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A 000	Initial Comment Annual Licensure Survey Conducted: 295.2000 a) 3) 4) 5) 295.4010 c) d) e) g) 2) 3) 295.4060 i) 2) A) B) Facility Reported Incident: IL196705/FRI 7/17/25: 295.6000 a) 1) 13) cited	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) 3) The person requires total assistance with 2 or more activities of daily living;	A2000		

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A2000	Continued From page 1 4) The person requires the assistance of more than one paid caregiver at any given time with an activity of daily living; 5) The person requires more than minimal assistance in moving to a safe area in an emergency. For the purpose of this Section, minimal assistance means that the resident is able to respond, with or without assistance, in an emergency to protect themselves, given the staffing and construction of the building. These requirements were not met as evidenced by: Based on record review and interview, the establishment failed to ensure prior to admission that 1 resident met all residency requirements. This involves 1 of 5 residents (R5) reviewed. Findings include: R5 is a 79 year old who moved into the memory care unit of the establishment on 8/4/24. R5 has a diagnosis of unspecified Dementia. Per the progress move in note dated 8/4/25, R5 is receiving hospice care. The establishment's service plan dated 8/4/25 show R5 is totally dependent on staff for bathing/showers, dressing, grooming needs due to memory impairment. R5 is to use a Hoyer Lift at all times with two staff members at all times when using the Hoyer Lift. On 8/19/25 at 3:45pm during the exit conference, E9 (director of nursing) was asked in R5 was receiving hospice care prior to moving into the	A2000		

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A2000	Continued From page 2 establishment. E9 (director of nursing) said yes.	A2000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 2 Violation Section 295.4010 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: 2) The amount, type, and frequency of health-related services needed by the resident; 3) Staff responsible for the provisions of the service plan.	A4010		

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A4010	Continued From page 3 These requirements were not met as evidenced by: Based on record review and interview, the establishment failed to: -revise with interventions to address unwitnessed fall incidents for one of 5 residents (R2) reviewed for falls. R2 had a total of 12 unwitnessed falls in a 7 month period; -address the amount, type, and frequency of physical therapy services received by one (R2) out of 5 residents reviewed for physical therapy services; -address the correlation of care between the agency and establishment staff. Findings include: R2 is a 92 year old who moved into the establishment 1/31/25. R2 has diagnoses including Major depressive disorder, GERD (gastro esophageal reflux disease), cancer of the left breast, Hypertension, Hypothyroidism, Hyperlipidemia, other Arthritis and Urinary tract infection. Per R2, she had a history of falls prior to move-in. R2 was transferred from assisted living to the memory care unit. The Fall Risk Assessment dated 7/1/25 shows a risk score of 11.0. The progress notes from January 31, 2025 through August 2025 were reviewed and showed the following related to unwitnessed fall incidents: -2/14/25: found sitting on floor in hallway, hit head, refused to be sent out to hospital,	A4010		

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A4010	Continued From page 4 neurochecks docuemented over a 24 hour period 9:25am: R2 observed sitting on the floor in bedroom -2/19/25: started PT (physical therapy) -3/25/25: fell, tripped over walker, no injury, transferred to hospital for evaluation -3/29/25: slid off of left side of recliner -4/2/25: noted sitting on floor in front of recliner -4/3 observed laying on carpet in front of recliner. Pain upon standing, sent to ER for evaluation Documentation does not show when R2 returned. -4/6/25: saw on floor in front of chair, with legs bend underneath her bottom, complained of right leg pain, 911 called Documentation does not show when R2 returned. -4/9: laying on floor next to bed wrapped in a blanket with pillow under her head -5/4: found sitting on floor in living room -6/7: found sitting beside tv -6/8: found sitting on floor beside her walker, hit her head, sent to ER (emergency room), R2 was transferred from hospital to rehab. R2 returned to the community 6/27/25 -6/28: SOC (start of care) for home health RN & PT (physical therapy)	A4010		

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A4010	Continued From page 5 -7/1: laying on her left side between bathroom & recliner -8/9: noted crawling on the floor -8/10: admitted to hospital for Encephalopathy & UTI (urinary tract infection) returned to the community on 8/15 The service plan dated 1/30/25 only shows revision of interventions for the unwitnessed fall incidents on 3/25/25, 4/2/25, 4/3/25, 4/6/25 & 7/1/25. Physical therapy is mentioned on the service plan however the name of the agency, the frequency of the therapy and the correlation of care between the agency and establishment staff is not addressed. On 8/19/25 at 3:45pm during the exit conference, these concerns were shared with and E9 (director of nursing) and E11 (executive director). No explanation was given to address these concerns.	A4010		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Type 2 Violation Section 295.4060 Alzheimer's and Dementia Programs i) Training requirements for individuals working in a special program:	A4060		

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A4060	Continued From page 6 2) Staff training: A) All staff members must receive, in addition to the training required in Section 295.3020, four hours of dementia-specific orientation prior to assuming job responsibilities without direct supervision within the Alzheimer's/dementia program. Training must cover, at a minimum, the following topics: i) basic information about the causes, progression, and management of Alzheimer's disease and other related dementia disorders; ii) techniques for creating an environment that minimizes challenging behavior; iii) identifying and alleviating safety risks to residents with Alzheimer's disease; iv) techniques for successful communication with individuals with dementia; and v) residents' rights. B) Direct care staff must receive 16 hours of on-the-job supervision and training within the first 16 hours of employment following orientation. Training must cover: i) encouraging independence in and providing assistance with the activities of daily living; ii) emergency and evacuation procedures specific to the dementia population;	A4060		

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A4060	Continued From page 7 iii) techniques for creating an environment that minimizes challenging behaviors; iv) resident rights and choice for persons with dementia, working with families, caregiver stress; and v) techniques for successful communication This requirement was not met as evidenced by: Based on record review and interview, the establishment failed to ensure: -six newly hired direct care employees (E1, E2, E3, E4, E7, E8) and one newly hired non direct care (E5) completed the required 4 hours of dementia specific orientation prior to assuming job responsibilities without direct supervision; -five newly hired direct care employees (E1, E2, E3, E4, E8) completed the required 16 hours of on-the-job supervision and training within the first 16 hours of employment following orientation. This failure has the probability to affect future newly hired direct and non direct care employees. Findings include: On 8/18/25, surveyor reviewed the personnel files of 8 newly hired employees with E10 (assisted executive director). The personnel files showed the following:	A4060		

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A4060	Continued From page 8 -E1 (RN), DOH (date of hire) 8/28/24 -E2 (caregiver), DOH 1/13/25 -E3 (caregiver), DOH 2/17/25 -E4 (caregiver), DOH 4/16/25 -E5 (housekeeper), DOH 4/16/25 -E7 (server), DOH 10/17/24 E8 (caregiver) DOH 6/18/25 Five direct care employees and two non-direct care employees did not complete the required 4 hours of dementia specific orientation prior to assuming their job responsibilities without direct supervision. Five direct care employees, E1, E2, E3, E4 and E8 did not complete the required16 hours of on-the-job supervision and training within the first 16 hours of employment following orientation. After personnel file review, E10 could not give an explanation why this these new hires did not complete the required hours of dementia-specific training.	A4060		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: General Violation SECTION 295.6000 RESIDENT RIGHTS	A6000		

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A6000	Continued From page 9 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: 1) The right to live in an environment that promotes and supports each resident's dignity, individuality, independence, self-determination, privacy, and choice and to be treated with consideration and respect; 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor This requirement was not met as evidenced by: Based on record review and interview, the establishment failed to ensure that abuse was prevented for 1 resident. This involves 1 of 3 residents (R1) reviewed for resident rights. This failure resulted in R1 being physically abused while receiving incontinence care. This failure has the probability to affect all residents in the facility. Findings include: R1 is a 78 year old resident who moved into the establishment 10/16/22. R1 has diagnoses including Dementia, unspecified personality and behavior disorder. At the time of this investigation, R1 residents in the memory care unit.	A6000		

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The initial incident report dated 7/17/25 shows alleged abuse and that staff involved E1 (caregiver). E1 was suspended pending investigation. The summary shows the following:

on 7/17/25 at 11:00am, E1 was providing incontinence care to R1 in the bathroom in front of the toilet. R1's pants were around her ankles. E1 attempted to pull R1's pants up. R1 became combative and E1 continued to pull R1's pants up. R1 became combative hitting E1. E1 put her hands out to prevent R1 from hitting her and continued to pull R1's pants up. E1 had no intentions of physically harming R1. Other staff witnessed the interaction and reported the incident to the assistant director of nursing (E7). E7 and E2 (director of nursing) spoke with E1, obtained staff statements and placed E1 on administrative leave pending investigation.

The final incident report shows the investigation and that E1 was terminated.

Written statements presented by E2 (director of nursing) dated 7/17/25 from E3 (caregiver), E4 (RN), E5 (housekeeper) and E6 (caregiver) all document that E1 would be unnecessarily rough with R1 and other residents.

E3 wrote in her statement that E1 was very rude to residents and verbally aggressive with residents. E1 was not able to care for R1 because of the way E1 would approach R1. E3 wrote that she herself never had a issue with R1 doing anything for her.

E4 wrote that she was in the office charting when she heard yelling coming from the Willow B hall. E4 walked onto the unit and into R1's room. E1 was walking out as she entered the room. R1 was

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A6000	Continued From page 11	A6000		

not yelling at this time. E6 was pulling up R1's pants. E6 said she heard R1 screaming and went into R1's bathroom to see E1 swatting at R1. E1's demeanor changed once E6 entered the room. E4 said that she was going to talk to E2 or E7 (assistant director of nursing) and that E6 should as well.

E5 wrote at 11:20 and 11:35am she walked into Willow and hear R1 yelling "help me" several times. E6 came. E1 was in R1's room.The nurse came in as well because she heard from the nurse's station. E1 came out of the room and said she was done.

E6 wrote E1 approached her at the door saying she (E6) needed to clean the bowel movement off R1's couch and floor. As E6 was cleaning up the mess she heard R1 yelling "please help me, please help me." When E6 looked up E1 was slapping R1's hands and pushing R1 forceably back. E6 proceed to go into the bathroom. E1 said she was done with this and left. R1 became calm once she saw E6.

The written statement dated 7/17/25, E1 wrote that she was assisting with personal care on the resident (R1). R1 became combative and starting fighting and hitting her. R1 always gets like that when she tries to do care on her. E1 wrote she just held R1's hand so she couldn't hit her. E1 was trying to pull up R1's pants and another caregiver came in and said she would finish R1. E1 left the room and went back to her unit. E1 was the floater on The Willows that day.

On 8/15/25 at 10:30am E2 stated, "the caregiver (E1) was terminated because she didn't know how to take care of the combative resident (R1). We had just had dementia training and Relias

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A6000	Continued From page 12 online training. The abuse wasn't substantiated. Unfortunately this caregiver (E1) wasn't able to articulate. I interviewed other staff who said E1 was unintentionally aggressive with other residents during care. I think it boils down to a cultural thing. I had previous conversation with E1 about being careful with handling other residents. E1 wasn't receptive to the advice."	A6000		