STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510052	A. BUILDING: _____ B. WING _____	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDALE CTR - VILLA ST BENEDICT	1920 MAPLE AVE LISLE, IL 60532

(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 Annual Licensure Survey	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: 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. a) 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). g) Service plans shall address: 1) The level of service the resident is receiving, including: A) assistance with activities of daily living. C) special accommodations for the resident. 2) The amount, type, and frequency of health-related services needed	A4010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510052	A. BUILDING: _____ B. WING _____	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDALE CTR - VILLA ST BENEDICT	1920 MAPLE AVE LISLE, IL 60532

(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
A4010	Continued From page 1 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. These requirements were not met, as evidenced by: Based on interview and record review, the facility failed to: 1. Develop service plans to address the specific needs/problems or concerns of the residents. 2. Implement interventions to minimize the risk factors and to provide appropriate care and services. 3. Identify the frequency and the staff responsible for the delivery of the services. 4. Follow the fall and admission/ readmission policy and procedures and, 5. Integrate the plan of care to include the outside support services/providers (R2 and R4) and, 6. Develop a significant change of status for R2. These failures resulted in: 1. R2 incident of falls with major injuries: a. On January 7, 2024 - R2 sustained fracture (left hip?) with surgical intervention and, b. On July 7, 2024 -R2 sustained right rib fracture, 2. R1- identified with "occasional falls-3-6 times per year." On October 7, 2024-sustained left hip fracture requiring surgical repair. 3. These failures apply to all residents in the community. The findings include: 1. R2 initially moved in the community on June	A4010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510052	A. BUILDING: _____ B. WING _____	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDALE CTR - VILLA ST BENEDICT	1920 MAPLE AVE LISLE, IL 60532

(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
A4010	Continued From page 2 21, 2019, with diagnoses to include asthma, hypertension, psychotic disorder, diverticulitis of the small intestine with perforation and abscess and osteoporosis without current pathological fracture. On November 8, 2024, at 2:35 PM, E1 (Director of Nursing), E3 and E4 (Registered Nurses) described R2 as confused, uses wheelchair for ambulation and a high risk for fall. E3 explained, "in her mind, she's still in better shape. Will take the wheelchair to the bathroom and transfer self." The staff said, "After R2's fall in January (7, 2024), after coming back from the rehabilitation center, that was the start of R2's demise. R2 was gone (from the community) until March (readmitted on March 11, 2024) and was not the same after she came back!" The following nurse's notes show: a. December 11, 2023 - with sacral ulcer covered with foam dressing. No further description regarding this wound. - The Reportable incidents submitted to the Department, R2 sustained a fall on January 7, 2024. R2 was admitted to the hospital and was diagnosed with fracture (site not identified)- with surgical intervention. b. March 11, 2024 - "returned" from Thrive (rehabilitation center?), with wound near buttocks. c. March 12, 2024 -seen by hospice Nurse. d. July 5, 2024- fell today at 12:00 PM was discovered lying on the floor ...sent to the hospital, possible rib fracture was noted. R2's (re- assessment) service plan dated April 12, 2024, failed to identify these areas of concerns and risk factors. For fall risk, E2 explained, "the stability/ fall" was identified but no intervention was listed and E2 confirmed that there was no	A4010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510052	A. BUILDING: _____ B. WING _____	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDALE CTR - VILLA ST BENEDICT	1920 MAPLE AVE LISLE, IL 60532

(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
A4010	Continued From page 3 significant change of condition developed for R2. II. R4 was placed under hospice care on August 28, 2024, no significant change of condition was developed to reflect the changes and there was no integration of services was noted; the utilization of the outside services were not reflected in R4's service plan. III. On November 8, 2024, at 2:40 PM, E2, E3 and E4 described R1 with cognitive impairment, requires stand by assist with all of activities of daily living. E1 claimed, "R1 always wanting to go home." R1's service plan dated September 16, 2024, identified R1 with "occasional fall 3-6 times per year." There were no individualized interventions listed to minimized R1's risk for falling except report increasing evidence of unsteadiness and to report falls. On October 7, 2024, R1 fell and sustained left hip fracture with surgical intervention. The community service plans had no individualized interventions listed, no frequency or staff responsible for the provision of the services was listed. On November 8, 2024, at 4:24 PM, these findings were discussed with E2. E2 stated, "there was no space to write interventions."	A4010		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs	A4060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510052	A. BUILDING: _____ B. WING _____	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDALE CTR - VILLA ST BENEDICT	1920 MAPLE AVE LISLE, IL 60532

(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
A4060	Continued From page 4 This Regulation is not met as evidenced by: Type 2 Violation- (REPEAT) Section 295.4060 Alzheimer's and Dementia Programs a) In addition to this Section, Alzheimer and dementia programs shall comply with all of the other provisions of the Act. (Section 150(a) of the Act) h) An establishment that offers to provide a special program for persons with Alzheimer's disease and related disorders shall: 2) Staff training: A) All staff members must receive, in addition to the training required in Section 295.3020, four hours of dementia-specific orientation prior to assuming job responsibilities without direct supervision within the Alzheimer's/dementia program. Training must cover, at a minimum, the following topics: i) basic information about the causes, progression, and management of Alzheimer's disease and other related dementia disorders. ii) techniques for creating an environment that minimizes challenging behavior. iii) identifying and alleviating safety risks to residents with Alzheimer's disease. iv) techniques for successful communication with individuals with dementia; and v) residents' rights. B) Direct care staff must receive 16 hours of on-the-job supervision and training within the first 16 hours of employment following orientation. Training must cover: i) encouraging independence in and providing assistance with the activities of daily living. ii) emergency and evacuation procedures	A4060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510052	A. BUILDING: _____ B. WING _____	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDALE CTR - VILLA ST BENEDICT	1920 MAPLE AVE LISLE, IL 60532

(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
A4060	Continued From page 5 specific to the dementia population. iii) techniques for creating an environment that minimizes challenging behaviors. iv) resident rights and choice for persons with dementia, working with families, caregiver stress; and v) techniques for successful communication. These requirements were not met, as evidenced by: Based on interview and record review, the facility failed to offer and complete the 4 hours and 16 hours of Dementia specific training to employees as required by the Department. This failure has the potential to affect the care and treatment of the resident in the Memory Care Unit The finding includes: On November 8, 2024, at 5:00 PM, the employee files were reviewed with E14 (H.R Director). E14 acknowledged that the community was not in compliance with the time frame required by the Department as well as the inclusion of the 16 hours of Dementia specific training. The employee files reviewed were: E5, E6 and E13- Care Assistants E7, E6, E8, E9, E10, E11 and E12- License Practical Nurses. These were hired from January-November 2024. These findings were also discussed with E2 (Director of Nursing).	A4060		
A7000	Secton 295.7000 Resident Records	A7000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510052	A. BUILDING: _____ B. WING _____	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDALE CTR - VILLA ST BENEDICT	1920 MAPLE AVE LISLE, IL 60532

(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
A7000	Continued From page 6 This Regulation is not met as evidenced by: Violation Section 295.7000 Resident Records 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) 6) Notation of assessments and evaluations conducted pursuant to Section 295.4000. 7) The service plan, its amendments and updates. 9) Notation of known accidents, incidents or injuries. 10) Documentation of any significant change in a resident's behavior or physical, cognitive, or functional condition that would trigger an assessment or evaluation, and action taken by employees to address the resident's changing needs. f) The following resident records and supporting documents shall be made available for on-site inspection by the Department upon request at any time: These requirements were not met, as evidenced by: Based on interview and record review, the facility failed to: 1. Document resident's assessment, evaluation, changes in condition and incidents of falls in the clinical records. 2. Have a complete, accurate documentation's, with sufficient information about the resident's condition and the services being provided. 3. Follow the establishment policy and procedures in areas of readmission and fall	A7000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510052	A. BUILDING: _____ B. WING _____	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDALE CTR - VILLA ST BENEDICT	1920 MAPLE AVE LISLE, IL 60532

(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
A7000	Continued From page 7 management. The failures to conduct a comprehensive assessment and documentation's of the progress and effectiveness of the nursing interventions resulted in R2 sustaining additional fall incidents with major injuries. 1. On January 7, 2024 - R2 sustained fracture of the left hip with surgical intervention and, 2. On July 7, 2024 -R2 sustained right rib fracture. The findings include: 1. On January 7, 2024, a reportable incident submitted to the Department show: R2 was found lying in a bathroom floor at 7:00 AM. R2 complaint of pain in leg and back. R1 was transported to the hospital and was admitted with fracture (site unidentified) with surgical intervention done on January 10, 2024. The establishment was unable to present any documentation in R2's clinical record regarding this incident although documentation's from the month of December 2023 were presented. On November 8, 2024, at 4:30 PM, E2 (Director of Nursing) confirmed and explained, "we do not have the documentation's for that incident. " The Fall management policy and procedure dated June 6, 2024, shows the following: Post fall procedures, the nurse completes an assessment of the resident condition ... and documentation is completed. This fall procedure was not followed during this survey and was confirmed by E2. 2. On March 11, 2024, at 3:57 PM, R2 was readmitted in the establishment. R2's nurses notes show: Returned from thrive (a rehabilitation center?).	A7000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510052	A. BUILDING: _____ B. WING _____	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDALE CTR - VILLA ST BENEDICT	1920 MAPLE AVE LISLE, IL 60532

(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
A7000	Continued From page 8 Vital signs ... (obtained); no complain of pain. Given pendant and reminded how to use. Skin assessment with superficial wound near buttocks . There was no further assessment obtained/ documented regarding this wound and no follow -up documentation's or monitoring was found. On March 12, 2024, R2's nurse's notes read: seen by Hospice Nurse ... No documentation as to when the order for hospice care was obtained or when the hospice care was initiated. The establishment readmission policy and procedure dated January 5, 2024, shows the following procedures: - Upon return, the resident is assessed by licensed nurse. - Progress notes will be entered with any change of condition or of treatment. - Progress notes will reflect the resident status, the effectiveness of the plan of care and the monitoring and reassessment of the effects of the care provided. These fall procedures were not implemented for R2. 3. R2's nurses notes dated July 5, 2024, show: Fell today around 12:00 PM, was discovered lying on the floor. R2 was transported to the hospital and was diagnosed with right rib fracture. On July 6, 2024, R2 "returned last night." No further assessment done. No follow up/ no monitoring was done. These concerns were discussed with E2 on November 8, 2024 at 5:00 PM	A7000		