

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ASL510518	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/25/2025
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NAME OF PROVIDER OR SUPPLIER BURR RIDGE SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 16W301 91ST STREET BURR RIDGE, IL 60527
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A 000	Initial Comment Facility Reported Incident Investigations: IL180610- Substantiated. IL181854-Not substantiated. IL183540-Not substantiated. IL186188-Substantiated. Complaint Investigations: 2571585/IL187134- Substantiated. 2573391/IL190490-Substantiated.	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Section 295.4010 Service Plan Type 2 Violation 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. g) Service plans shall address: 1) The level of service the resident is receiving, including: A) assistance with activities of daily living; 2) The amount, type, and frequency of health-related services needed by the resident;	A4010		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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A4010	<p>Continued From page 1</p> <p>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).</p> <p>This requirement was not met as evidenced by:</p> <p>Based on interview and record review the facility failed to revise a residents service plan after a fall, episodes of elopements and failed to follow the service plan for a resident who needs assistance receiving showers. This applies to 4 of 4 residents (R3, R5, R6, R2) reviewed for service plans in the sample of 8.</p> <p>The findings include:</p> <p>1. R3's EMR (Electronic Medical Record) shows that R3 moved in to the facility on 7/28/24 with diagnoses that include Parkinson's Disease and hypertension.</p> <p>The Facility Reported Incident (FRI) dated 10/25/24 timed at 6:20 AM documents resident (R3) observed on apartment floor after an unwitnessed fall. Hematoma (bruised) noted to left side of forehead. Resident is alert and admitted to hitting her head. 911 called and sent to hospital. Came back with no findings except for hematoma to left forehead.</p> <p>On 4/25/25 at 10 AM, R3 was in her apartment sitting in her recliner. R3 said she toileted herself using her walker. R3 stated "I remembers falling and hurting here (pointing to her left side of forehead). While in the bathroom, I lost my balance and fell on my left side, hitting my forehead on the floor. I used my pendant (life</p>	A4010		

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A4010	<p>Continued From page 2</p> <p>alert) to ask for help, they (staff) were here within 5 minutes. R3 said she had other falls lately "but I have not hurt myself yet. "</p> <p>On 4/25/25 at 11:30 AM, E7 (Assisted Living Manager) said R3 was sent out to the hospital after her fall in the morning of 10/25/24 when R3 sustained a bruised to her left forehead. R3 came back to the facility the same day, all of R3's tests were normal. E7 said R3 had a fall earlier that morning (10/25/24) around 2 in the morning trying to go to the bathroom.</p> <p>R3's latest service plan under falls show, "fall prevention- resident will be monitored for safety in their environment. Community team will check for appropriate lighting clutter, and spills in the apartment, encourage proper footwear/ non skin footwear and educate resident to push pendant as needed for assistance with mobility."</p> <p>R3's service plan did not include any new interventions to R3's multiple falls.</p> <p>R3 fell last 10/25/24 at 6:20 AM when R3 lost her balance in the bathroom hitting her forehead on the floor.</p> <p>R3 had a fall earlier the same day (10/25/24) at 2:51 AM, R3 was "observed sitting on the floor next to her recliner, states that she was trying to go to the bathroom."</p> <p>R3 fell again last 11/23/2024 at 7:43 PM, Resident noted falling in bathroom.</p> <p>R3 had another fall on 3/28/25, Resident called for assist using pendant, upon arrival to room resident was observed sitting on the floor next to bed.</p>	A4010		

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A4010	<p>Continued From page 3</p> <p>On 4/26/25 at 2 PM, E2 (Director of Nursing) said service plan should be updated with new interventions in place for every fall incidents to minimize falls. E2 confirmed R3 had no service plan updates to addressed R3's multiple falls.</p> <p>2. R5's EMR shows that R5's moved in to the facility on 9/17/19 with diagnoses that include diabetes and vascular dementia.</p> <p>The Facility Reported Incident dated 2/10/25 documents, "The resident (R5) was found at the bottom area stairwell, it is unknown how she got down there or if she fell, no injuries were noted, no complaints of pain or discomfort. Called 911 the resident was sent to a local hospital. The resident returned on 2/10/25 (same day) no new orders. Recommended to the family to provide 24 hour care pending her move to Memory Care."</p> <p>On 4/25/25 at 9:40 AM, R5 was sitting in the dining room in the Memory Care unit alert and pleasant. R5 said she "was just doing fine." R5 cannot recall the incident when she was found on the bottom of the stairs.</p> <p>On 4/25/25 at 12:30 PM, E9 (LPN) said he was the night Nurse last 2/9/25 going to 2/10/25. "I saw her (R5) last around 8-9 PM when she took her bedtime medication. R5 was supposed to be checked 2x a shift. It was the end of the shift when they found her at the bottom of the stairs."</p> <p>On 4/25/25 at 11 AM, E7 (Assisted Living Manager) said last 2/10/25 she was working as the day shift Nurse in 2nd floor Assisted Living.. She came to work around 6AM. "Before I can even get report from the Night Nurse I was told that (R5) who was a 2nd floor resident was at the</p>	A4010		

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A4010	<p>Continued From page 4</p> <p>bottom of the stairs. I immediately went to check R5, she was lying on her back on the floor on the last step of the stairs by the door leading to the Memory Care Unit on first floor. I asked R5 what happened, she cannot remember. R5 looked very tired. No complaints of pain, she was sent out via 911. She came back and had no injuries.</p> <p>On 4/25/25 at 9:48 AM, E4 (License Practical Nurse-LPN) said she was the day shift Nurse in the Memory Care Unit. It was the beginning of the morning shift around "6ish". R5 was found on the bottom of the stairs leading to the Memory Care unit. R5 was lying on the floor after the last step of the stairs. R5 looked tired. R5 tried to open the door that was alarmed, "that's how we knew someone was at that area" R5 was now moved on first floor Memory Care Unit. E4 (LPN) said R5 used to be a 2nd floor resident. R5 opened the door on the 2nd floor unit which was not alarmed since 2nd floor was an Assisted Living Unit. The door leads to two flight of stairs. At the bottom of the stairs was an alarmed door connected to Memory Care Unit. That was where R5 was found.</p> <p>On 4/25/25 at 12PM, This surveyor and E1 (Executive Director) went to the 2nd Floor Assisted Living, then to the stairs where R5 went down to, to the alarmed door that when opened, leads to first floor Memory care locked unit. R5's previous room on the 2nd floor was approximately 75 feet away from the door leading to the stairs where R5 went down. This door was not alarmed. R5 uses a walker when walking. The stairs where R5 went down was with 2 flight of stairs with 10 steps on the first flight and 9 steps on the 2nd flight- a total of 19 steps. E1 said R5 was found lying on the floor at the end of the step. E1 said R5 was now moved in the</p>	A4010		

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A4010	<p>Continued From page 5</p> <p>Memory Care Unit after the incident for her safety.</p> <p>R5's latest Service Plan dated 2/20/25 under falls show, "fall prevention-potential fall risk, Community team will check for appropriate lighting clutter, and spills in the apartment, encourage proper footwear/ non skin footwear and educate resident to push pendant as needed for assistance in mobility." This latest Service plan did not addressed R5's fall incident last 2/10/25.</p> <p>On 4/25/25 at 2 PM, E2 (Director of Nursing) said R5's service plan should have been updated as soon as the incident happened last 2/10/25 when she was found lying on the floor on the bottom of the stairs. Service Plan updates should be immediate, meaning within 24 hours.</p> <p>3. R6's Service Plan with an activation date of 6/18/24 shows R6 has long and short term memory impairment, does not have behavior or wandering issues, ambulates independent with a walker, and has been assessed as a potential fall risk.</p> <p>R6's Progress Note dated 7/6/24 shows R6 was found sitting on the floor in his room and assessed to have a small abrasion to his right knee.</p> <p>R6's Progress Note dated 9/9/24 shows R6 was observed by staff sitting on curb outside. R6 stated he tripped over his feet. R6 was wearing house slippers and his feet weren't properly in them.</p> <p>R6's Progress Note dated 9/12/24 shows R6 fell in the independent area community restroom and</p>	A4010		

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A4010	<p>Continued From page 6</p> <p>has an abrasion to his right knee.</p> <p>R6's Progress Note dated 9/26/24 shows R6 was observed laying on the ground on the front porch. R6's left ring finger was hyperextended at the first knuckle, and there was bleeding noted to the tip of the finger. The side of R6's head was on the ground.</p> <p>R6's Progress Note dated 10/10/24 shows R6 had a fall outside, stating he fell while moving a chair. Assessment shows the back of R6's head was bleeding and required sutures.</p> <p>R6's Progress Note dated 10/11/24 shows the paramedics reported to the front desk that R6 has a fall with head injury near McDonalds (walking distance from facility) and was being transferred to the ER.</p> <p>R6's Service Plan with an activation date of 10/17/24 was updated to show "Escorts-Physical Assist: R6 requires assistance with escorts due to frequent falls, R6 will need frequent reminders to use his pendant to as for help. R6 frequently will ambulate without escort assistance. On 9/27/24 (after 5 falls) an intervention under fall prevention shows R6 continues to work with therapy, reminded to call for assistance and always wear appropriate footwear." R6's memory impairment, behaviors, and or wandering issues were not updated.</p> <p>R6's Progress Note dated 10/18/24 shows R6 was confused and restless and was at the front entrance at 12 AM trying to leave the building. R6 was stating his daughter would pick him up at the train station. When staff tried to orient R6, he became agitated, and verbally and physically aggressive.</p>	A4010		

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A4010	<p>Continued From page 7</p> <p>R6's Progress Note dated 10/19/24 shows R6 was observed sitting on the floor in his room next to his recliner. R6 stated he was trying to close the window, went to sit down, and missed the recliner. R6 was found to have a skin tear to his left lower arm.</p> <p>R6's Progress Note dated 10/3/124 shows R6 was observed sitting on the floor next to the refrigerator in his room. R6 said he lost his balance, fell, and hit the back of his head on the refrigerator door. A laceration was noted to the back of R6's head and R6's left hand was bleeding.</p> <p>R6's Progress Note dated 11/21/24 shows R6 was agitated and consistently wanting to roam outside of his room.</p> <p>R6's Progress Note dated 11/26/24 shows R6 was noted leaving the community unattended around 6:40 PM in his wheelchair. R6 was later found at the intersection of 91st Kingery and brought back to the community by the police department around 7:20 PM.</p> <p>R6's Service Plan with an activation date of 11/27/24 shows R6 Care Plan was updated (after 4 incidents) showing R6 has some long and short term memory impairment, extensive wandering issues with episodes of confusion and has tried to leave the building at night (10/18/24). R6 was most recently escorted back to the community by police on 11/26/24. R6 now has a 24 hour caregiver in place and must be accompanied at all times.</p> <p>On 4/25/25 at 12:45 PM, E1 Executive Director said a resident's Care Plan should be updated</p>	A4010		

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A4010	<p>Continued From page 8</p> <p>after every 6 months, after a hospitalization, an incident, or a fall, with new interventions added. E1 said E2 Director of Nursing investigated R6's elopement on 11/26/24 and the nurse that was on duty that night is on medical leave and not available.</p> <p>The facility's Care Plan Policy dated 2/1/23 shows " The Care Plan along with the Assessment is reviewed and revised upon admission, within 30 days of admission, every 3 months for residents residing in Memory Care or every 6 months for resident residing in Assisted Living or following a change in condition.."</p> <p>4. R2's face sheet shows she is 93 year old female admitted to the establishment on 1/4/24. R2's diagnoses include vascular dementia unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, history of falling, anemia, hypertension, edema and aortic stenosis.</p> <p>On 4/25/25 at 9:45 AM, R2 was observed in her apartment sitting in her wheelchair. R2 was alert to self, and forgetful to time. R2 was pleasant, she was eating her breakfast meal in her apartment. Z1 (R2's POA) was in her apartment. Z1 said there has been an on-going issue with R2 not receiving her showers three times a week.R2 is supposed to receive her showers on Monday, Thursday and Saturday. Z1 said sometimes he helps assisting his mom with a shower when the staff do not provide the showers. A white board with R2's shower schedule shows she should receive showers three times a week on the coffee table in her apartment.</p> <p>On 4/25/25 at 10:33 AM, E5 (Resident Assistant-RA) said R2 is supposed to receive</p>	A4010		

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A4010	<p>Continued From page 9</p> <p>showers three times a week. On Monday, Thursday and Saturdays.</p> <p>On 4/25/25 at 2:10 PM, E7 (Assisted Living Manager) said R2 is supposed to receive shower three times a week.</p> <p>R2 did not receive her shower on 4/5/25 and staff should document if R2 refuses and offer at a later time. E7 confirmed R2 has not been receiving her showers three time a week and should be.</p> <p>R2's current service plan dated 2/27/25 shows she needs physical assist with showers. Showers are scheduled Monday, Thursdays and Saturdays.</p> <p>R2's April 2025 Task Log Report shows two showers were not provided. On 4/5/25- "RA did not have time for the shower on 4/5/25." On 4/19/25 there is no documentation of R2 receiving her shower.</p>	A4010		
A6000	<p>Section 295.6000 Resident Rights</p> <p>This Regulation is not met as evidenced by: Type 3 Violation Section 295.6000 Resident Rights</p> <p>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:</p> <p>1) The right to live in an environment that</p>	A6000		

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A6000	<p>Continued From page 10</p> <p>promotes and supports each resident's dignity, individuality, independence, self-determination, privacy, and choice and to be treated with consideration and respect;</p> <p>2) The right to respect for bodily privacy and dignity at all times, especially during care and treatment;</p> <p>3) The right to retain and use personal property, unless such use infringes on the health, safety, or welfare of other individuals, and a place to store personal items that is locked and secure;</p> <p>4) The right to designate any individual to participate with the resident or in the resident's name in the development of the written service plan;</p> <p>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;</p> <p>14) The right to confidentiality of the resident's medical, financial, or other records. The release of a record shall be by written consent of the resident or the resident's representative and shall specify the circumstances under which each individual record may be released, except as specified by law;</p> <p>This requirement was not met as evidenced by:</p> <p>Based on interview and record review the facility failed to ensure the residents representative was informed of the service plan changes and informed of the cost changes in the service plan and failed to honor the residents representatives request of obtaining medical information. This</p>	A6000		

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A6000	<p>Continued From page 11</p> <p>applies to 1 of 3 residents (R2) reviewed for resident rights in the sample of 8.</p> <p>The findings include:</p> <p>R2's face sheet shows she is 93 year old female admitted to the establishment on 1/4/24. R2's diagnoses include vascular dementia unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, history of falling, anemia, hypertension, edema and aortic stenosis. Z1 (R2's POA) is listed as her power of attorney.</p> <p>On 4/25/25 at 9:45 AM, R2 was observed in her apartment with Z1. R2 was eating her breakfast meal, sitting in her wheelchair in her robe.</p> <p>On 4/25/25 at 9:45 AM, Z1 (R2's POA) said in February 2025 R2's assessment jumped from a level 1 to a level 5. R2 does not receive medications from the establishment, her service includes showers three times a week, bedding change and laundry services. R2 transfers herself, toilets and dresses herself. They did not inform us of the changes until we received the bill. Z1 said he reached out to Z2 (Ombudsman) regarding several concerns and she confirmed there was not justification of the changes or notice. Z1 said E7 contacted R2's physician regarding medical information and he requested all medical requests should go thru him and he will contact Z2's physician. E7 contacted R2's physician requesting medication for anxiety without my consent. Z1 said he comes daily from 7:00 AM and stays four to five hours.</p> <p>On 4/25/25 at 10:33 AM, E5 (Resident Assistant-RA) said R2 is alert and forgetful. Z1 comes daily for several hours. R2 only needs</p>	A6000		

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(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
A6000	<p>Continued From page 12</p> <p>assistance with showers and toileting. R2 eats her meals in her room and we change her bedding when needed.</p> <p>On 4/25/25 at 10:39 AM, E 12 (RA) said R2 is alert and forgetful, Z1 comes daily to visit. We assist her with toileting if she lets us and showers. R2 eats her meals in her room and we change her bedding.</p> <p>On 4/25/25 at 11:58 AM, Z2 (Ombudsman) said she has been involved with Z1 and his concerns. One of the concerns is the level of service change without notifying Z1 prior to the changes. The establishment said they can not change the level change until a new assessment is done and they did not notify him of the changes. Z2 said she was present for R2's care plan last week and confirmed the service plan and the assessment was not accurate to the services R2 was receiving. Z1 was upset E7 contacted R2's physician requesting medication without notifying Z2.</p> <p>On 4/25/25 at 10:58 AM, E7 (Assisted Living Manager/LPN) said nursing performs the service plan assessments on the computer and this will generate the level of care the resident is, it goes by a point system. The assessment is done every six months and as needed. We discuss the changes with resident and POA prior to the changes and they would sign in agreement. A Level one is a resident with minimal assistance and Level 5 would be a resident requiring additional needs including medication, escorts, toileting, frequent monitoring and increased assistance with activities of daily living.</p> <p>On 4/25/25 at 1:29 PM, E2 (Director of Nursing) said service plan assessments are done every six</p>	A6000		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ASL510518	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/25/2025
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A6000	<p>Continued From page 13</p> <p>months and as needed. E7 usually does the assessment and should gather information from the RA's, family and resident to answer the questions. If there is a level change it should be discussed with resident and POA prior. The assessment and service plan should match. There was a careplan meeting with Z1 recently, he had questions about the service plan and assessment. It is my understanding they would like another assessment done but has not been done yet.</p> <p>On 4/25/25 at 2:10 PM, E7 said R2's assessment was done in February 2025. She did not do the assessment because she was not working for the establishment at the time. Z1 wants another assessment to be done because he said it's not accurate. Another assessment has not been done yet. She did not know why R2's level changed from level 1 to level 5 because she did not do the assessment. E7 confirmed the level change and R2's care plan does not match. It shows she is being escorted three times a day but she eats all of her meals in her room. E7 said she contacted R2's physician and Z1 requested we go through him first.</p> <p>R2's Illinois Health and Service Evaluation Results dated 6/20/24 shows she is a care Level 1; score of 21 points.</p> <p>R2's Illinois Health and Service Evaluation Results dated 2/27/25 shows she is a care Level 5, score of 166 points. The report shows it was not signed by the POA, resident care director of executive director.</p> <p>R2's Consolidated Assessment Report shows the score breakdown for billable service for R2 including mobility/ambulation, bathing, dressing,</p>	A6000		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ASL510518	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/25/2025
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A6000	<p>Continued From page 14</p> <p>toileting. The assessment is not signed by Z2.</p> <p>R2's progress note dated 3/2/25 and 3/6/25 documents left a voicemail for (Z1) to set up a care plan meeting and to discuss the changes in plan of care. (After the assessment was performed).</p> <p>R2's service plan dated 2/27/25 shows she requires assisting with dressing two times a day, she requires toileting assistance four times a day, weekly laundry services, daily bed making, daily trash removal, escort services three times a day. The care plan show R2 prefers to stay in her room, she does not come to meals or activities. RA to assist three time a day. (48 points for this service). R2's service plan shows if R2 has any medical needs outside of an emergency (R2's POA) would like to be called and he call the MD to set up appointments and follow up care for his mom.</p>	A6000		