STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510340	A. BUILDING: _____ B. WING _____	C 04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR CREEK ALZHEIMER'S SCC	505 E VERNON AVE NORMAL, IL 61761

(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 IL201026 Section 295.4010 d) e) Section 295.6000 a) 13)	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Section 295.4010 Service Plan 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). Type 2 Violation Based on interview and record review, the establishment failed to update services plans for two (R1 and R3) of five residents reviewed after instances of aggression. R1 pushed R5, pushed R4 to the ground causing a hematoma to back of R4's head, and hit R1 in the stomach. R3 hit R1. This has a substantial probability to cause harm to establishment residents.	A4010		

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A4010	Continued From page 1 Findings include: On 3-31-26 at 1:00 pm, E1 Executive Director stated on 3-17-26, after 1:00 pm, R1 was sitting in a chair in the back area when R3 walked up and hit R1 with R3's closed fist. R1 and R3 were sent to the emergency room for evaluation. R1 returned that night and was in bed. Staff came in several times to assist R5, R1's roommate, with incontinence. R1 got out of bed, became aggressive and pushed R5 and tried to hit staff. R1 then leaves his room and comes into contact with R2 and hits R2 in the stomach. R2 then hits R1 in the jaw. R1 was transferred again to the emergency room for evaluation. E1 stated no one sustained injuries from these altercations. E1 continues that after the above incidents, R1 had a private sitter providing one to one supervision. On 3-29-26 about 3:15 pm, R1 was being aggressive with staff while receiving toileting care. R1 left his room, went up to R4 and pushed her down to the ground causing a hematoma to her head. R3's 3-17-26 incident report documents on 3-17-26 at about 8:30 pm, R1 was sitting in a chair when R3 grabbed R1 by R1's shirt and was hitting R1. R1 was yelling and putting his arms up in a protective manner. R1's 3-17-26 Incident Report documents on 3-17-26 at 10:53 pm, R1 pushed R5, attempted to hit staff, left his room and became aggressive with R2. R1 and R2's Incident Report documents on 3-17-26 at 11:50 pm, R1 was observed hitting R2 and R2 then hit R1 back with a closed fist to	A4010		

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A4010	Continued From page 2	A4010		

his left cheek.

R1's Incident Report dated 3-29-26 documents about 3:15 pm, R1 was being aggressive with staff and chasing a caregiver down the hall., pushed R4 to ground, and went after another resident before hitting E3 LPN/Licensed Practical Nurse in the face. R4 sustained a hematoma to the back of her head.

R1's progress notes dated 12-28-25 documents a resident was found on the floor and stated R1 pushed them down. Progress note dated 1-9-26 document R1 was aggressive and hitting the doctor and assistant. Progress notes dated 2-28-26 documents R1 hit a caregiver.

R1's service plan dated 3-31-26 documents R1 has dementia and has a one to one private caregiver after the 3-17-26 incident. No interventions related to R1's aggressive behaviors were included in R1's service plan before the 3-17-26 incident.

R3's face sheet documents he has diagnoses of dementia and Alzheimer's disease. R3's progress notes dated 10-15-25 document R3 pushed another resident to the floor. That resident sustained a hip fracture. R3's progress notes dated 12-3-25 document R3 hit staff, had fist balled and hit police and EMS (emergency) personnel while being transported to the hospital.

R3's 3-18-26 service plan does not contain any interventions related to R3's behaviors until 3-18-26.

On 4-1-26 at 11:45 am, E1 verified R1 and R3's service plans were not updated with interventions for aggressive behaviors until after the 3-17-26

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A4010	Continued From page 3 incidents.	A4010		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: 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: 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; Type 1 Violation-Repeat Based on interview and record review, the establishment failed to prevent physical /abuse involving R1, R2, R3, R4 and R5 for five of five residents reviewed for abuse in a sample of five. R1 was observed pushing R5, pushing R4 who hit her head causing a hematoma, and hitting R2 in the stomach. R2 punched R1 in the face. R3 hit R1 in the face. This failure has a substantial probability of causing severe harm to establishment residents. Findings include: On 3-31-26 at 1:00 pm, E1 Executive Director of the memory care establishment, stated on 3-17-26, after 1:00 pm, R1 was sitting in a chair in the back area when R3 walked up and hit R1 on	A6000		

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A6000	Continued From page 4	A6000		

the left cheek with R3's closed fist. R1 and R3 were sent to the emergency room for evaluation. R1 returned that night and was in bed. Staff came in several times to assist R5, R1's roommate, with incontinence. R1 got out of bed, became aggressive and pushed R5 and tried to hit staff. R1 then leaves his room and comes into contact with R2 and hits R2 in the stomach. R2 then hits R1 in the jaw. R1 was transferred again to the emergency room for evaluation. E1 stated no one sustained injuries from these altercations.

E1 continues that after the above incidents, R1 had a private sitter providing one to one supervision. On 3-29-25 about 3:15 pm, R1 was being aggressive with staff while receiving toileting care. R1 left his room, went up to R4 and pushed her down to the ground. E1 stated R2 has not had any other aggressive incidents. R1 and R3 have had incidents of agrression.

R3's 3-17-26 incident report documents on 3-17-26 at about 8:30 pm, R1 was sitting in a chair when R3 grabbed R1 by R1's shirt and was hitting R1. R1 was yelling and putting his arms up in a protective manner.

R1's 3-17-26 Incident Report documents on 3-17-26 at 10:53 pm, R5, R1's room mate was being assisted to bed when R1 got out of his bed and pushed R5. R1 was attempting to hit staff. R1 left his room and was walking in the hallway and was aggressive with R2.

R1 and R2's Incident Report documents on 3-17-26 at 11:50 pm, R1 was observed hitting R2 and R2 then hit R1 back with a closed fist to his left cheek.

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A6000	Continued From page 5 R1's Incident Report dated 3-29-26 documents about 3:15 pm, R1 was being aggressive with staff and chasing a caregiver down the hall. E3 LPN/Licensed Practical Nurse instructed staff to give R1 space to calm down. R1 walked to the back of the building and pushed R4 who fell to the ground hitting her head. R1 threatened to "get her" while darting towards another resident. Paramedics were called and R1 was sent to the hospital for evaluation. On 4-1-26 at 1:05 pm, E3 LPN/Licensed Practical Nurse stated on 3-28-26, E3 was called to assist staff as R1 was becoming aggressive. Approaching R1's room, she saw R1 chasing a caregiver down the hall. E3 instructed caregivers and R1's one to one monitor to give R1 some space allowing R1 to calm down but to follow him. Soon after, caregivers called for assistance again and E3 found R4 lying on the ground after being pushed by R1. R4 had hit her head on the ground sustaining a hematoma. R1 starting walking faster and said he was "going to get her" indicating another female resident. E3 hugged R1 attempting to protect other residents when R1 hit E3 in the face. R1 and R4 were sent to the hospital for evaluation. R1's progress notes dated 12-28-25 documents a resident was found on the floor and stated R1 pushed them down. Progress note dated 1-9-26 document R1 was aggressive and hitting the doctor and assistant. Progress notes dated 2-28-26 documents R1 hit a caregiver. R1's service plan dated 3-31-26 documents R1 has dementia and has a one to one private caregiver after the 3-17-26 incident. No interventions related to R1's aggressive behaviors were included in R1's service plan before the 3-17-26 incident.	A6000		

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A6000	Continued From page 6 R2's face sheet documents he has dementia and Alzheimer's disease. R3's face sheet documents he has diagnoses of dementia and Alzheimer's disease. R3's progress notes dated 10-15-25 document R3 pushed another resident to the floor. That resident sustained a hip fracture. R3's progress notes dated 12-3-25 document R3 hit staff, had fist balled and hit police and EMS (emergency) personnel while being transported to the hospital. R3's 3-18-26 service plan does not contain any interventions related to R3's behaviors until 3-18-26. R4's face sheet documents she has a diagnosis of Dementia. R5's face sheet documents R5 has a diagnosis of Alzheimer's disease and anxiety. The establishment's 3-10-23 Resident Abuse and Neglect policy documents "Physical Abuse: Any willful action of inflicting bodily injury or physical mistreatment. Physical abuse includes but is not limited to striking with or without an object, slapping, kicking, pinching, choking, grabbing, shoving, or prodding."	A6000		