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	5108250	A. BUILDING: _____ B. WING _____	C 04/10/2026

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A 000	Initial Comment Complaint Investigation Survey IL00200924 295.4020 f) 295.5000 a) d) IL200929-none IL00201124 295.2000 a) 1)	A 000		
A2000	Section 295.2000 Residency Requirements This Regulation is not met as evidenced by: Type 1 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) 1) The person poses a serious threat to themselves or to others. These requirements are met as evidenced by: Based on interview and record review, the establishment failed to ensure residency requirements are met for one (R2) resident with aggressive behavior. This affected one of three residents reviewed for this requirement.	A2000		

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A2000	Continued From page 1 This failure creates the substantial probability of severe harm or death to a resident or residents. Findings include: R2 ' s medical records show R2 is 59 years old, R2 resided on Memory care unit. R2 moved to the community on 7/31/24. R2 ' s diagnoses include but not limited to Dementia, and Essential Hypertension. R2's Service plan dated 3/30/2026 indicated the following: Extensive assist with bathing, personal hygiene, dressing, and toileting. Total assistance with medication. Need: Psychosocial- Goal: Resident will maintain and/or maximize current level of functioning with disruptive/socially inappropriate behavior- Action: current behavior type... occasional/infrequent aggression towards staff during ADL care. R2's Progress Notes indicated the following 12/13/2025- R2 was observed exhibiting aggressive behavior toward a new male staff member. R2 appeared unfamiliar with surroundings and reacted with aggression toward the staff member. To prevent escalation, writer and another staff member intervened promptly. R2 was safely separated from nearby residents and staff without injury. Writer assessed R2's behavior, maintained a calm demeanor, and spoke gently to R2 during the interaction. 1/5/2026- R2 with increased agitation. R2 combative and resisting care. R2 had just had pm medication. Care redirected R2 to his room, allowing him time to calm down.	A2000		

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A2000	Continued From page 2 2/10/2026- At around 4PM, a male resident in memory care reported being punched in the face by another male resident, resulting in a bleeding mouth. The incident was not witnessed by staff. 3/19/2026- Writer called to unit by care staff. R2 refusing ADL care. Writer attempted with care staff to perform ADL care. R2 agitated and resisting care. No PRN medication available. Writer attempted to provide reassurance and redirection to R2 with limited effect. Writer advises staff to leave R2 alone until he comes back to baseline. Writer advises staff to monitor behavior and increase agitation. R2 is stable. No distress noted. 3/19/2025- Writer called to floor by panicked care staff members. Writer immediately came to unit. Writer observed R2 chasing staff around unit. Writer and other care staff tried to redirect R2 away from attacked care staff member. Situation deescalated and blood noted on back of R2's head. Writer attempted to assess R2 but couldn't due to agitated .911 was called. Incident Report dated 3/19/2026 indicated in part On 3/19/2026 at approximately 3:00AM, in the Memory Care unit. resident R2 demonstrated escalating agitation and aggressive behavior that resulted in staff injury. ... CNA E11, the assigned caregiver, was physically assaulted and struck multiple times with a closed fist to the face and head. E7 (Resident Assistant) and additional staff intervened to separate R2 and protect those involved, During the altercation, R2 tripped over a laundry cart while holding onto a staff member's clothing, fell to the floor, stood up while continuing to swing, and fell a second time. The aggression persisted despite staff interventions.	A2000		

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A2000	Continued From page 3 On 4/7/2026 at 3:57PM, E7 (Resident Assistant/RA) R2 is very aggressive, the first day I was working, the first week on the I saw R2 hit another resident on the mouth, both residents were sent out. The other resident had fracture on the jaw, R2 was out for a couple of days and then came back. E7 said When we tried to change him began to hit us, we called the nurse to help, and the nurse tried to see if R2 has a PRN but R2 didn't have any. Nurse told us to leave R2 alone. Nurse went to another floor, at this time we noticed R2 had poop, we tried to change him, R2 was very aggressive, R2 went to the common area and tied to attacked a resident who was already in the common area, the CNA (E11) who usually works with R2 tried to redirect him and E11 was not able to calm R2 down." E7 said "R2 attacked E11, we tried to help E11. I told the other caregiver to stay back. We called for assistance and nurse came back, and R2 was sent out to the hospital. I didn't see staff hitting R2." On 4/8/2026 at 7:35AM, E10, (Licensed Practical Nurse/LPN) said she was called around 3:30ish to the fourth floor that R2 was agitated, E10 said that she has good rapport with R2, E10 went to talk to R2 and noticed that R2 was a little agitated, E10 walked with R2 to the bathroom but then R2 refused to be changed. E10 told the caregivers to leave R2 alone for a while and try again later, E10 said she checked for any PRN (as needed medication) but R2 didn't have any. E10 said that around 4:00am she heard someone calling for help in the microphone, E10 went upstairs again and when E10 arrived at the fourth floor, E10 saw R2 chasing someone, E10 called R2 and R2 came to her, E10 got scared because R2 was agitated, male caregiver and another CNA were able to get R2. E10 said that R2 had	A2000		

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A2000	Continued From page 4	A2000		

blood on his mouth and the back of the head. E10 said she is not aware if resident was hit by staff.

On 4/8/2026 at 8:09AM, E11, (Certified Nursing Assistant/CNA) said "R2 attacked me" it was the morning of the 20th, I think. R2 got up and was walking around, which R2 never does, R2 usually doesn't get up. I tried to talk to him into going back to his room, but R2 was not listening. I knew something was not right because R2 is not like this, I know that when R2 gets agitated it is best to leave him alone. R2 kept walking back and forth. There was a female resident up and was sitting in the common area, she is a fall risk. I noticed that R2 needed to be changed, his brief was heavy, R2 refused with me. E7 (RA) tried to change him too but R2 was getting irritated, we left him alone. R2 kept walking around and around. We tried to change R2 again later because R2 had bowel movement but R2 refused again. I called the nurse to see if he had a PRN and the nurse came, nurse checked for PRN and said that R2 didn't have any, nurse told us to leave R2 alone to calm down." E11 said "I went to the bathroom and when I was coming back, I saw R2 next to the female resident with his fist balled up. I thought R2 was going to hit her, I tried to redirect R2, I called R2 and R2 then focused on me, R2 started going after me. I never had a problem like this with R2. We had a cart where we put our stuff to change the beds and I put it between us, R2 hit me upside the head and we ended up on the floor, I tried to get up but R2 was pulling my arm, the other caregivers were really scared and they were in the corner, telling R2 to stop. I was able to get up because I took the jacket off." E11 said "I called the nurse and nurse called 911, R2 was sent out." E11 said that she didn't notice anyone hitting R2. E11 was not aware R2 sustained an injury until it was

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A2000	Continued From page 5 mentioned during this interview. E11 said that the time R2 broke the jaw of another resident, they had an in-service how to handle his behavior but there were no interventions, they were told to talk to him and never approach him from the back. On 4/9/2026 at 9:11AM, E13 (RA) said I heard over the walkie talkie that a resident was in distress and the CNAs needed assistance with the resident. When I arrived I observed a confrontation with CNA and R2, I had to get in between them and separated them. I took R2 to his room, R2 was agitated, R2 kept walking back and forth. I didn't observed anybody hitting R2 but it was obvious that R2 had hit E11 on the face. R2 had blood on his face. I stayed with R2 until the paramedics and the police came."	A2000		
A4020	Section 295.4020 Mandatory Services This Regulation is not met as evidenced by: Violation Section 295.4020 Each establishment shall provide or arrange for the following mandatory services: f) Assistance with activities of daily living as required by each resident. (Section 10 of the Act) This requirement is not met as evidenced by: Based on observation, interview, and record review, the establishment failed to provide showers and medicated shampoo to one (R1) resident of three residents reviewed for ADLs (activities of daily living).	A4020		

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A4020	Continued From page 6 This failure has the probability to affect all residents in the establishment. Findings include: R1's medical record showed R1 moved into the establishment on 3/15/2024, resides in the memory care unit, and has multiple diagnoses, including but not limited to Parkinson's disease, Dementia in other diseases classified elsewhere without behavioral disturbance, History of falling, other abnormalities of gait and mobility. R1's Service Plan, dated 1/10/2026, shows R1 was independent, with the use of a walker, for transfers and mobility. R1's service plan addressed R1 as a fall risk and had interventions in place. R1 requires total medication administration by nurse and requires extensive assistance for bathing three times weekly. R1 is independent with meal consumption. Medicated shampoo to be administered on Shower days (Mondays, Wednesdays and Saturdays). R1's Skin monitoring: Comprehensive CNA Shower review form for 3/11/2026 and 4/4/2026 were provided to surveyor. On 4/7/2026 at 10:20AM, Z1 (R1's Power of Attorney/POA) said that showers are not done three times a week, because saw camera and for at least for 2 weeks R1 didn't have a shower, R1 is supposed to have medicated shampoo twice a week. On 4/8/2026 at around 12:00PM, E3 (Memory Care Director) stated that only these two forms were found. Unaware if showers were given or	A4020		

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A4020	Continued From page 7 not.	A4020		
A5000	Section 295.5000 Medication Reminders, Supervision of Self Med This Regulation is not met as evidenced by: Type 1 Violation Section 295.5000 Medication Reminders, Supervision of Self-Medication, Medication Administration and Storage a) An establishment may provide medication reminders, supervision of self-administered medication, and medication administration as an optional service. 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) This requirement is not met as evidenced by: Based on interview and record review, the establishment failed to follow physician orders for medication administration and failed to follow their Medication Policy and procedure for one (R1) resident of six reviewed for medication administration.	A5000		

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A5000	Continued From page 8 This failure creates the substantial probability of severe harm or death to 1 or all residents. Findings include: On 4/7/2026 and 4/8/2026 resident documents were reviewed during onsite survey. R1's medical record showed R1 moved into the establishment on 3/15/2024, resides in the memory care unit, and has multiple diagnoses, including but not limited to Parkinson's disease, Dementia in other diseases classified elsewhere without behavioral disturbance, History of falling, other abnormalities of gait and mobility. R1's Service Plan, dated 1/10/2026, shows R1 was independent, with the use of a walker, for transfers and mobility. R1's service plan addressed R1 as a fall risk and had interventions in place. R1 requires total medication administration by nurse and requires extensive assistance for bathing three times weekly. R1 is independent with meal consumption. R1's eMAR dated 3/22/2026 indicated that Carbidopa-levodopa was given at 7:10AM for 6AM, for the 11AM dose, it was given at 12:03PM and for the 4PM dose, it was given at 3:52PM Reviewed of R1's eMAR from 3/12/2026 to 3/22/2026 medication was not given at the scheduled time as follows: 3/12/2026- given at 5:04PM for (4PM) 3/12/2026- given at 1:09pm for (11AM) 3/13/2026 given at 10:28AM for (6AM) 3/13/2026 - given at 7:08 PM for (4PM) 3/14/2026 - given at 11:24AM for (6AM) 3/14/2026- given at 7:14pm for (4pm) 3/15/2026 - given at 9:38 AM for (6AM)	A5000		

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A5000	Continued From page 9	A5000		

3/15/2026- given of 1:32 PM for (11PM)
3/15/2026 - given at 5:30 PM for (4pm)
3/16/2026 - given at 7:07 PM for (4PM)
3/17/2026- given at 10:21 AM for (6AM)
3/18/2026- given at 12:41pm for (11Am)
3/18/2026 - given at 7:17PM for (4PM)
3/19/2026 - given at 9:27AM for (6AM)
3/19/2026 - given at 7:02PM for (4PM)
3/20/2026- given at 6:00PM for (4pm)
3/21/2026- given at 5:55pm for (4PM)
3/21/2026 - given of 7:13AM for (6AM)
R1's eMAR also showed that besides these specific dates. R1's medication was not administered as prescribed as follows:
10/1/2025-10/31/2025- 52 times
11/1/2025-11/1/2025- 55 times
12/1/2025-12/31/2025- 49 times
1/1/2026-1/31/2026- 44 times
2/1/2026-2/28/2026- 35 times
3/1/2026-3/31/2026- 55 times

R1's Physician Order sheet dated 2/14/2024 indicated the following:
Parkinson's medication to be given at exact times: 0730-1130-1630 before meals.
On 4/7/2026 at 3:10 PM, E4 (Licensed Practical Nurse/LPN) said "we are short staffed, and my medication probably will be late because I need to help caregivers to get resident sup, especially on weekends."

4/9/2026 at 10:56AM, E15 (Former Nurse) said R1had her medication scheduled at 6am 11 am 4pm family was very particular about given her Carbidopa-Levodopa on time. R1's medication was given ahead of other residents. There is a window to give medication one hour before and one hour after. I tried to give medication on time, but I know that there was a problem with medication not given on time, I explained to the

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A5000	Continued From page 10	A5000		

family that unfortunately I can't speak for other nurses, I can just speak for myself. I spoke to the Nursing Supervisor about finding medication in the trash or in cups with resident's name on it, but she didn't do anything about it. E15 said that she was also instructed to give the medication to help the next shift and not sign off, just to let the oncoming nurse know which medications were given. I always signed off the medication I gave." E 15 said that medication was crushed because R1 was having problems swallowing, it was mixed either with pudding or applesauce.

On 4/9/2026 at 4:08PM, Z2 (Pharmacist) said that medication is recommended to be given with meals for better absorption.

Establishment t Policy title "Medication Administration" Policy and Procedure Revision Date: 8/1/2022
Policy: It is the American House policy to appropriately administer medications as required by the physician's order and in accordance with state regulation.
Procedure:
9- Observe each resident as they take their medication-regardless of their level of orientation.... Do not give medication to another staff to administer.
10- Only the individual administering the medication is to document on the MAR or EMAR.
11. Administer only the medication you have prepared. Never give a resident a medication which is unlabeled or prepared by someone else.