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	ASL510369	A. BUILDING: _____ B. WING _____	C 04/20/2026

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A 000	Initial Comment Facility Reported Incidents IL201065 and IL201199 IL201065 Section 295.2000 a) c) 1) d) Section 295.4000 c) Section 295.4010 d) e) IL201199 Section 295.5000 a) c) f) 4) 5)	A 000		
A2000	Section 295.2000 Residency Requirements This Regulation is not met as evidenced by: 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) c) A person shall not be accepted for residency if: 1) The person poses a serious threat to themselves or to others; d) A resident with a condition listed in	A2000		

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A2000	Continued From page 1 subsection (c) shall have their residency terminated in accordance with Section 295.2010. (Section 75(d) of the Act) Type 2 Violation Based on observation, interview and record review, the establishment kept in residency a resident who poses a threat to himself for one of three residents (R1) reviewed for residency requirements in a sample of three. R1 has fallen over 20 times since admission in November 2025 sustaining three closed head injuries and multiply skin tears, contusions, lacerations and bruising. This failure caused harm to a resident or creates a substantial probability of harm to a resident or residents. Findings include: R1's progress notes and incident reports from R1's admission date of 11-20-25 document the following falls: On 11-21-25 fell with right shoulder, elbow and rib pain. R1's hospital evaluation showed a dislocated shoulder with a skin tear to his left elbow. On 12-18-25, R1 fell two times sustaining a minor head injury and contusion of the left knee. On 12-19-25, R1 was found face down on the floor bleeding from his head. R1's hospital visit showed a hemtoma/laceration to his forehead and skin tear to his left hand. On 1-8-26, R1 became sick and fell forward off the bed. R1 was sent to the hospital with a head injury. R1 tested positive for pneumonia. R1's progress notes documents after R1's hospital visit, he was sent to a skilled nursing facility for rehab and returned to the establishment on	A2000		

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A2000	Continued From page 2	A2000		

1-30-26. On 2-5-26, R1 was found on the floor with shoulder pain. On 2-10-26, R1 fell and hit his head on the dresser. R1 was sent to the hospital with a minor closed head injury. On 2-19-26, R1 fell sustaining a skin tear to his elbow. On 2-22-26, R1 was found on the floor. On 2-23-26, R1 fell, was sent to the hospital with a closed head injury/contusion to the scalp. On 3-12-26 and 3-13-26, R1 fell with no injuries reported. On 3-31-26, R1 fell two times with the second fall requiring a hospital visit after hitting his head and obtaining several skin tears.

On 4-5-26, R1 fell and refused hospital visit. On 4-8-26, R1 fell with no injuries reported. On 4-16-26, R1 fell complaining of rib pain. An X-ray was obtained showing an old injury. R1 sustained another fall on 4-17-26.

R1's undated Mini Mental State Examination for cognition documents R1 scored a 26 out of 30 noting cognition intact.

R1's 11-21-25 service plan documents R1 is independent with stand by assistance needed for mobility/ambulation and bathing. R1's service plan does not list R1 as being a fall risk or have any fall interventions until 1-9-26. Interventions listed at that time include therapy, frequently remind/encourage R1 to use his call button, frequent checks, keep apartment door open and a call don't fall sign in R1's room.

On 4-17-26 at 9:30 am, E1 Administrator stated R1 is alert and oriented with some confusion at times. R1 is reminded daily to use his call button for assistance with ambulation to prevent falls. R1 is able to understand but chooses not to use the call button. E1 stated family will have to arrange for a private sitter or R1 will have to

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A2000	Continued From page 3 move to a skilled nursing facility. On 4-17-26 at 10:00 am, R1 was sitting in his chair in his room. R1 was alert. R1 only shrugged his shoulders when asked why he did not want to call for assistance. .	A2000		
A4000	Section 295.4000 Physician/s Assessment This Regulation is not met as evidenced by: Section 295.4000 Physician's Assessment c) A physician's assessment shall be completed by a physician upon identification of a significant change in the resident's condition. Violation Based on interview and record review, the establishment failed to obtain a comprehensive assessment by a physician after a significant change in condition for one (R1) of three resident's reviewed for physician assessments in a sample of four. Findings include: R1's face sheet document R1 moved into the establishment on 11-20-25. R1's initial Physician Assessment was completed 11-20-25. R1's Level of Care Assessment dated 11-19-25 document's R1's score as 10 making him a "Level 1" for care. A score of 30 and above is the	A4000		

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A4000	Continued From page 4 highest level of care needed at the establishment. R1's 11-24-25 Level of Care Assessment documents R1's score as 26 making him a "Level 3" for care. R1's progress notes and incident reports since R1's move in date to present date of 4-17-26, documents over 20 falls with five hospital visit evaluations for R1 hitting his head during a fall. R1's progress notes document on 1-8-26, R1 fell, was transported to the hospital, found to have pneumonia and Covid 19. After R1's hospitalization, he was admitted to a skilled nursing facility for rehab and returned to the establishment on 1-30-26. There is no new Physician Assessment after this change of condition found in R1's record. On 4-17-26 at 9:30 am, E1 Administrator stated R1 has had a change of condition but they have not obtained an updated physician assessment for R1.	A4000		
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	A4010		

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A4010	Continued From page 5 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-Repeat Based on interview and record review, the establishment failed to update a resident's service plans with new interventions to help prevent falls for one of three residents (R1) reviewed for service plans in a sample of four. R1 sustained numerous falls with injuries including several minor head injuries, skin tears, contusions and bruising. This failure caused harm to a resident or creates a substantial probability of harm to a resident or residents. Findings include: R1's 11-21-25 service plan documents R1 is independent with stand by assistance needed for mobility/ambulation and bathing. R1's progress notes and incident reports document R1 has fallen over 20 times since admission in November 2025 sustaining numerous closed head injuries and multiply skin tears and contusions. R1's progress notes and/or incident reports from R1's admission on 11-20-25 document the following: On 11-21-25 fell with right shoulder, elbow and rib pain. R1's hospital evaluation showed a dislocated shoulder with a skin tear to his left elbow. On 12-18-25, R1 fell two times	A4010		

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A4010	Continued From page 6	A4010		

sustaining a minor head injury and contusion of the left knee. On 12-19-25, R1 was found face down on the floor bleeding from his head. R1's hospital visit showed a hematoma/laceration to his forehead and skin tear to his left hand. On 1-8-26, R1 became sick and fell forward off the bed. R1 was sent to the hospital with a head injury. R1 tested positive for pneumonia. R1's progress notes documents after R1's hospital visit, he was sent to a skilled nursing facility for rehab and returned to the establishment on 1-30-26. On 2-5-26, R1 was found on the floor with shoulder pain. On 2-10-26, R1 fell and hit his head on the dresser. R1 was sent to the hospital with a minor closed head injury. On 2-19-26, R1 fell sustaining a skin tear to his elbow. On 2-22-26, R1 was found on the floor. On 2-23-26, R1 fell and was sent to the hospital with a closed head injury/contusion to the scalp. On 3-12-26 and 3-13-26, R1 fell with no injuries reported. On 3-31-26, R1 fell two times with the second fall requiring a hospital visit after hitting his head and obtaining several skin tears. On 4-5-26, R1 fell and refused hospital visit. On 4-8-26, R1 fell with no injuries reported. On 4-16-26, R1 fell complaining of rib pain. An xray was obtained showing an old injury. R1 sustained another fall on 4-17-26.

R1's 11-21-25 service plan does not document R1 is a fall risk or contain any fall interventions until after R1's 1-9-26 fall. The interventions added documents R1 is to complete physical therapy at a skilled nursing facility. No new interventions are again added to R1's service plan until after R1's 2-10-26 fall. R1's added interventions include encourage continued participation in therapy, frequent reminders to call for assistance and to encourage use of call button. Another intervention of keeping R1's

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A4010	Continued From page 7 apartment door open for frequent checks was added on 2-24-26 after three more falls. Placing a "call don't fall" sign was placed in R1's room to the service plan on an undocumented date. There are no other new interventions added to R1's service plan to assist with preventing R1's falls. On 4-17-26 at 9:30 am, E1 Administrator stated the establishment does not have a service plan policy. An establishment fall policy was requested. R1 supplied an incident/accident policy which does not contain any information/procedure for updating a resident's service plan after a fall. E1 stated when a resident falls, staff fill out an incident report. The management team will look at the falls and determine interventions which are then added to the service plan.	A4010		
A5000	Section 295.5000 Medication Reminders, Supervision of Self Med This Regulation is not met as evidenced by: 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. c) Supervision of self-administered medication means assisting the resident with self-administered medication using any combination of the following. Supervision of self-administered medication by unlicensed	A5000		

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A5000	Continued From page 8 personnel shall be under the direction of a licensed health care professional. f) If an establishment provides medication administration or supervision of self-administered medication, the establishment's medication policies and procedures shall be approved by a physician, pharmacist, or registered nurse and shall address: 4) Assisting in the self-administration of medication and medication administration, as applicable; and 5) Recording of medication assistance provided to residents and maintenance of medication records. Type 1 Violation Based on interview and record review, the establishment failed to follow their medication policy for one of four residents (R2) reviewed for medications in a sample of four. R2 was sent to the hospital for low blood pressure after receiving twice the ordered dose of blood pressure medication. This failure creates a substantial probability of severe harm to a resident or residents. Findings include: R2's physician order sheet for April 2026 documents R2 is to receive Amlodipine 10 mg (milligrams) and Losartan Potassium 100 mg, both for high blood pressure, Vitamin D 1000 units, Vitamin B12 1000 mcg (micrograms), Potassium 20 meq (milliequivalents), Sertraline 25 mg, and Memantine 5 mg every morning. R2's Medication Error Report dated 4-7-26 at 9:00 am documents "Resident (R2) had taken present day AM meds and next day AM meds.	A5000		

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A5000	Continued From page 9 MAR/Medication Administration Record and date overlooked." On 4-17-26 at 9:40 am E3 Care Coordinator stated on 4-7-26, E3 went to assist R2 with self admministering her morning medications. E3 overlooked the date on the medication roll and handed R2 her 4-8-26 morning medications. E2 stated when she went to sign R2's medications out on the MAR, E4 Wellness Director/Licensed Practical Nurse, has already signed R2's morning medication out as given. E3 immediately reported the incident to E1 Administrator and E4 Wellness Director. E3 stated she does not look at the MAR before she gives the medication. E4 stated there was a miscommunication and E4 did not tell her she had already given the medications. On 4-17-26 at 1:00 pm, E4 Wellness Director stated on 4-7-26, R2 was not feeling well so E4 took R2 to her room and gave R2 her morning medications. E4 signed off the medications on the MAR. Later, E3 Care Coordinator came in and provided R2's morning medications again from the next day roll pack, went to sign them out and discovered the error. E4 stated she does not routinely give R2 her medication. E4 stated staff should check the MAR before they help residents' self-administer medications, so errors do not occur. The establishment's Medication Management policy dated 10/06 documents "Medication Error Reporting - all medication errors that occur for residents receiving medication assistance from our facility are required to be reported. A medication error include: Wrong medication, wrong dosage, wrong time, wrong route, missed medication."	A5000		

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A5000	Continued From page 10 On 4-17-26 at 9:30 am, E1 Administrator stated R1 was sent to the hospital later in the day on 4-7-26 with a blood pressure reading at the low end of R2's physician ordered parameters.	A5000		