STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510170	A. BUILDING: _____ B. WING _____	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CELEBRATE SENIOR LIVING OF NILES	7000 N NEWARK AVENUE NILES, IL 60714

(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 Violations 295.2000a) 295.4000a)b)	A 000		
A2000	Section 295.2000 Residency Requirements This Regulation is not met as evidenced by: Type 3 Violation Section 295.2000 Residency Requirements a) No individual shall be accepted for residency or remain in residence if the establishment cannot provide or secure appropriate services, if the individual requires a level of service or type of service for which the establishment is not licensed or which the establishment does not provide, or if the establishment does not have the staff appropriate in numbers and with appropriate skill to provide such services. (Section 75(a) of the Act) Based on interview and record review, the establishment failed to ensure one (R1) of two residents reviewed met residency requirement for residents housed in an Assisted Living. This deficient practice has the probability to affect all residents. Findings include: On 7/29/25 at 11:46am, R1 was observed in the dining area with her husband. Resident Roster indicated, R1 moved to the Assisted Living with	A2000		

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A2000	Continued From page 1 her husband on 11/1/24. R1 is 78 years old. According to R1's document titled Physician Assessment Form/Assisted Living signed by Advance Nurse Practitioner dated 10/24/24 documented R1's medical history which include but not limited to Dementia and Anxiety. Per this assessment, R1 was alert and oriented x1-2, occasional anxiety and confusion at baseline. Elopement risk was also identified as safety risk. R1's Brief Interview for Mental Status (BIMS) score dated 6/19/25 is 3/15 indicating severely impaired cognition. R1's Negotiated Risk Agreement documents dated 11/19/24, acknowledged wandering behavior, "Episodes of wandering in the facility and had to be redirected back to Assisted Living by staff. Potential dangers consequences that might occur as a result of this behavior: (R1) will not have a 24- monitoring for elopement risk. (R1) ambulates independently and will be able to come and go without staff escort. (R1) has a history of being confused, disoriented and shown poor judgement. (R1) will not be able to safely care for herself outside of the facility. (R1) has history of wandering and trying to leave facility unsupervised. Possible alternative: NO alternatives based on facility assessment." R1's "Physician Progress Notes" reviewed on 7/29/25 and 7/30/25 documented the following: 6/18/25:Pt (Patient) was transferred to ALF from ILF by daughter due to self-care deficit from dementia .... Confusion. Had multiple discussion with daughter about pt's wandering behavior and recommends that pt gets admitted to the locked unit, however, daughter POA refuses and understands the risk."	A2000		

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A2000	Continued From page 2	A2000		

7/7/25: "Sundowning 2/2 dementia". Sundowning per definition "State on increased confusion, agitation and disorientation that some individuals with dementia experience"

R1's Psychiatric Notes dated 6/24/25 documented, "Continues to wander around the building and often reported to get lost. Requires close monitoring and supervision ...Continues to display significant memory deficits ...Orientation: Remains easily confused and disoriented to time and place. Memory: Decreased. Judgement: Poor."

R1's incident report dated 1/3/25 10:30 documented R1 was found outside of the building without her walker. R1's Nurse's Notes reviewed indicated multiple entries of R1's wandering behavior. 1/25/25, 4/8/25 (found on the 5th floor), 5/16/25 (found on the 2nd floor). On 6/2/25, at 11pm as staff was leaving for end of shift, R1 was noted going out of the building by Supervisor, staff went back in and assisted R1 back to the building.

On 7/29/25 at 3:50pm, E5 (Certified Nursing Assistant) indicated R1 wanders and at times hard to redirect.

On 7/29/25 at 3:54pm, E10 (Nurse Supervisor) said R1 has Dementia and confusion, and at times wanders. E10 said R1's physician is aware and recommended memory care unit but the daughter refused.

On 7/29/25 at 11:46am, R1 was observed in the dining area with her husband. R1 was asked how she was and stated everything was fine.

Wandering behavior was identified by

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A2000	Continued From page 3 establishment and signed a Negotiated Risk with R1's daughter since November 2024. The Negotiated Risk agreement did not cancel potential risk to resident brought about by her elopement risk, wandering behavior, confusion and poor judgment. On R1's Service Plan signed 7/24/25 documented, R1's increased confusion, staff redirecting resident from leaving the 4th floor, safety concerns due to wandering was discussed with R1's Power of Attorney (POA) and the need of higher level of care, however POA wishes R1 to continue living in AL with husband. Intervention remains: Staff to continue to redirect when resident is seen trying to leave 4th floor without escort.	A2000		
A4000	Section 295.4000 Physician/s Assessment This Regulation is not met as evidenced by: Type 3 Violation Section 295.4000 Physician's Assessment a) No more than 120 days prior to admission of a resident to any establishment, a comprehensive assessment that includes an evaluation of the prospective resident's physical, cognitive, and psychosocial condition shall be completed by a physician. b) At least annually, once a resident has moved into the establishment, a comprehensive assessment shall be completed by a physician.	A4000		

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A4000	Continued From page 4 Based on interview and record review, the establishment failed to ensure a Physician completed the physician assessments for three (R1, R2, R3) of four residents reviewed for this requirement. This deficient practice has the probability to affect all residents. Findings include: R1's Initial Physician Assessment Form/Assisted Living was signed and completed by an Advance Nurse Practitioner on 10/24/24. R1 moved to the community on 11/1/24. R3's Annual Physician Assessment Form/Assisted Living was signed and completed by an Advance Nurse Practitioner on 6/18/25. R4's Annual Physician Assessment Form/Assisted Living was signed and completed by an Advance Nurse Practitioner on 6/18/25. On 7/29/25 at 3:09pm, E1 (Executive Director) confirmed Physician Assessments are done by physician or the physician's Nurse Practitioner.	A4000		