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A 000	Initial Comment Complaint Investigation: #2577001/IL196652 - 295.6000 a) 5) 13) Facility Reported Incident: Facility Reported Incident of 7/13/2025/IL196431 - 295.4010 a) d) g) 1) A) C) 2) 3) h)	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: General Violation Section 295.4010 Service Plan 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. 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) g) Service plans shall address: 1) The level of service the resident is receiving, including:	A4010		

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A4010	Continued From page 1 A) assistance with activities of daily living; C) special accommodations for the resident; 2) The amount, type, and frequency of health-related services needed by the resident; 3) Staff responsible for the provisions of the service plan; h) The service plan shall include all support services provided or arranged for by the establishment. This requirement WAS NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to implement a service plan and maintain one (R1) of three residents at risk for elopement in a monitored environment and failed to assist one (R3) of three residents at risk for falls. These failures resulted in R1 eloping from the secured memory care unit and found wandering outside on the independent living side of facility and creates a substantial probability of severe harm to all 37 residents residing in memory care and R3 falling and sustained a bump on head, sacral tenderness, and L1 compression fracture. Findings include: R1 was a 96-year-old with diagnosis not limited to: Alzheimer's Disease, Macular Degeneration, Primary Open-Angle Glaucoma, Allergic Rhinitis, Atherosclerotic Heart Disease of Native Coronary	A4010		

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A4010	Continued From page 2 Artery, Primary Open-Angle Glaucoma, Bilateral, Essential (Primary) Hypertension, Transient Cerebral Ischemic Attacks and Related Syndromes, Cognitive Communication Deficit, Unspecified Psychosis, Anxiety Disorder, Unspecified According to R1's face sheet printed 8/29/2025, R1 was admitted to facility on 6/30/2022 and expired on 8/15/2025. The establishment's Final Report to the department dated July 15, 2025, documented (in part): On 7/13/2025, the resident (R1) was participating in an outdoor activity with other residents on the Memory Care patio. At the conclusion of the program, staff began assisting residents back inside. During this transition, the resident became separated from the group. It appears the resident, who has dementia and impaired safety awareness, became disoriented while attempting to locate the restroom and exited the secure Memory Care neighborhood through an adjacent door. A dining room staff member observed the resident outside of the secured area speaking with an Independent Living resident and promptly returned her to Memory Care. While being assisted to sit down on a bench, the resident slowly lowered herself to the ground, reporting that her knee gave out. The fall was controlled and there was no observed impact to the head or major injury. Immediate Actions Taken: Resident was assessed by licensed nurse; no injuries noted outside, Vitals were checked and found to be within normal limits. Range of motion in all extremities observed to be within resident's baseline. Resident was monitored for the remainder of the shift for any signs of pain or delayed symptoms. Contributing Factors: Resident has dementia with poor safety	A4010		

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awareness and impaired judgment. Staff were engaged in assisting other residents during transition back inside. Preventive/Corrective Interventions: Increased supervision and monitoring during transitions, especially when moving residents between indoor and outdoor areas. Staff reminded to perform headcounts before and after group activities. Staff re-education on visual cueing and redirection strategies for residents with awareness deficits. Resident's care plan updated to reflect increased safety monitoring needs and reinforce toileting support. Continued monitoring of resident's ambulation status and lower extremity weakness. Ongoing staff training on dementia-related disorientation and exit-seeking behavior. Reinforcement of existing door monitoring systems and protocols, including staff awareness of door monitoring responsibilities and documentation of compliance with safety checks.

R1's Service Plan dated 5/1/2025 documented (in part) Need: Judgement Goal: To assist resident with judgement Action: Frequent poor judgement issues R1 displays frequent poor judgement in decision-making, particularly regarding her personal safety and care needs. She may not recognize the consequences of her actions, often leading to situations where her well-being is at risk. Staff should remain vigilant, providing clear guidance. Gentle redirect R1 ensuring she is protected from harm. Regular observations and prompt intervention are required to ensure her safety.

Need: Wandering/Elopement risk Goal: Monitor resident for wandering and/or elopement. Action: Wandering: Severe R1 wanders outside and leaves immediate area. Has a history of leaving immediate area, getting lost, or being combative

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A4010	Continued From page 4 about returning. Requires supervision. On 8/29/2025 at 2:12pm E4, Licensed Practical Nurse (LPN) stated, I am familiar with R1 7/13/2025. R1 was in the garden and when staff were bringing in all the residents, R1 went the other way. The caregivers were bringing them in. There are 4 doors going out of the garden, R1 walked independently with walker so she may have gone to the door leading to the back. That door leads to another door then another door that leads to another before you get outside. Apparently, she went outside of the building and the people that were on the IL patio saw R1 outside and brought her inside. There is an alarm on one of the doors. Door number 6 has the alarm. The alarm did go off but not on my side, you cannot hear the alarm. The door R1 walked out was on the south side, but R1 was on the north side. Door number 6 is on the south side. When that door is open and it alarms, the south side will hear the alarm, but the north side will not hear the alarm. There were 3-4 aides but while they are bringing them in everybody goes the way they want to go. They randomly take the resident in. No one stays with the residents on the patio while the caregivers take residents to the dining room. Someone from the kitchen brought R1 to the patio which was on the other side of the building. When they were about to sit her on the bench, R1 fell on her knees. She had walker and that happens when she is very tired, she falls because that was quite a long walk for her. The nurse E17 (RN) called me and said one of my residents fell and she is there on the back garden. I went there and she was sitting down on the bench. I did assessment asked if she was in pain. She said she was not in pain. She did not tell me what happened just she was looking for the bathroom. The memory care residents wear	A4010		

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a pendant. Residents do not wear wrist guards. R2 did not go to the hospital. She was able to walk with me back to the memory care unit in memory care they have activities in the small garden, and they usually come inside. She went the other way. They usually come in through the second door that connect north and south memory care. I was told someone heard the alarm and just checked to see if anyone went out the door, but that person did not see anyone. I am not sure who heard the alarm. R1 was groomed and wearing shoes. The person that answered the alarm was probably inside south and when she went out R was probably already out of sight from the door. The person should have gone outside and upstairs so you could see if someone left. You are not supposed to just check the door, you need to go beyond the doors to check to see if a resident left. Surveyor asked if a head count was done. The caregivers are supposed to do head count and make sure all residents are accounted for. The caregiver assigned is responsible for doing head count to make sure all of their residents are accounted for. I did not ask if a head count was done, but the last time she saw the resident, she answered, I think 11:10am or 11:15am. There is not standard time to count residents. When I walk by, I check to make sure residents are there. For elopement risk, I check them at least every hour. If they are in an activity, I check to make sure they are there. I saw Irene about 11:10am or 11:15am something like that. All caregivers are oriented regarding watching residents and what to do when a door alarm goes off. R1 was a fall risk but was able to talk and was pretty independent but hard to redirect. Alert and oriented X2-3. She had episodes of confusion. On the way back I had her to take a couple of rest stops because she seemed a little weak. She was confused at that

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time. She kept asking me where we are going. I called E2, Director of Health Services and told her what happened. I informed E3, Director of Memory Care as well but she knew because someone has already called her. Surveyor and E4 toured location of incident. E4 stated, here on the independent side is where I came to get R1. I saw her here on the patio, but she was on the street side. Surveyor asked, are cars able to come back here. E4 stated, yes cars can come back here. R1 fell in front of the bench on the independent patio. R1 went through one single door and three sets of double doors on the north/south side of memory care. There are double doors going out. The fire doors are now open, but they use to be closed, but now we hope we can hear the alarm. Door number 6 now has new alarms that has been put on and you have to turn the alarm off with a key and scan our badge, but this was put in after R1 eloped out of the building. These double doors (double doors #4) are the doors that go to the street, and she went out these doors. These doors do not have an alarm. Surveyor observed doors open directly to long driveway across from strip mall. Surveyor asked E4 did you hear alarm when door 6 was opened. E4 stated, no you cannot hear alarm from back here or on the north side, now the doors are left open between north and south. Surveyor observed north and south doors open.

On 8/29/2025 at 3:32pm E3 (Memory Care Director) stated, I was not here. Sometimes the residents will make a lap around the courtyard. I think she was looking for the bathroom and she went through the other side of the door. When you come in that door, you are facing another door, and she just went straight instead of turning and went out the facility. Memory care is a locked unit. Alarms on the door are very low and we

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added new alarms called screamers and they are much louder. These alarms were added right after incident. At the time she exited could not hear alarm, but now can hear the alarms. Did you hear the alarm No, I did not through the entertainer. From what I understand R1 walked out and someone from culinary department found her on the independent patio. I did not get the name of person. When the door alarms it goes to the unit and staff can see it through the app and check and go out the doors to make sure no resident has exited then we do a head count. A head count was done and found out R1 was the one that eloped. Staff go to the alarm not sure what the breakdown was and why no one responded. We had staff outside with residents as well, but alarms were low at that time and north side could not hear. South side could only hear faint alarm, music plays and residents on the courtyard could not hear alarm. The staff members did not check the door in a timely manner to catch it. Not sure if anyone went out the doors to check, just that culinary person found R2. During activity there were 3 caregivers on the patio and all three caregivers are responsible for all the residents collectively. They were doing activities and passing out hydration and one doing a game. They honestly did not see her go through the door. The staff on the patio did not get an alarm on their phone. In the building the other 2 should have gotten an alarm. I did not interview them, but my understanding is they did not hear the alarm nor respond to the alarm on the device. The nurse came to assess her right away and I was called about the elopement and then went to staff to see what happened. I was not aware she had a fall. Walkies used in memory care and front desk and app is used by entire building. They brought her back and she was fine. She was looking for a bathroom. When

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residents are together everyone is responsible for them resident. All know how to care for residents. I am not sure if the nurse on the south side heard alarm.

On 8/29/2025 at 4:19pm E7 (QLS) stated, I only work in memory care. I was here on 7/13/2025 with R1. We were on the courtyard, and we got a call from the front desk that R1 was in the independent living (IL) courtyard. They said she walked there. At that moment we guess she left through the back courtyard to door 6. Door 5 is not alarmed but door 6 alarmed and at that time could barely hear alarm only know through the app. I did not get an alarm on app because, it does not work when you are on the patio, only works in the building. We showed the director there is no connection when we are on the courtyard patio. All the caretakers take residents in all at the same time. Usually there is someone that is behind all the residents. I was one of the first to bring people in, I am not sure who was behind. I did not see her leave. I had just seen her. We were all just sitting on the patio and if someone has to go to the bathroom, we take them and still check on the residents that are inside. R1 was on the patio but in the back and R1 decided to sit next to another resident that sits in the back. R1 used her walker. I was the first to check the app and it said she had been gone for 15 minutes. Rick was the MOD that day. I am not sure if R1 fell. I cannot remember if the nurse came. Yes, I think he did E4 was the nurse. When alarms go off, we respond immediately and if door 6 we run to the door and the others do head count. Head counts done every 30 minutes to every hour. In rooms, dining room or living room. When residents on patio all of us are responsible for the residents. We go out the door to see if resident is out there. Walk through the

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parking lot and look for the resident. We have to open the door and check surrounds. That was not done because I ran to R1. We only knew R1 was gone when independent living called us. At that time, we did not know the app did not work when we were on the patio. For north all the caregivers were on the patio. South should have gotten an alert. The alarm not loud so could not hear. Now the new alarm is loud, you can hear it.

On 8/29/2025 at 4:47pm E2, Director of Health Services stated, I am familiar with R1. She ambulatory and walks with walker. She had a lot of behaviors and strong willed. Depends on how she is that day. She can manage toileting on her own. She walked around with walker and some decline and put more supervision. Her family would come a lot and pick her up. Family updated about her falls and aware that she could hurt herself. Put additional interventions with falls. That day with all the other residents and doing sunshine club on patio. Everyone busy bring residents in the building and did not notice R1 walked out the exit on the patio. The staff were busy and did not realize she walked out the door. R1 was looking for the bathroom and went outside. The kitchen supervisor saw her outside and overheard her talking to an independent resident and came outside and walker her back to memory care. While walking her knee gave out and assisted her back to chair and then brought her back to memory care. The nurse was called, and he came and assessed the resident. Doors were alarmed. Alarm went off. The alarm was a little faint and staff did not hear the alarm right away. I believe the device went off. The staff said they saw the app late. We did a lot of education regarding paying attention to the app. App goes to everybody. The nurses probably did not see it. When they heard about it, they went to get the

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resident. The staff were in the process of bring residents in when they got a call that R1 was on the independent side. The dining room manager (E8) brought R1 back to memory care. When the door sends a signal immediate head count and notify the manager or nurse on duty and look for the resident. Inform me and the E3. The nurse did assessment to make sure not hurt, do incident report and I do a state reportable. notify the family, and doctor. She had a scrape when walking back to memory care knee gave out and she fell and had scrape on knee.

On 8/30/2025 at 10:18am E8, Food and Beverage Manager stated, I was here on 7/13/2025 when R1 was found. I was in the dining room serving during lunch and I saw a resident against the wall waiting at the window and talking to R1 through the window. I recognized R1 from memory care and went outside. R1 was outside the fenced in patio. I got her right away and walked her through the fence and called the front desk to tell memory care that one of their residents was outside. She did fall right before I got her to a bench her legs gave out and she fell. I was able to get her up and had her sit on the bench. E4 came outside to the patio, and I believe at least 2 caretakers were outside with her. They gave her some water and once she regained her energy, they brought her inside and took her back towards memory care unit. E8 showed surveyor where she saw R1. Surveyor observed location of where R1 was in the corner of building, outside of fenced next to bushes speaking to an independent resident through the window next to the driveway.

On 8/30/2025 at 12:10pm E12 Quality of Life Specialist (QLS) stated, I am familiar with the incident on 7/13/2025 when R1 eloped. I came in

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A4010	Continued From page 11 on my off day. I was doing activities I was helping transition from outside to inside I did a head count, and everyone was there, they were still outside. I turned on church service and went to the kitchen to get their drinks. While I was in the kitchen the front desk called that R1 was in IL and asked to come get her. Me and another caregiver came to get R1. They were trying to see how see came out, was it from the front or the back doors. I did not hear an alarm go off. When we are outside app does not connect to phones outside. I did not hear any alarm. The nurse went over to IL as well. I did not see her fall. When I got to where she was, the IL staff had her outside drinking juice or water. The nurse took her back to memory. She was alert because she was able to tell us how she got out. She said she went out the back alarmed door and went around. The people in IL saw her and helped her back into the facility. R3 is a 87-year-old with diagnosis not limited to: Unspecified Dementia, Unspecified Severity, Acute Kidney Failure, Unspecified, Cognitive Communication Deficit, Essential (Primary) Hypertension, Generalized Anxiety Disorder, Hyperglycemia, Unspecified, Long Term Use of Insulin, Major Depressive Disorder, Metabolic Encephalopathy, Muscle Weakness (Generalized), Paroxysmal Atrial Fibrillation, Rhabdomyolysis, Type 2 Diabetes Without Complications, Acute Conjuctivitis, Left Eye, Spinal Stenosis, Hypothyroidism, Hyper Lipidemia According to R3's face sheet printed 8/29/2025, R3's move in date was 4/30/2020 and remains in facility. The establishment's Final Report to the department dated July 27, 2025, documented (in	A4010		

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A4010	Continued From page 12 part): R3 date of incident: 7/26/2025, Time of Incident: 11:50am, Location: Dining Room, Description: Resident attempted to ambulate unassisted from the common area/TV lounge to her regular spot in the dining room. Staff observed the resident already near her usual seat, just a few steps away, using her walker. As she attempted to reposition herself to sit down, she lost her balance and leaned on the door, hitting the back of her head on the door bar handle as she fell or slid onto her buttocks. The nurse on duty responded immediately upon hearing the commotion from the med room. A bump was palpated on the back of the head, which the resident reported as painful. The resident also complained of sacral pain when touched. 911 called for evaluation. Resident transported to local hospital and diagnosed with syncope and an L1 compression fracture. Investigation Findings: Staff only became aware of the resident's movement when she was already close to her chair. Resident has known balance issues and requires standby assistance for ambulation. Resident has poor safety awareness and judgement secondary to dementia. Interventions Implemented and Reinforced: 1. Standby assistance required for all mobility and ambulation tasks. 4. Staff re-educated on importance of close observation of high-risk residents during mealtimes. 7. Post-fall huddle conducted with all involved staff to review incident and reinforce protocol of adherence. R3's Service Plan dated 2/26/2025 documented (in part): Need: Mobility/Ambulation Goal: *Mobility/Ambulation Enabling Devices Action: Mobility/Ambulation: Minimal Level of Assistance. R3 is ambulatory with a walker but requires standby assistance due to unsteady gait and poor	A4010		

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balance. Staff should remain close by and provide support as needed to ensure her safety during mobility.
Need: Potential of Actual risk for falls/injuries Goal: To maintain safety and/or comfort of resident according to fall potential. Action: Frequent Monitoring, R3 requires frequent monitoring due to poor safety awareness. Anticipate needs and provide timely assistance to reduce fall risk Need: Orientation Goal: Orientation stats Purpose of service: Benefit of service: safety Action: Orientation - Moderate Impairment R3 has current or history of occasional disorientation to person, place, time or situation even in familiar surroundings and requires supervision and oversight for safety.

On 8/29/2025 at 3:17pm R3 sitting in high back chair dressed, groomed, alert wearing shoes and participating in activity. R3 smiling and able to clap hands to music.

On 8/29/2025 at 2:12pm E4 stated, R3 had a recent fall. She was alert x1 before the fall used walker but unsteady, she is one assist because she can be off balance. She was in the dining room. No one was beside her; the caregiver was assisting someone else and moving a chair so other residents could pass because R3 was about to position herself to take a seat at the dining table. R3 was not walking when the caregiver left her because she was about to sit down. The caregiver is supposed to make sure the resident is seated before leaving because she is a resident that is unsteady, and it is in her service plan that she should not be left alone while ambulating. It is a gray area because she was not ambulating, but the caregiver is supposed to make sure she is seated. She tried to pivot from her walker to the chair and that is

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when she fell. The instructions for R3 are she should not be left alone standing or walking because she is unsteady and a fall risk. This was on her service plan. Caregiver are informed about resident service plans. I was the nurse that day. I was doing my charting and heard the crash and went out and saw her sitting on the floor. She was injured a lump on the back of her head. She went to hospital, and they found a compression fracture of L1. E5 (QLS) was the caregiver for R3 that day.

On 8/29/2025 at 3:32pm E3 stated, I am familiar with R3, but I was not here, sounds like they were going to lunch, and she lost her balance. They kept asking her to sit down and she lost her footing and fell. It was witnessed and staff were present. E5 and E6 (QLS) were present. R3 at that time was able to ambulate independently. What does stand by assistance mean. E3 stated, someone needs to be standing by them to help prevent fall.

On 8/29/2025 at 4:19pm E7 (QLS) stated, I only work in memory care. R3 is alert and able to talk. She could walk with a walker, just hard to stand up but could not walk by herself. Someone has to be beside her at all times due to her becoming unstable, but she has to have someone next to her when walking. Someone is supposed to be with her to make sure she sits down in the chair because the chair would move so we had to hold onto her, and the chair not just leave her, so she does not fall.

On 8/29/2025 at 4:47pm E2 stated, I am familiar with R3. It was time for lunch, and she was sitting in the living room next to dining room and staff bringing resident to dining room one by one and told her to wait for them and R3 stood up to walk

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A4010	Continued From page 15 on her own and loss her balance and fell. She can walk but for safety we want to assist her so stand by assist with walking. Staff is next to them when walking and make sure they get to seat and sit down. Memory Care Disclosure Statement (undated) documents (in part): Nature of Care: facility provides a residential assisted care program for individuals with dementia-related diseases. Facility has security features in place to keep out residents safe. These security features include keypads with secure codes that allow access to the rest of the community as well as the outside. Continuous care by trained direct care employees providing monitoring 24 hours a day and observation for changes In physical, cognitive, emotional, and social functioning. Philosophy We regularly monitor assisted living and memory care residents regularly Activities The activity program is based on resident hobbies and interests. Activities are planned by trained staff and provide entertainment including supervised outings, parties, movies, exercise, cognitive stimulation, small groups and individual activities. Facility Policy Policy Title: Missing Resident Policy Category: Elopement (dated 3/2025) documents (in part): Policy: When residents are noted to be missing from the community staff will conduct a thorough search to locate the resident. Procedure: 10. Staff will identify any community area that needs immediate attention to assure resident safety (i.e alarms/locks are working properly, windows and doors are secured appropriately, etc.) Community building needs addressed Policy Title: Fall Prevention Policy Category (rev. date 3/2025) documents (in part): Policy: The	A4010		

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A4010	Continued From page 16 purpose of this policy is to identify residents at risk of fall and consider individualized interventions to promote an environment of safety. Procedure: 2. Residents identified at a high-risk for falls will have individualized interventions included in service-plan. Assisted Living Resident Rights in Illinois Requirements documents (in part): In Illinois, residents of assisted living facilities have specific rights and requirements that must be adhered to by the facilities. Facilities must also provide services specified in the service plan	A4010		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: General Violation Resident Rights 295.600 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: 5) The right to receive the services specified in the service plan, to review and renegotiate the service plan at any time; and to be informed of the cost of the changes; 13) The right to be free of abuse or neglect or financial exploitation or to refuse to	A6000		

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A6000	Continued From page 17 perform labor; This requirement WAS NOT MET as evidenced by: Based on interview and record review, the facility failed to conduct well-being checks for one (R2) of three residents reviewed for resident rights. This failure resulted in R2 not having a well-being check for over 13 hours and found in her apartment on the floor. Findings include: R2 was a 95-year-old with diagnosis not limited to: Hypertension, Overactive Bladder, Right Artificial Knee Joint, Neuropathy, Atherosclerosis of Aorta, Chronic Kidney Disease, Stage 3 Unspecified, Hypothyroidism, Unspecified, Pain I Left Knee, Permanent Atrial Fibrillation, Unspecified, Inflammatory Spondylopathy, Cervical Region, Vitamin D Deficiency, Postherpetic Nervous System Involvement, Unspecified Urinary Incontinence, Long Term Use of Anticoagulants, Edema, Unspecified According to R2's face sheet printed 8/29/2025, R2's move in date was 5/15/2021 and expired on 8/2/2025. The establishment's Final Report to the department dated July 26, 2025, documented (in part): R2, date of incident 7/25/2025, Time of Incident: approximately 8:20 AM Location: Resident's Apartment - Bathroom Area Summary of Incident: writer was called by caregiver to the resident's apartment due to a report of a fall. Resident was found lying face down on the bathroom floor with her head near the sink and feet toward the doorway. Her pants were halfway	A6000		

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down, and the lower half of her body was soaked in urine. Her walker was noted near the sink. The resident was alert and responsive, answering questions appropriately, but appeared confused and repeatedly verbalized, "I don't want to fall." Facial swelling and discoloration were noted. Vital signs: BP 116/68. P74, RR 18, T97.5, SpO2 97%. There was no indication that she used her emergency pendant to summon help. Resident transferred to hospital and admitted for sepsis, secondary to a urinary tract infection (UTI) and contagious pneumonia. It is unclear how long she was on the floor. Incident Investigation & Root Cause Analysis: Emergency pendant was not activated, causing a delay in assistance.
R2's service plan dated for pain and discomfort to maintain safety and/or comfort staff to monitor pain level and notify nurse on duty. Potential or Actual risk for falls/injuries ensure adequate lighting, night light, extra lamps in rooms Short Term Memory mild impairment. R2 has history of occasional difficulty remembering and using information, requires some directions and reminding from others

On 8/29/2025 at 4:47pm E2, Director of Health Services stated, I am familiar with R2. R2 is independent with care and only assist with bathing and dressing. She did not call for assistance; she did have pain in shoulder. That day of fall when morning caregiver came in, she saw R2 on the floor, she did not press her pendant. She had pneumonia and UTI but no change that we noticed, pain or symptoms that she was having an issue. No SOB (shortness of breath), no cough. Residents in Assisted Living (AL) not checked during the night unless in service plan. We do courtesy check. She toilets so she does not call. R2 was checked around 7:00pm at night. No one checked during the

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night. She was in the same clothes as the day before. Surveyor asked if R2 should have had a well-being check during the evening or night. E2 stated, she did not have that in her service plan.

On 8/30/2025 at 10:45am E9, Licensed Practical Nurse (LPN) stated, I remember R2, I knew after my shift, I was told after that. They found her. I saw her after I got report. R2 was sitting in room watching TV around 7:00pm or 7:30pm as usual. Surveyor asked if residents in AL are checked on during shifts. E9 stated, yes if in their care plan but also courtesy check ins are done. The caregivers also check on them as well. R2 was good with pressing pendant, had a lot of shoulder pain but good for calling for help. She had no symptoms of any change of condition.

On 8/30/2025 at 11:08am E10, Registered Nurse (RN) stated, I remember R2. Just came into work and going around giving meds. Got call form caregiver Maria that she was on the floor. I was close by and went to see her. R2 was face down laying on floor wearing clothes not pajamas pants halfway down. She was responding, had swelling on face and sent out to the hospital. I asked her what happened, and she kept saying I don't want to fall I don't want to fall, but she was already on the floor. She was pretty independent. We helped her with changing her clothes. We helped her put on her clothes because of chronic shoulder pain.

On 8/30/2025 at 2:55pm E13, Quality of Life Specialist (QLS) stated, I am familiar with R2. I saw her. We remove the hearing aids and sometimes we help her dress and sometimes she does it by herself. She is independent. I forgot to dress her up. I saw her at 7:30pm on 7/24/2025 R2 had already taken out her hearing aids and

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they were on the charger, so I then left. I failed to go back to check on her to help her change. Like I said, sometimes she will dress up herself. She was sitting on the chair in the living room like she always did. She did not complain of not feeling well. I did not go to see her again that night. Usually on AL side we do rounds. Surveyor asked how often you check on residents in AL. E13 stated, usually 1-2 hours as often as we can. Sometimes we cannot do the rounds because of hospice resident. I am not sure if the nurse saw her. I spoke to E2 and told her I forgot to dress her up, I just checked on R2 about her hearing aids that were already out. We check on residents when they call, she did not usually call. If the resident does not call, we will still check on them. I saw her at 7:30pm she seemed okay, and I did not see her the rest of my shift. R2 was able to use pendant and used it when she was experiencing pain, or she would go to the nurses' station because it was close by. There is an endorsement paper that is submitted to each QLS that comes on shift. I am not sure what happened to the endorsement paper after I gave it to the 11p-7a QLS. I did not write down that I did not help her get dressed. I documented in care stream medical record and that tells me what I need to do as well. When I left, I endorsed to E14 (QLS). Did you tell E14 the last time you saw her. E13 stated, no.

On 8/30/2025 at 11:22pm E14 (QLS) stated, I remember R2. I was doing my rounds and, in a rush, to try to find another resident whose pendant had been going off for 30 minutes, I did not see R2. I knew for a fact it was not R2, because her pendant sounds different. I did a quick scan of her but failed to realize she was not in bed. Should lights be on in her room. I failed to turn on the light. She did not press her pendant.

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There was a silhouette, but she was on the ground. How often are residents supposed to be checked during your shift? We check residents once at the beginning once in the middle and once at the end. Did you see/check R2 during the night. Visually, no I did not see her. What is the purpose of checking on residents. To make sure they are in bed and not wet and to see if need to use the toilet or if they need any help from me. Did E13 endorse to you anything about R2 and that the last time she saw her was about 7:00pm. E14 stated, "No, E13 did not endorse to me anything". I endorse everything important to the morning E11 (QLS). That night R2 did not press her pendant. I was not there when they found her.

On 8/29/2025 at 12:51pm E15 (QLS) stated, I always work in AL. Residents wear pendants that they press if they need something. We also do frequent rounds to make sure residents are okay. I remember R2, she sometimes used her pendant, She was able to walker but she was in a lot of pain but she was alert and able to make her needs known, but we still checked on her to make sure she was okay.

Memory Care Disclosure Statement (undated) documents (in part): Nature of Care: facility provides a residential assisted care program for individuals with dementia-related diseases. Philosophy We regularly monitor assisted living and memory care residents regularly

Residents in assisted living facilities have specific rights designed to protect their dignity, autonomy, and well-being, including the right to privacy, adequate care, and freedom from discrimination.

Facility Job Description Community Assignment

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A6000	Continued From page 22 Name Quality of Life Specialist Group Resident Health & Wellness Services (dated 8/2017) documents (in part): Position Summary: Perform various resident care activities and related nonprofessional services essential to caring for personal needs and comfort of residents. Essential Job Functions: 1. Assist all residents/clients witb a high quality of personal carem but not limited to; dressing, grooming 11. Document resident status as per policy. 21. Follow Residents" Rights policies at all times.	A6000		