STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510535	A. BUILDING: _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDING ON DUNDEE SENIOR LIVING (THE)	156 WEST DUNDEE ROAD WHEELING, IL 60090

(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 IL00185078 of January 21, 2025 - Section 295.6000 Resident Rights -cited IL00185292 of January 20,2025- No violation cited. IL00183075 of December 19, 2024- No violation cited. 24910131/IL00182406 - No violation cited. 2499677/IL00181602- No violation cited. 2499327/L00180913- No violation cited. 2499240/IL00180772- No violation cited.	A 000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 1 Violation Section 295.6000 Resident Rights 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: 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor. Based on interview and record review, the facility failed to: 1. Provide immediate care and services to residents identified as non-responsive, "not waking up and snoring loud.". 2 .Follow the establishment policy and procedures during medical emergencies . 3 .Immediately utilize outside emergency	A6000		

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A6000	Continued From page 1	A6000		

assistance (911) and,
4. Assign staff to continuously monitor changes and to ensure resident's safety.

These failures resulted in R2's admission to the hospital on January 21, 2022. R2 was diagnosed with brain bleed that led to R2's demise on January 22, 2025.

The findings include:
R2 moved in establishment on June 29, 2022, with diagnosis to include hypertension, diabetes mellitus type 2, Aortic stenosis, and dementia. Described by the staff as alert times 2 with periods of confusion and requires one person assistance from the staff and redirection with activities of daily living; ambulates with a walker.

The reportable incident submitted to the Department dated January 21, 2025, at 11:40 AM read as follows:
R2 was very sleepy and was not waking up. Family was in the room trying to wake R2 up ... resident lying on her recliner noted snoring and sleeping. Attempted to wake resident up but resident did not wake up. At around 11:50 AM, call 911 ... R1 was admitted to the hospital with diagnosis of brain bleed.

On February 3, 2025, 3:21 PM, E3 (LPN) explained, "The Caregiver (E4) told me that the patient (R2) was not waking up. When I went to the room, R2 was in the recliner and the family was in front of R2 trying to wake her up. I called the R2's name and shook her but R2's not responding and was snoring loud, and I cannot wake her up! I check the vital signs. Yes, R2's unconscious, not responding to anything! I told the family; I'll go and find the doctor. I saw the doctor doing rounds earlier, so I went out from the

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A6000	Continued From page 2	A6000		

Unit and tried to find the doctor, but the doctor already left the building. As I was returning to the unit, the family was outside (the Unit) looking for me and said, "you really need to call 911!' I called the Nurse Practitioner and got an order to call 911. Then I notified my Director of Nursing, then, I called 911."

E3 further claimed, "I used to work in a nursing home, they do not want you to send the patient to the hospital immediately; before you could send a patient out, you must do and follow the steps; call the doctor, notify your supervisor then call 911."

The establishment emergency medical services policy and procedure identify the following guidelines for the staff to follow during minor/major emergency (life threatening, etc...)
- For vital signs outside normal range perform appropriate first aid while waiting for the arrival of 911.
- call 911 and summon additional help if necessary.
- Notify residents Attending Physician and family.

These procedures were not followed during this incident.

On February 5, 2025, at 4:05 PM, a confidential interview(Z2) disclosed, three family members of R2 arrived in the room at around 10:30 AM and found R2 in the recliner (slouch back) "unconscious and unresponsive and was breathing heavy". R2's family tried to wake R2 in different ways (shaking, calling R2's name, moving the residents into different position ...). A Care Giver (E4) came in the room and was told of R2's condition. E2 went out from R2's room and said she will notify the Nurse (E3). E3 came and tried to wake R2 as well. Z2 claimed R2's family

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A6000	Continued From page 3 requested E3 to call 911 right away, instead E3 took R2's vitals; R2 remains unresponsive and started to snore loud. E3 responded and said, 'I'll go get the doctor!" Z2 said, R2's family were trying to wake R2 for about 15 minutes, then E3 left the Unit (Memory Care Unit). Z2 said the family waited for another 8-10 minutes for E3 to locate the doctor and decided to go out from the Unit as well to look for the Nurse and insisted to call 911. E3 finally said yes but needed to let the Supervisor know (E2/Director of Nursing). Z2 recalls and said R2's family asked E3 to call 911 at least three times and waited at least 30 minutes from the time the family arrived and found R2 in such condition until 911 arrived. Z2 claimed this is a case of "neglect!" If they had called the 911 earlier, R2 could still be alive!" On February 6, 2025, at 11:13 AM, E2 (RN/Director of Nursing) confirmed and stated, "911 should had been called immediately because the patient was nonresponsive, not waking up and someone should have stayed with the residents."	A6000		