by: Type 3 Violation Section 295.2050 Incident and Accident Reporting (REPEAT) 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. 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. c) A copy of the report shall be maintained by the establishment for one year after the date of the incident or accident. (Source: Amended at 47 Ill. Reg. 13264,	A2050		

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A2050	Continued From page 1 effective August 30, 2023) This requirement was not met, as evidenced by: Based on interview and record review, the establishment failed to report serious incidents or accidents to the Department or reported outside the required 24-hour time frame. This applies to 5 of 8 residents (R1, R2, R3, R4, R6) reviewed for this requirement. The findings include: On 7/15/25, an Annual Licensure Review was initiated. There was no documentation to show the following incidents that caused physical or emotional harm or injury were reported to the Department: R1's Progress Notes, date/time 12/17/24 at 10:54 AM, showed R1 was sent out for a psychiatric evaluation due to an incident where R1 placed a diaper with feces in E3's (Dining Services Director) office, yelled, swore, and alleged dining poisoned R1. R2's Progress Notes, date/time 9/23/24 at 3:42 PM, showed R2 presented with a bruise and swelling to the left leg, of unknown origin. R4's Progress Notes, date/time 3/29/25 at 11:31 PM, showed R4 presented with a bruise under the left eye, of unknown origin. There was no documentation to show the	A2050		

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A2050	Continued From page 2 following Incident/Accident Reports were reported to the Department within 24 hours of the occurrence: R3's Incident/Accident Report, date/time 10/20/24 at 1:15 PM, showed R3 had a fall that resulted in a cut to the right eyebrow and complaint of right rib pain. The report showed R3 was sent to the hospital for evaluation and returned with three stiches to the right eyebrow. R6's Incident/Accident Report, dated 3/28/25 at 3:00 PM, showed R6 complained of pain to the right hip area and an x-ray was ordered. The follow-up report, dated 4/3/25, showed the x-ray showed a right hip fracture, and R6 was sent to the hospital and admitted. On 7/16/25 at 3:52 PM, E1 (Executive Director) and E2 (Resident Services Director) was given the opportunity to provide further documentation. On 7/17/25 at 3:04 PM, E1 confirmed they provided all reportables they could find. The establishment policy titled Incident and Accident Reporting - Illinois (Review date: 5/15/24) mirrored Department regulation 295.2050.	A2050		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 2 Violation Section 295.4010 Service Plan	A4010		

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A4010	Continued From page 3 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. b) The service plan shall be developed by: ... 2) The manager or manager's designee; and 3) A registered nurse, if the resident is receiving nursing services or medication administration, or is unable to direct self-care. c) The service plan shall be signed and dated by all individuals involved in its development. d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act) e) The service plan shall be reviewed and revised if necessary immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000). This requirement was not met, as evidenced by: Based on interview and record review, the	A4010		

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A4010	Continued From page 4	A4010		

establishment failed to follow their policy and state regulation when a resident's service pan was not consistent with the physician's assessment; they failed to ensure service plans were signed and dated by all individuals involved in its development; and they failed to ensure the service plan was reviewed and updated for fall incidents. This requirement was not met for 8 of 8 residents (R1, R2, R3, R4, R5, R6, R7, R8) reviewed for this requirement. These failures have the potential to affect all residents that reside in the establishment and creates a substantial probability of harm to a resident or residents, in that it cannot be determined if the establishment is aware of and addressing the safety needs and concerns of the resident.

The findings include:

1) R1's medical record showed R1 moved into the establishment on 7/23/19 and has multiple diagnoses, including diabetes mellitus type 2, diabetic neuropathy, chronic ischemic heart disease, delusional disorder, Asperger's syndrome, anxiety disorder, and major depressive disorder.

R1's Service Plan, dated 12/18/24, was not consistent with the level of assist determined by the physician's assessment. R1's Physician's Assessment, dated 12/1/24, showed R1 required assist with transfers. R1's service plan showed R1 is independent with transfers. R1's Progress Notes, reviewed for June 2024 to July 2024 showed multiple falls related to self-transferring (see fall incident dates below).

R1's service plan was not signed and dated by the manager and a registered nurse. R1's service

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A4010	Continued From page 5 plan showed R1 receives medication administration. R1's service plan was not reviewed, and interventions updated for fall incidents. R1's Progress Notes showed falls on 12/24/24, 12/28/24, 1/2/25, 1/6/25, 5/10/25, 6/1/25, 6/23/25, and 6/27/25. 2) R2's medical record showed R2 moved into the establishment on 7/31/22 and has multiple diagnoses, including hypertension and dementia. R2's Service Plan, dated 6/3/25, was not signed and dated by the manager and a registered nurse. R2's service plan showed R2 receives medication administration. 3) R3's medical record showed R3 moved into the establishment on 6/20/24 and has multiple diagnoses, including diabetes mellitus type 2 and Parkinson's disease. R3's Service Plan, dated 12/10/24, was not signed and dated by the manager and a registered nurse. R3's service plan showed R3 receives medication administration. R3's service plan was not reviewed, and interventions updated for a fall incident. R3's Progress Notes showed a fall on 7/5/25. 4) R4's medical record showed R4 moved into the establishment on 2/29/24 and has multiple diagnoses, including below the left knee leg amputation and diabetes mellitus type 2.	A4010		

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A4010	Continued From page 6 R4's Service Plan, dated 4/2/25, was not signed and dated by the manager. 5) R5's medical record showed R5 moved into the establishment on 12/27/23 and has multiple diagnoses, including diabetes mellitus type 2, glaucoma, dementia, and Alzheimer's disease. R5's Service Plan, dated 1/30/25, was not signed and dated by the manager and a registered nurse. R5's service plan showed R5 receives medication administration. 6) R6's medical record showed R6 moved into the establishment, resides in memory care, and has multiple diagnoses, including right clavicle fracture, hypertension, and breast cancer. R6's Service Plan, dated 1/21/25, was not signed and dated by the manager and a registered nurse. R6's service plan showed R6 receives medication administration. 7) R7's medical record showed R7 moved into the establishment, resides in memory care, and has multiple diagnoses, including cognitive communication deficit and dementia. R7's Service Plan, dated 6/12/25, was not signed and dated by the manager and a registered nurse. R7's service plan showed R7 receives medication administration. 8) R8's medical record showed R8 moved into the establishment, resides in memory care, and has multiple diagnoses, including hypertension	A4010		

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A4010	Continued From page 7 and Alzheimer's disease. R8's Service Plan, dated 5/28/25, was not signed and dated by the manager and a registered nurse. R8's service plan showed R8 receives medication administration. R8's service plan was not reviewed, and interventions updated for fall incidents. R8's Progress Notes showed R8 had falls on 3/4/25 and 6/28/25. On 7/16/25 at 3:52 PM, during interview with E1 (Executive Director) and E2 (Resident Services Director), indicated, E1 and E13 (Registered Nurse) is involved in the development of the service plan, but could not provide documentation of involvement, and indicated that going forward, they will ensure all signatures are provided. During the interview, service plan concerns were discussed and confirmed. The establishment policy titled Service Plans - Illinois (Effective date: 4/21/23) mirrored Department regulation 295.4010. The establishment policy titled Minimizing Fall Risk Policy (Effective date: 4/3/18) showed: ...It is the policy of the Company to identify residents at risk for falls and to implement a program to reduce the risk of falls and possible injury ...An evaluation to determine the resident's risk for falls will be completed for every Assisted Living resident at move-in, quarterly and on an as needed basis ...A resident identified as being at risk for falls and injury. Further, these approaches will be documented in the Resident Record and on the Resident Care/Service Plan ...Residents	A4010		

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A4010	Continued From page 8 will be reviewed routinely as noted above and reevaluated each time a resident experiences a fall, and approaches will be evaluated for effectiveness and updated as indicated ...	A4010		