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	ASL5105850	A. BUILDING: _____ B. WING _____	07/01/2025

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A 000	Initial Comment Annual Licensure Survey 295.4010a)b)c) Complaint Investigation Survey: 2572580/188774-Substantiated 295.3000 h)1)2)3) 295.6000 13) 295.7000 a)d)2)3)4)5)	A 000		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: Type 2 Violation Section 295.3000 Personnel Requirements, Qualifications and Training h) The establishment shall have sufficient personnel to provide the following for its current resident population: 1) All mandatory services; 2) Services established in each resident's service plan; 4) Food services (if provided by the establishment). These requirements were not met as evidenced by: Based on interview and record review, this establishment failed to have adequate dining staff to ensure residents received meals in a timely manner for three residents (R1, R3, R4) reviewed for dining services. This failure has the probability to affect all residents receiving services from the dining room.	A3000		

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A3000	Continued From page 1 Findings include: During interview with R3 and R4, both said that it seems there are shorted staff in the dining room, and that it can take from 30 minutes to one hour and a half for food to be served. On 6/25/2025 Resident Council Meeting Minutes were reviewed. 12/17/2024 Dining-Noticed that some employees appear overworked due to staff shortages. 3/19/2025- the dining servers on weekends are perceived to be very slow in serving. 5/21/2025- Dining Room Staffing: There is a requirement for more servers in the dining room, particularly during evenings and weekends. Dietary: A resident brought up, why it takes so long to get served after they get to the dining room. Other residents agreed and stated that it takes a long time just to get their drinks. On 6/26/2025 at 12:56PM Surveyor requested the Server's schedule for March 2025 and Current Servers. Schedule, which was not provided by either E1 (Executive Director) or E4 (Dining Service Coordinator). On 6/26/2025 at 9:06AM, Z1 (R1's family Member) said that the incident in March, resident came to the dining room area (Complainant said that this was on ongoing issue before) waited about 45 minutes to place her order for dinner, then she waited about 30 minutes, and food was never brought to her. Resident left to her room without having dinner. On 6/30/2025 at 9:32AM, E4 (Dining Service Coordinator) said "We give the beverage first and then the salad or soup, residents place the orders either when we provide them the drinks or after	A3000		

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A3000	Continued From page 2 they finish their soup or salad. Usually within 10-15 minutes of arriving to the dining room area. They are served within 10-15 minutes after they placed the order unless they order hamburgers and fish, because those are not readily available, it will take a little longer to cook. But we let the residents know. E4 said "It is not acceptable for residents to wait 30-45 minutes to place their orders and another 30-45 minutes to be served. I have been here about one month, and servers are going to be trained again to my standards next week because a lot of servers are new, and they were not properly trained."	A3000		
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) e) The service plan shall be reviewed and	A4010		

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A4010	Continued From page 3	A4010		

revised, if necessary, immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000).

These requirements are not met as evidenced by:

Based on interview and record review the establishment failed to ensure residents' service plans are updated to include interventions to prevent falls for three of five high risk residents (R5, R7, R8), reviewed for service plan. This has the potential to affect all residents.

Findings include:

1. R5's medical record showed R5 moved into the establishment on 12/2/2024, resided in the memory care unit, and had multiple diagnoses, including but not limited to Epigastric Pain, Rheumatoid Arthritis, Osteoarthritis, Hallucinations, Repeated Falls, Abnormalities of Gait and Mobility, Seborrheic Dermatitis, Malignant Melanoma of Skin, Essential Hypertension, Alzheimer's Disease.

R5's has the following fall incidents:
6/14/2025- Fall was witnessed in resident's room. was assisted with ADLS (Activities of daily Living) knees buckled and hit knee on the carpeted floor. Abrasion to left knee, redness to right knee.
5/3/2025- Fall was unwitnessed in resident's room. No injury noted at time of fall.
4/15/2025- Fall was unwitnessed in resident's room. No injury noted at time of fall.
4/6/2025- Fall was unwitnessed in resident's room. Fall resulted in an injury to the resident, Sent out to ER (Emergency Room).
4/5/2025- Fall was unwitnessed in resident's room. Fall resulted in an injury to the resident:

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A4010	Continued From page 4 Skin tear on left forearm and hit his head. 3/13/2025- Fall was unwitnessed in resident's room. No injury noted at time of fall. 2/13/2025- Fall was unwitnessed in resident's room. No injury noted at time of fall. 12/27/2024- Fall was unwitnessed in resident's room. No injury noted at time of fall. R5's Service Plan, dated 12/2/2024, shows R5 uses a wheelchair and needs physical assist of 1 person with mobility and stand by assistance with transferring. R5's service plan addressed R5 as a fall risk due to Parkinson's Disease and has the following general interventions in place, remind me to rise and change positions slowly, Staff immediately report any new onset of confusion, sleepiness, inability to maintain posture, agitation to the Floor Nurse and Resident Care coordinator. Staff when I am in my room, keep the door open and encourage me to participate in activities. However, there are no updated personalized interventions to prevent further falls. 2. R7's medical record showed R7 moved into the establishment on 6/30/2019, resided in the memory care unit, and had multiple diagnoses, including but not limited Type 2 Diabetes Mellitus, GERD, Essential Hypertension, Anemia, Hyperlipidemia, Dementia, Atrial Fibrillation, Insomnia, Polyarthritis, Chronic Pain Syndrome, Wedge Compression Fracture of Unspecified Thoracic Vertebra. R7's has the following fall incidents: 11/11/2024- Resident noted on the bedroom floor at the foot of her bed. Sent to local hospital for further evaluation. Diagnosed with Right Femur Fracture. 1/5/2025- Resident observed sitting on the floor next to the bed. bruising and discoloration noted	A4010		

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A4010	Continued From page 5 on right orbital area... sent out to local hospital for evaluation... diagnosis: Facial contusion, head injury 1/25/2025- resident observed lying on the floor in her bedroom next to the bed... observed with pain on right shoulder... sent out to local hospital for further evaluation and treatment. 3/28/2025- Observed lying on the floor in her bedroom near the door in a sitting position... sent out to local hospital for evaluation. Progress Notes 5/5/2025- Resident stated she was getting out of bed and slipped. No injury noted at time of fall. 4/18/2025- resident statement fall off her chair when trying to go to bed. No injury noted at time of fall. R7's Service Plan dated 12/11/2024, shows R7 uses wheelchair for locomotion and needs physical assist of 1 person with mobility and transfers. R7's service plan addresses R7 as risk for potential fall due to Dementia and history of falls and has the following general interventions in place: Evaluate / assess me for physical, cognitive and/or environmental factors that could contribute to a fall such as poor lighting, uneven, slippery, cluttered floor surfaces, improper footwear, failure to use my assistive device, etc. Provide me with a safe environment by ensuring that my apartment is clutter free and surfaces are even without slipping hazards. However, there are no updated personalized interventions to prevent falls/falls with injuries. 3. R8's medical record showed R8 moved into the establishment on 2/7/2022, resided in the memory care unit, and had multiple diagnoses, including but not limited Urinary Tract Infection, Hyperlipidemia, Essential Hypertension, Depression, Dementia.	A4010		

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A4010	Continued From page 6 R8 has the following fall incidents: 6/24/2025- Fall was unwitnessed in resident's room. No injury noted at time of fall. 5/25/2025- Fall was unwitnessed in resident's room. No injury noted at time of fall. 3/29/2025- Fall was witnessed in resident's room. Fall resulted in an injury to the resident: Abrasion noted to left temporal area. Resident complained of pain to left arm. Sent out to local hospital. resident was assisted in morning care and transfer when resident became weak and fell to the floor. Resident observed lying on her back on the floor of her apartment. 3/7/2025- Fall was unwitnessed in hallway. No injury noted at time of fall. 3/2/2025- Fall was unwitnessed in hallway. No injury noted at time of fall. 2/15/2025- Fall was unwitnessed in resident's room. resident stated she got up from her wheelchair and it was not locked and slipped, falling to floor denied head pain. No injury noted at time of fall. 1/20/2025- Fall was unwitnessed in resident's room. Fall resulted in an injury to the resident: Previous bruising and hematoma from a previous fall, Resident expressed pain when her head was touched by moaning loudly and was unable to verbalize if she hit her head. Sent out to local hospital. 1/8/2025- Fall was unwitnessed in resident's room. Fall resulted in an injury to the resident: Hematoma developing in left temporal region. Sent out to local hospital. 11/30/2024- Fall was unwitnessed in resident's room. Per resident fall off when she was trying to get up from the chair. No injury noted at time of fall. R8's Service Plan dated 2/13/2025, shows R8	A4010		

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A4010	Continued From page 7 uses Broda Chair and needs physical assist of 1 person with mobility and transfers. R8's service plan addresses R8 as Fall risk and has in placed general interventions. However, there is no personalized interventions in place to prevent falls/falls with injury. On 6/30/2025 at 3:40PM, E2 (Resident Care Director) said "Both the Resident Care Coordinator and I work together on the service plans to update with interventions for fall, hospice, and pt/ot Physical Therapy/Occupational Therapy)." E2 said that updates are made as needed and yes, the interventions are current.	A4010		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: General Violation Section 295.6000 Resident Rights 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor. This requirement is not met as evidenced by: Based on record review and interview the facility failed to provide adequate and appropriate care and monitoring for one of five residents (R1). The resident sat in the recliner in her room for hours without staff checking on her for safety. Findings include: R1's medical record showed R1 moved into the establishment on 7/17/2022, resided in the	A6000		

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A6000	Continued From page 8	A6000		

Assisted Living unit, and had multiple diagnoses, including but not limited to Essential Hypertension, Hypothyroidism, Wedge Compression Fracture of Unspecified Thoracic Vertebra.

R1's Service Plan, dated 6/22/2025, showed R1 was independent with mobility but needs assist of 1 person with transfers and mobility. R1's Service Plan also indicate that R1 needs physical assist of 1 person with toileting and incontinence care.

On 6/26/2025 at 9:06AM Z1 (R1's family member) stated that the incident in January, her brother came to see R1, and that the door was locked, and she was crying for help. Apparently, resident was in her recliner and that she was not able to lower it because the remote control fell and that nobody came to check on her for about 20 hours, R1 missed breakfast, lunch, and dinner. Z1 said that her brother had to come to the front desk to request a key to open the door. Z1 said that this concern was brought up to the attention of the Executive Director and that the Executive Director was apologetic stating that this thing should have not had happened.

On 6/26/2025 E10, E11, both care Manager said that they don't recall any incidents with R1 and that they don't recall having taken care of R1 in January or March. E10 said that per policy they are supposed to check the residents every 2 hours. E11 said that they are supposed to check residents every 30 minutes.

On 6/26/2025 at 3:17PM E12 (Concierge) said that she does not recall R1's son coming to ask her for a key to open R1's apartment.
On 6/26/2025 at 3:24PM, E2 (Resident Care Director) said that she was not aware of any

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A6000	Continued From page 9	A6000		

incident with R1, E2 said "I believe the Executive Director discussed a concern regarding R1 with the Senior Care Coordinator but not with me." E2 said that staff is supposed to check residents at shift change, at least once a shift.

On 6/30/2025 at 9:10AM, E13 (Resident Care Coordinator) said that E17 (Former Executive Director) said that family reported that R1was on the chair and that the pendant, the phone and remote fell down and she was not able to reach them to call staff for assistance. E13 said that when she asked night staff about it, they said that when they checked on R1, she was sleeping in the chair, because she is independent, when the morning shift checked on her they found her, no time given as when the resident was checked by staff, E13 said that resident is independent, alert and oriented X3, limited mobility due to oxygen use, uses walker for mobility. E13 said that the incident was probably not reported because resident was not harm, no bruises, etc. E13 said she is not aware if resident missed any meal. E13 said that the dining room is like a restaurant that there is no set time for residents to be served.
On 6/30/2025 at 10:45AM, E16 (Care Manager) said "We are supposed to check on residents every two hours regardless of if they are independent or not. I make sure I know where my residents are. If I don't find them in their apartments, I will call to see who has seen them and where."

On 6/30/2025 at 11:00AM, E1 (Executive Director) said that she was not aware of the incident with R1, until surveyor began to ask questions, E1 said that E13 told her that apparently R1 was sleeping in the recliner and that the next morning she was soiled. This incident allegedly happened overnight. E1 said

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A6000	Continued From page 10 "The family wanted our staff to clean the recliner because it was soiled. This was nobody's fault because, resident was not receiving any services from us, she was very independent, overnight staff saw her sleeping in the recliner, during the morning shift when noticed she didn't come for breakfast, they when to check on her and that's when she was found in the recliner." When surveyor asked E1 if staff was supposed to make rounds on her or any residents, she said "nobody goes to check on them". E1 said that she was not able to fine any report about this incident. On 6/30/2025 at 4:45PM E1 (Executive Director) said "that I was not able to locate anything other than we did perform a staff in-service immediately following this incident with Care Managers on prompt and appropriate resident checks per shift. I know this resident family did talk with E17 (Former Executive Director) extensively and her care level was changed to provide daily hands-on care. Establishment's Policy title "Abuse, Neglect and Exploitation-Prevention, Reporting and Investigation: Revised 4/24/2025 indicates Neglect: the failure to provide goods and services necessary to protect the resident from health and safety hazards.	A6000		
A7000	Secton 295.7000 Resident Records This Regulation is not met as evidenced by: Type 3 Violation Section 295.7000 Resident Records	A7000		

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A7000	Continued From page 11 a) Service delivery contracts and related documents executed by each resident or resident's representative shall be maintained by the establishment from the date of execution until three years after the date the contract is terminated. (Section 105 of the Act) d) An establishment shall ensure that a resident's record is: 2) Maintained at the establishment; 3) Legibly recorded in ink or electronically recorded; 4) Retained for 3 years from the date of termination of residency (closed records may be retained off-site); and 5) Available for review by the resident or the resident's representative during normal business hours or at a time agreed upon by the resident and the manager. These requirements are not met as evidenced by Based on interview and record review, the establishment failed to keep Resident Records as required for one of five residents (R1). This failure has the potential to affect all residents. Finding Include On 6/25 and 6/26/2025 Establishment's resident's record was requested for review. R1's records were not provided by E1 (Executive Director) upon request.	A7000		

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A7000	Continued From page 12 On 6/30/2025 at 4:45PM, E1 said that he was not able to locate R1's record.	A7000		