STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510148	A. BUILDING: _____ B. WING _____	09/15/2025

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EVERGREEN PLACE SENIOR LIVING - ORLAND PARI	10820 183RD STREET ORLAND PARK, IL 60467

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A 000	Initial Comment Annual Licensure Survey 295.4010 Service Plans a) c) d) e) g) 1) 2) 3) 295.4060 Alzheimer's and Dementia Programs a) i) 1) A) i) ii)	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: General Violation Section 295.4010 Service Plan a) c) d) e) g) 1) 2) 3) 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. c) The service plan shall be signed and dated by all individuals involved in its development. 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)	A4010		

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A4010	Continued From page 1 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: 2) The amount, type, and frequency of health-related services needed by the resident; 3) Staff responsible for the provisions of the service plan. These requirements were not met as evidenced by: Based on record review and interviews, the establishment failed to revise the service plan with interventions to address: 1) unwitnessed falls incidents for 5 out of 5 residents (R1, R2, R3, R4, R5) in the sample reviewed for fall incidents; 2) application and removal of compression stockings for 1 of 1 residents (R2), application and removal of splint and boot for 1 of 1 residents (R2), care and monitoring of a air cast and boot for one of one resident (R4) and a splint and sling for one resident (R5) reviewed for medical assistive devices These failures have the probability to affect all residents with the same or similar health concerns who reside in Assisted Living or	A4010		

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A4010	Continued From page 2 Dementia Care unit. Findings include: 1. R1 is a 78 year old resident who moved into the establishment 6/25/25. Medical diagnoses were not listed on R1's facesheet. The physician's order sheet shows an order dated 7/22/25 for HHRN (home health registered nurse) to evaluated and treat left elbow skin tear from recent fall. Review of the progress notes for July 2025 show the following: -7/16/2025, 10:34am: Caregiver reported to the nurse on duty that R1 said he had a fall. Noted left forearm was bleeding. It was noted that an old skin tear reopened. The left forearm area cleaned and covered with dry dressing. R1 said while turning to sit in recliner lost his balance and tried to brace his fall resulting in rubbing his arm on the arm of the chair and landed on his bottom. R1 denies hitting his head and was able to get off the floor on his own. -7/18/2025: Received T.O. (telephone order) per Z1 for home health to treat wound to left forearm The service plan dated 6/25/25 was not revised to include interventions to address the treatment for R1's left elbow skin tear. There are no interventions to address the unwitnessed fall incident on 7/16/25. There is no frequency of the home health visits or the correlation of care between the home health nurse and establishment nurses.	A4010		

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A4010	Continued From page 3 2. R2 is a 88 year old resident who moved into the establishment 3/6/25. R2 has diagnoses including moderate late onset Alzheimer's disease, Myelodysplastic syndrome and Anemia. The progress note dated 8/19/25 shows R2 told the caregiver that she fell in the shower but was able to get back up. Several dates in August 2025 show R2 was taken by family to the hospital for blood transfusions. The service plan dated 3/8/25 was not revised with interventions to address the anemia and blood transfusions. The service plan does not address the fall incident that occured in the shower as well as evacuation assistance and activities. 3. R3 is a 90 year old resident who moved into the establishment 5/25/25. R3 has diagnoses including Degenerative dementia, (alzheimer's type) senile onset, Antalagic gait, Osteoarthritis of right knee, Peripheral venous insufficiency, Essential hypertension and Lumbar radiculopathy. The physician's order sheet shows orders dated 5/28/25 and 7/15/25 for compression stocking on every morning and remove at bedtime. The progress notes from July 2025 through September 2025 were reviewed and show the following: -7/31/25: it was brought to the nurse's attention that R3 is on the floor in her apartment. upon The nurse noticed a gash with bright red blood coming out on the right top	A4010		

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A4010	Continued From page 4	A4010		

side of R3's head. R3 complained of right leg and hip pain. 911 called to transport R3 to the hospital for treatment.

The incident and accident report shows caregiver heard noise from R3's room. R3 was observed on the floor with walker. R3 said she used walker to hold on to while getting up from the chair, leaned forward, R3 and walker fell to the floor. R3 was sent to the hospital and was diagnosed with a right hip fracture.

-8/29/25: readmission from rehabilitation center, diagnosis of right femur fracture

-9/4/25: nurse was called by caregiver to R3's apartment. R3t was noted lying on her right side on the floor and on the side of her bed, towards the closet. Incontinent brief noted to be soiled with stool. R3 was observed to be picking at the area. Mechanical lift pad was placed under R3. R3 needs 2 person assist & use of the mechanical lift to assist lifting R3 off the floor and transferred into her bed. Hospice on call notified.

The service plan dated 6/25/25 was not revised with interventions to address the right hip fracture and the application and removal of compression stockings as ordered. Transfer assistance using a mechanical lift is not addressed.

4. R4 is a 80 year old resident who moved into the establishment on 12/27/24. R4 has diagnoses including Dementia, Type 2 diabetes melitus and primary Hypertension.

Review of the progress notes from January 2025 through September 2025 show the following:

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A4010	Continued From page 5 -1/20/25: Caregiver reported to nurse at 6;40pm that R4 came and told her that she fell in her room by the bed. Upon assessment, writer observed R4 sitting up on sofa in room, watching tv with socks and shoes on. Nurse asked R4 what happened, R4 stated, "I fell by the door, and got up." -4/24/25: Upon rounds R4 noted on the floor on the side of her bed. R4 alert and responsive, small cut noted to left side of forehead near her eye, scant amount of blood noted. 911 called, R4 transferred to hospital R4 returned from hospital with no new orders. 4/24/25, 1:22pm: R4 complained of pain to left ankle. Swelling noted. Ice pack applied and Tylenol given as needed for pain R4 on fall follow up. Nurse received R4 in wheelchair at start of shift, R4 complained of pain to left ankle, area swollen, ice pack applied and as needed Tylenol given. Family with R4 and said he brought R4 back from ER (emergency room) yesterday but he's not sure if they did an Xray to ankle. Nurse called and requested discharge papers. Papers received and did not include x-ray to left ankle -4/26/25: R4 sent out to hospital per NP for left ankle fracture. R4 returned after 7pm with aircast and weight bearing as tolerated. R4 states that cast is uncomfortable and foot/ankle feels sore. Educated R4 that cast needs to stay on and help from caregivers/CNAs will assist with ADLS (activities of daily living) -4/27/25: Aircast is WBAT (weight bearing as tolerated) and R4 is able to remove cast at night while she sleeps and reapply when R4 is awake	A4010		

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A4010	Continued From page 6 in the morning -5/9/2025: R4 returned from appointment with family member from the Illinois Bone and Joint institute at 11:30 am. R4 observed with boot to left foot/ankle. R4 has new orders stating that boot must be worn at all times, including sleep, may use walker and/or wheelchair to ambulate, allow time to ice and elevate foot/ankle for 15 min every 2 hours, and limit the amount of walking/standing for long periods of time -5/25/2025: Writer alerted by staff that resident was sitting on the floor in her apt. Writer and caregiver assisted resident off the floor using electric lift. R4 unable to remember why she was sitting on the floor. R4 was observed with no shoes or socks on feet. -8/18/2025: R4 walking with her walker to common area, trying to sit back in the chair, wasn't close enough to the chair and slid down to the floor on her buttocks -9/4/2025: nurse was summoned to the back dining area due to R4 being on the floor. R4 unable to elaborate how she fell but was observed on her buttocks at the time The service plan dated 12/27/24 was not revised with interventions to address falls as well as the unwitnessed fall that resulted in the left ankle fracture, the ordered treatment for the ankle fracture (aircast, ice and weight bearing as tolerated), application of boot as ordered. 5. R5 is 79 year old resident who moved into the establishment 6/19/25. R5 has diagnoses including Dementia, Parkinson's without dyskenesia and primary Hypertension. R5 resides	A4010		

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A4010	Continued From page 7 in the Legacy (memory care) unit. The progress notes from July 2025 through September 2025 were reviewed and shows the following: -7/23/25, 21:04: Caregiver stated that R5 was observed on the floor by sofa, on heritage side, with pillow underneath her sleep. Caregiver stated that R5 got up and walked off. Nurse received R5 up, walking the unit, attempting to knock on doors. Nurse redirected R5 to room. -8/17/25, 12:30pm: Nurse was notified by CNA regarding R5 behaviors. R5 de-robed as well as was observed playing in the bathroom toilet. R5 was cleaned up by CNA and then became aggressive, hitting CNA grabbing utensils from the kitchen (butter knife) and refusing to release it. Caregiver was able to retrieve knife and at this point R5 begin taunting other residents and making attempts to hit them as well. R5 was redirected several times without success. DON and ED made aware. -8/24/25: R5 came out of room, wandering with just incontinent brief on and toothpaste in hand. -8/26/25: R5observed wandering and exit seeking. R5 redirected by nurse and caregiver. PRN Xanax given without difficulty. -9/6/25: Writer was called to heritage courtyard at 6pm by another resident's personal caregiver, that resident was outside lying in the bushes. Writer observed resident lying on the rocks in a fetal position, alert and verbally responsive, picking leaves off the bushes and counting them. R5 unable to verbalize what happened. R5 proceeded to get off the rocks on her own and	A4010		

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A4010	Continued From page 8	A4010		

writer guided her for safety. R5 unable to state if she fell or layed down in that position. Head to toe assessment revealed an abrasion to top of right hand and an abrasion to the left side of forehead with scant amount of bleeding noted. Nurse called 911 and R5 was transferred to the hospital for evaluation since noted to be taking Aspirin daily.

Incident & Accident report dated 9/6/25 shows R5 has a hospital diagnosis of left arm radial fracture. R5 placed in a soft splint with sling.

-9/7/25: Resident returned from hospital via ambulance. Left arm is in soft splint and sling, R5 continues to remove sling and will not keep on. Per hospital nurse, R5 was discharged with left forearm fracture.

-9/7/25: nurse observed R5 removing cushions off of sofa and took phone off of another resident's walker and attempted to run off with it. R5 was redirected with difficulty. Nurse and caregiver was able to give cell phone back to the other resident. R5 then began to move furniture around and became combative with staff. R5was redirected with difficulty by nurse and caregiver walking with her. Nurse administered scheduled medication along with PRN Xanax. Staff currently taking turns to sit with R5.

-9/9/25: the care manager called the nurse at 03:30 and reported finding R5 on the floor. The nurse observed R5 on her right side on the floor. R5 is confused and could not state what happened or what she was doing prior to the fall. R5 stated that she has pain "when the cars come." R5 also stated that she hit her head. R5 head was by a dresser. No open areas found on resident. 911 called at 03:50am

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A4010	Continued From page 9 -9/9/25, 2:47pm: R5 seen by NP (nurse practitioner) and has a new order for PT/OT (physical therapy/occupational therapy) to evaluation and treat for unsteady gait/BLE (bilateral lower extremities) weakness/OA (osteoarthritis) /OP. NP also wants previous x-ray order to bilateral hip reordered since resident was in the ER. Nurse called and ordered hip x-ray -9/9/25, 23:17: Care Manager called the nurse as R5 is not sleeping and is wandering into other people's rooms. R5 observed not wearing her sling and picking at the wrap around her soft cast. Sling replaced and R5 continued to take off. R5 going in circles around her room while picking things up, mumbling to herself and then moving the items. Resident administered as needed Xanax. R5 continued to wander around her room for about 7minutes and then agreed to get in bed. The service plan dated 4/15/25 wasn't revised with interventions to address physical aggression towards residents and staff, wandering and exit seeking behaviors. The service plan wasn't revised after each fall and does not address the fracture to the left radius, soft splint and sling.	A4010		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Type 3 Violation 295.4060 Alzheimer's and Dementia Programs a) i) 1) A) i) ii)	A4060		

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A4060	Continued From page 10 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) i) Training requirements for individuals working in a special program: 1) Manager qualifications and training: A) The manager of an establishment providing Alzheimer care or the supervisor of an Alzheimer program must be 21 years of age and have: i) a college degree with documented course work in dementia care, plus one year of experience working with persons with dementia; or ii) at least two years of management experience with persons with dementia. These requirement were not met as evidenced by: Based on record review and interview, the establishment failed to present documented course work and years of experience for one of one employee (E9) reviewed for manger qualifications for the memory care unit. Findings include: On 9/11/25 at 10:30am the personnel file for E9 (memory care unit director) was reviewed with E10 (administrative service director). E9's personnel file did not include documented course work in dementia care or E9's year's of experience working with residents who have	A4060		

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A4060	Continued From page 11 dementia. On 9/11/25 at 11:30am E9 was asked if he had documentation to show his credentials. E9 said the last place he was employed was asked to release his personnel file as of 9/10/25 but hasn't heard from the previous place of employment. E9 also said unfortunately he doesn't have any documentation to show his previous experience working in dementia care. At 3:00pm, E11 (executive director) presented a copy of E9's employment application for the establishment dated 6/27/25. UnderLicenses and Education, the application shows E9 is certified as a nurse aide. The application does not show a college degree with documented course work in dementia care nor at least two years of management experience with persons with dementia.	A4060		