STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510341	A. BUILDING: _____ B. WING _____	C 09/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT OF UPTOWN	10 N SUMMIT PARK RIDGE, IL 60068

(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 Facility Reported Incident: Facility Reported Incident of August 2, 2025/IL197171 295.2050 a) b) c) Type 1 Violation 295.4010 a) c) d) e) g) 1) C) 3) h) Type 2 Violation	A 000		
A2050	Section 295.2050 Incident and Accident Reporting This Regulation is not met as evidenced by: Type 2 Violation Section 295.2050 Incident and Accident Reporting a) An establishment shall report to the Department any serious incident or accident. For the purposes of this Section, "serious" means any incident or accident that causes physical or emotional harm or injury to a resident. A change in an individual's (resident's) condition that is due to health or medical decline is not a reportable incident or accident. b) The report shall be made by contacting the Department of Public Health Division of Assisted Living via email at DPH.LTCAL@illinois.gov or as requested by the Department within 24 hours after the occurrence of the incident or accident. c) A copy of the report shall be maintained by the establishment for one year after the date of the incident or accident. (Source: Amended at 47 Ill. Reg. 13264,	A2050		

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A2050	Continued From page 1 effective August 30, 2023) This requirement was NOT MET as evidenced by: Based on interview and record review the facility failed to report within regulatory requirements to Illinois Department of Public Health ,a residents change in condition for one (R1) of three residents reviewed for accident/supervision. This failure resulted in R1 being sent to local emergency room due to R1 experiencing severe pain to right hip and diagnosed with right femur closed intertrochanteric fracture due to a fall. This failure creates a substantial probability of harm to a resident or residents. Findings include: R1, 84-year-old with diagnosis not limited to: Hypertension, Stogner's Syndrome, Osteoporosis, Anxiety, Dementia, Anemia According to R1's face sheet printed 9/19/2025, R1's move in date 6/30/2023 and currently resides at facility. The establishment's initial report documents (in part) R1, Incident/Accident Date 8/2/2025, Accident/Incident Time 7:20pm Description of Incident/Accident: Per nursing/CNA reporting: Resident observed right by her bed on the floor. Resident was placed on her bed for the night. Upon staff rounding they noticed her on the floor. Resident complained of severe pain to right leg. Resident sent out because of pain to right leg. Diagnosis: closed intertrochanteric fracture. Facility presented reportable fax document which shows Incident/Accident was reported to IDPH on	A2050		

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A2050	Continued From page 2 8/4/2025 at 4:31pm. On 9/19/2025 at 1:57pm observed R1 lying in hospital bed watching TV. Bed in lower position, no floor mats on sides of bed. R1 stated, she does not remember when she fell out of bed. R1 pointing to right hip and said painful. R1 appeared to be sleepy but able to say staff help her and she does not think she has fallen again. 1/2 rails on bed and high back chair in room. There were no floor mats next to bed. On 9/20/2025 at 12:56pm E8 (LPN) stated, I am familiar with R1. I worked that day (8/2/2025) in the evening. On that evening, I passed meds for memory care first, then AL and I was paged to go to R1's room. When I came, I saw the staff with R1. She was laying on the floor. I asked what happened and they said around 7:00pm or so putting residents to bed and change them and put in the room. CNA went to another room and one of the residents passed by the room and told staff he saw R1 on the floor. The E9 ran down and saw R1 fell on the floor. I was called and came and assessed her. I asked staff if she hit her head. When we asked R1 she said no did not hit her head, she was still alert. When she moved her legs her face grimace and she complained of pain. I let her stay immobile on the floor. I checked to see if on blood thinner. I sent her to the hospital. R1 did not talk to me. She was tired and in pain. E10 said she changed her and put her in bed. R1 got up and probably loss her balance and ended up on the floor. R1 used a wheelchair. She did not walk with walker. We keep the doors open when residents are in room so we can monitor especially in memory care. New interventions mats and bed low. Any fall is reported to E11(Memory Care Program Director/RN), I did not send a reportable to state.	A2050		

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A2050	Continued From page 3 On 9/20/2025 at 4:48pm E2 stated (in part), yes, I am familiar with the fall R1 had on 8/2/2025. E11 was the one that did the investigation for the incident, but I am familiar with the incident. E10 (Resident Assistant) put her in the bed, and she went to another resident and in the meantime heard another resident say a woman was on the floor. They ran into the room and found R1 on the floor. E9 (Resident Assistant) found her. E8 and E10 were called and came, and the nurse assessed R1. She complained of pain and then R1 was sent to the hospital. R1 had a hip fracture, they did not want to do the surgery, the family did not want to do the surgery and they put her in hospice. Surveyor asked E2 what is the regulation for reporting an incident/accident. E2 stated, we are to report to the state within the first 24 hours of the incident. She sent it within 48 hours, probably because it was on a Saturday, she (E11) sent it on Monday 8/4/2025). We have a form it is to be sent within 24 hours of the incident happening. R1's progress note dated 08/02/2025 09:28 PM Fall documents Critical by E8 (Licensed Practical Nurse (LPN)) Resident was changed and put in bed after having BM around 7:05PM. At 7:20 PM, one people passed by her room and came to inform to the staff that he saw there was one people was on the floor. Staff came right away and this writer promptly get into resident's room.. Resident was observed lying on right side, at the end of her bed, socks on. No obstacles around. Total body assessment made. Resident alert, verbally responsive. Resident answered that she hit her head when being asked. Complaints of pain on her right leg, right hip and head. Denied nausea, headache. Facial grimace noted when moving extremities.. Skin intact, no redness, no	A2050		

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A2050	Continued From page 4 opened skin noted. Resident on DNR. Family Z1 and MCD notified. VS obtained. 911 was called. Paramedic came, took the resident to ER at Lutheran General Hospital, left at 7:40pm. MD Z2 notified via fax. Endorse next shift to follow up. Location: Resident's Room Day & Time: 08/02/2025 7:20 PM Facility Policy: Reportable Events - Illinois (June 2025) documents (in part): Policy Company and regulatory guidelines for reporting and investigating incidents as defined in this procedure will be followed and completed in a timely manner. Procedure Timeframe and Notification Protocol 3. The Executive Director, Resident Care, or Memory Care Director will notify the VP/Regional Director of Resident Care within 24 hours of the following situations: Any time a Resident suffers a major injury defined as fractures, lacerations, subdural hematomas, or burns State Reporting Requirements - Illinois The Executive Director or Designee shall report to the Illinois Department of Public Health, Division of Assisted Living any incident or accident that has a significant negative effect on a Resident's health, safety or welfare. 1. A significant negative effect shall be assumed whenever an unplanned or unscheduled visit to a hospital is necessary as a result of that incident or accident, treatment is provided, and follow-up care is required 3. The report shall be made by contacting the Department of Public Health Central Complaint Registry or by fax or by other electronic means within24 hours after the occurrence of the incident or accident. 4. A copy of the report shall be maintained by the Community for one year after the date of the incident or accident.	A2050		

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A4010	Continued From page 5	A4010		
A4010	Section 295.4010 Service Plan	A4010		

This Regulation is not met as evidenced by:
Type 1 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.

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)

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:

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A4010	Continued From page 6 1) The level of service the resident is receiving, including: C) special accommodations for the resident; 2) The amount, type, and frequency of health-related services needed 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 observation, interview and record review, the facility failed to update and implement new interventions, to reduce the risk of falls, in a resident's service plan when a changes in condition and fall risks were identified for one resident (R1) out three residents reviewed for falls in the sample of three. This failure resulted in R1 sustaining a right femur closed intertrochanteric fracture due to a fall. This failure creates a substantial probability of severe harm to a resident or residents. Findings include: R1, 84-year-old with diagnosis not limited to: Hypertension, Stogner's Syndrome, Osteoporosis, Anxiety, Dementia, Anemia According to R1's face sheet printed 9/19/2025,	A4010		

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A4010	Continued From page 7 R1's move in date 6/30/2023 and currently resides at facility. The establishment's Final Report to the department dated 8/22/2025, documented (in part): On 8/2/2025 at 7:20pm, R1 was placed on her be after 7pm for the night. Around 7:20pm upon staff performing rounding they observed 1 on the floor. It appears R1 got up on her own right after she was put to bed. Upon nursing assessment, R1 complained of severe pain in her right hip and leg. R1 was transferred immediately to local hospital. R1 diagnosed with a right femur closed intertrochanteric fracture. R1 had surgery to place a pin. R1 developed pneumonia with fluid in her lungs after surgery. She spent days in the hospital after surgery due to pneumonia and could not rehab after surgery. R1's family decided at the hospital to route to hospice care at this time. Goal: Provide comfort care with the support of hospice are and prevent future falls. Interventions: 1) Service plan updated to reflect recent fall and updated to meet resident current physical and cognitive needs. 2. 4) Hospital bed lowest to the floor with safety mats on the floor R1's Individual Service Plan dated 8/11/2025 documents (in part): Need: Fall Risk Goal: Resident will safely transfer and ambulate with assistance from care staff to minimize incidence of falls. Intervention: Care staff will utilize agreed upon interventions to assist with fall prevention for resident. Person/Location Resident Assistant Frequency: Daily Schedule: Shift I, Shift II, Shift III Has one or more of the following medical conditions that affects balance and mobility: cardiac, dementia. Interventions as stated in final submitted reportable updated interventions omitted from 8/11/2025 updated service plan and not signed by	A4010		

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A4010	Continued From page 8 responsible party. R1's progress note dated 08/02/2025 09:28 PM Fall documents Critical by E8 (Licensed Practical Nurse (LPN)) Resident was changed and put in bed after having BM around 7:05PM. At 7:20 PM, one people passed by her room and came to inform to the staff that he saw there was one people was on the floor. Staff came right away and this writer promptly get into resident's room.. Resident was observed lying on right side, at the end of her bed, socks on. No obstacles around. Total body assessment made. Resident alert, verbally responsive. Resident answered that she hit her head when being asked. Complaints of pain on her right leg, right hip and head. Denied nausea, headache. Facial grimace noted when moving extremities.. Skin intact, no redness, no opened skin noted. Resident on DNR. Family Leo Foley and MCD notified. VS obtained. 911 was called. Paramedic came, took the resident to ER at Lutheran General Hospital, left at 7:40pm. MD Mark Conley notified via fax. Endorse next shift to follow up. Location: Resident's Room Day & Time: 08/02/2025 7:20 PM On 9/19/2025 at 1:57pm observed R1 lying in hospital bed watching TV. Bed in lower position, no floor mats on sides of bed. R1 stated, she does not remember when she fell out of bed. R1 pointing to right hip and said painful. R1 appeared to be sleepy but able to say staff help her and she does not think she has fallen again. 1/2 rails on bed and high back chair in room. There were no floor mats next to bed. On 9/19/2025 at 2:09pm E5 (Resident Assistant) stated, I have not worked her that long. R1 was already in memory care when I started. She can	A4010		

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A4010	Continued From page 9	A4010		

make some needs known by facial expressions. We check her every hour and turn every 2 hours. She has upper movement but no lower body movement. We know what interventions are in place from the computer system we can see and the nurse can tell us or E11 (Memory Care Program Director). R1 does not have mats down. R1 fell but I was not here when she fell.

On 9/19/2025 at 2:13pm E6 (Resident Assistant) stated, I know who R1 is and I was here when she fell and I saw her on the floor. E10 (Resident Assistant) put R1 in the bed about 10 minutes before R3 said he saw a woman on the floor. I headed to R1's room and saw her on the floor lying sideway. R1 was able to talk but could not say what happened. She was by the end of the bed. R1 was able to walk prior to the fall with assistance small steps with transfer to wheelchair. R1 did not know what happened. Residents have service plan and nurses let us know what service plan says. We call the nurse for any fall and the nurse comes to assess and will send to hospital if required. R1 was sent to the hospital.

On 9/19/2025 at 4:15pm observed R1 lying in bed. Her bed was in low position, 1/2 side rails present, no floor mats present next to bed. R1 groomed and dressed. R1 awake but confused and could not remember when she fell, but stated, she does not want to fall again. R1 stated, she does not think she has fallen again.

On 9/20/2025 at 11:17am E10 (Resident Assistant), I remember were doing rounds and putting residents in the bed, one caregiver went first. I took R1 to bed and changed her and put her pajamas on and put her in bed, turned TV on and went to do rounds with others. When I put

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A4010	Continued From page 10	A4010		

her in the bed, she was fine. She has never had a fall and has not attempted to move or fall. I do not work with her all the time. She is not a busy type of person, normally calm and relaxed. I went to the front so someone could do their rounds, then I went to do another person. I was in another room about 10 or 15 minutes. As I was coming out the room a co-worker (E9, Resident Assistant) called and asked me to come to R1's room. I went to room and R1 was on the floor and another caregiver was in there with her. I am not sure how long she was on the floor. She asked her what happened, we did not move her, and the nurse came in and took over from there. The other caregiver was asking her small questions, and she would nod her head but could not speak. E8 (LPN) sent her to the hospital. Some residents have interventions, R1 had her own bed and she never tried to get out. I check on residents about every 30 minutes after I get them in the bed. I had just put her in the bed about 30 minutes before. I started putting residents in bed about 7:00pm.

On 9/20/2025 at 11:25am E9 (Resident Assistant), I am familiar with R1. I do remember when she fell. I was there but she was not my resident that day. I was in the living room while E10 went to put R1 to bed. Another resident told me a resident was on the ground. I used my walkie and called the nurse. I ran to room, and I saw R1 on the ground and asked her what happened. R1 was very confused and told me she fell. She never gets up by herself. She said she was walking down the street. At first, she said she did not hit her head then said she hit her head. R1 to my knowledge as long as she was in memory care, she did not get up. She worked with physical therapy but did not do anything on her own. In Assisted Living her mobility was very

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A4010	Continued From page 11	A4010		

slow, and she was getting confused, and she used a walker. R1 wears non-skid socks but did not use a walker. She had been using a wheelchair in memory care.

On 9/20/2025 at 12:56pm E8 stated, I am familiar with R1. I worked that day (8/2/2025) in the evening. On that evening, I passed meds for memory care first, then assisted living and I was paged to go to R1's room. When I came, I saw the staff with R1. She was laying on the floor. I asked what happened and they said around 7:00pm or so caregivers were putting residents to bed and changing them and putting in their room. E10 put R1 to bed and went to another room. One of the residents passed by her room and told staff he saw R1 on the floor. E9 ran down and saw R1 had fell on the floor. I was called and came and assessed her. I asked staff if she hit her head. When we asked R1 she said no did not hit her head, she was still alert. When she moved her legs her face grimace and she complained of pain. I let her stay immobile on the floor. I checked to see if on blood thinner. I sent her to the hospital. R1 did not talk to me. She was tired and in pain. E10 said she changed her and put her in bed. R1 got up and probably loss her balance and ended up on the floor. R1 used a wheelchair. She did not walk with walker. We keep the doors open when residents are in room so we can monitor especially in memory care. E11 would put new interventions in place. I am not sure if new intervention is floor mats, we keep bed low.

On 9/20/2025 at 4:48pm E2 stated, yes, I am familiar with the fall R1 had on 8/2/2025. E11 was the one that did the investigation for the incident, but I am familiar with the incident. E10 put her in the bed, and she went to another

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A4010	Continued From page 12	A4010		

resident and in the meantime heard another resident say a woman was on the floor. They ran into the room and found R1 on the floor. E9 found her. E8 and E10 were called and came, and the nurse assessed R1. She complained of pain and then R1 was sent to the hospital. R1 had a hip fracture, they did not want to do the surgery, the family did not want to do the surgery and put her in hospice. R1 returned to facility and in hospice and received a hospice bed and we are taking care of her as a hospice resident. R1 was able to walk only with assistance before the fall and she would not get up by herself. It was a shock as to how she got up because she only got up with assistance. She had not had too many falls; she has a shared responsibility agreement, but she was not a high-risk fall. We have the hospital bed and keep the bed in lower position, we turn her in the bed to avoid skin issues and increase monitoring. Surveyor asked where the intervention would be on the updated service plan (8/11/2025). E2 stated if you do not see it E11 probably did not put it in there. R1 does have the mats and she is supervised every 30 minutes. Surveyor asked if the floor mats are to be on each side of her bed. E2 stated, yes. The care team has a report in the book, and it pops up in electronic medical record under care tracking. When R1 is in the bed she should have mats on each side of bed. The mats are used to be easier, so she does not have another break or hit her head.

Facility Policy
Resident Evaluation - Individual Service Plan - Care Plan - Illinois, dated April 2025 documents (in part) Policy All Residents will be assessed for physical, functional, and cognitive needs prior to move-in, 30-45 days after move-in, semi-annually, and/or upon change of condition.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510341	A. BUILDING: _____ B. WING _____	C 09/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT OF UPTOWN	10 N SUMMIT PARK RIDGE, IL 60068

(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 13 Residents residing on designated memory care units will be assessed every 6 months. Procedure There are three parts to documentation related to the Resident's care: the Evaluation, the Individual Service Plan, and the Care Plan. Individual Service Plan Information entered in the A*** evaluation will populate the Resident's Individual Service Plan after the Evaluation is complete. Completing the Service Plan results in a standardized review of residents' needs, and a clear plan to provide for their needs in A*** Care Tracking. The Resident Individual Service Plan must be reviewed with and signed by family/POS/Resident. Re-Assessments Each Resident will be reassessed 30-45 days after move-in, semi-annually, and/or upon change of condition. Guidelines for Changes in Condition/Reassessment Criteria Triggers Most significant changes may be in ADLs requiring more time, assistance, attention from staff Resident has repeated falls (note: major injury). Recent hospitalization or rehab stay that has caused a decline or change in condition Reassessment Procedure Verify Resident Personal Service Plan with support staff Fall Management Guide - Illinois (November 2014) documents (in part) As Residents age in place, their risk of falling and sustainin injuries from those falls increases. While no assisted living community can prevent fall, our goal is to understand each Resident's risk of falling through careful assessment and to minimize those risks wherever possible with the use of appropriate interventions.Specifically, we strive to: Provide a physical environment that minimizes the risk of falls. Use careful assessment to education staff. III Risk Management Program Procedure 1. Update Resident Plan of Care.Service Plan accordingly and include any interventions. 3.	A4010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A4010	Continued From page 14 Specific Resident interventions will be identified to assist the Resident in potentially reducidng the risk of falls. The interventions must be specific to the Resident. 3. Interventions are to be listed. Assisted Living Resident Rights in Illinois Requirements documents (in part): In Illinois, residents of assisted living facilities have specific rights and requirements that must be adhered to by the facilities. Facilities must also provide services specified in the service plan	A4010		