STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146173	A. Building B. Wing	06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springs at Monarch Landing, The	2308 North Route 59 Naperville, IL 60563

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to supervise a high-risk fall resident (R1) and provide a safe environment to a dependent resident (R2) when rendering care.These failures resulted in R1 having an unwitnessed fall and sustaining a laceration to her right posterior scalp requiring sutures, and in R2 having a witnessed fall and sustaining a fracture to her left ninth rib. This applies to 2 out of 3 (R1 and R2) reviewed for falls.The findings include:1. The EMR (Electronic Medical Record) said R1 had multiple diagnoses, including a history of falls, dementia with anxiety disorder, muscle weakness, osteoporosis, and osteoarthritis. R1's MDS (Minimum Data Set) dated 4/21/2026, said she had moderate cognitive impairment and had limited memory recall. The MDS also said R1 required supervision and touch assistance from staff when transferring and ambulating with her rolling walker. R1's EMR also said she was at risk for falls and required staff supervision.On 6/09/2026 at 9:40 AM, R1 was sitting in her personal transport wheelchair in the dining room, eating breakfast. R1 said she was unable to recall the details regarding her fall on 5/26/2026 but believes she stood up and fell in the dining room. R1 said she was transferred to the hospital and required four sutures to the back of her scalp. R1's right posterior scalp laceration was dry and scabbed over. R1 continued to say that she was able to ambulate with her rolling walker, and staff assisted her with her mobility. R1 then displayed anxiety when she overheard the phone in her room ringing, and V8 (Certified Nurse Assistant/CNA) proceeded to approach her to provide her with reassurance. Then V4 (Registered Nurse/RN) also approached R1 and wheeled her to her room. On 6/09/2026 at 9:50 AM, V8 (CNA) said R1 had a history of falls and her fall interventions included having her meals in the dining for supervision, participating in activities, and being monitored in the common areas. V8 said R1's memory was impaired and she would frequently try to stand without assistance, requiring frequent monitoring and redirection to ensure her safety. On 6/09/2026 at 10 AM, V4 (RN) said R1 tended to try to stand and ambulate with and without her rolling walker. V4 said R1 was considered a high-fall risk and staff were to monitor her when in the common areas, including when in the dining room for meals. V4 said R1 was able to ambulate with a rolling walker but required contact guard assistance with the use of a gait belt to ensure her safety. R1's unwitnessed fall incident report dated 5/26/2026 said that at 5:40 PM, R1 was observed on the floor in the dining room on her left lateral side. R1 was unable to provide details regarding her fall and sustained a laceration to the right posterior area of her head. R1 had to be transferred to the hospital for emergency treatment for her injury.R1's progress note dated 5/27/2026 said R1 returned from the hospital's ER (emergency room) after receiving medical treatment for her laceration. The note said the Laceration noted to the right posterior parietal side measured 4 cm x 2 cm. 4 sutures noted.On 6/09/2026 at 1:15 PM, V9 (CNA) said she was assigned to R1 on 5/26/2026 and was familiar with her safety interventions, including requiring supervision during meals. V9 said that she left the dining room to assist another resident with care in their room. V9 said she did not notify V10 (CNA), who remained in the dining room assisting and supervising the other residents. V9 said she then heard a loud noise from the dining room, and when she returned, R1 was on the floor next to her walker. V9 continued to say R1's fall (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	could have been prevented if she had been supervised. V9 said she failed to communicate with V10, to inform her to continue to monitor R1 and the other residents in the dining room.On 6/09/2026 at 1:20 PM, V10 (CNA) said she was also aware of R1's high-risk for falls and the need to be supervised. V10 said that on 5/26/2026, during the meal service, she was unaware that V9 (CNA) had left the area. V10 said she had also left the dining room to assist another resident in their room. V10 said when she returned, R1 was on the floor. V10 continued to say that if she had been informed by V9 that she was leaving, she would have stayed in the dining room to ensure the residents were being monitored appropriately. On 6/09/2026 at 12:30 PM, V7 (RN) said she was R1's assigned nurse on 5/26/2026, and when V9 and V10 called her in the dining room, they informed R1 had an unwitnessed fall. V7 said R1 was identified and known to V9 and V10 as a high fall risk due to her cognitive impairment and poor safety awareness. V7 said she immediately educated both V9 and V10 regarding providing proper continuous supervision during the meal service to ensure the safety of all residents. R1's care plan said she was at risk for falls and included multiple interventions, including Identify resident-specific interventions to aid in the prevention of falls and communicate interventions.On 6/09/2026 at 1:35 PM, V3 (Nursing Supervisor) said she responded to R1's unwitnessed fall incident on 5/26/2026 and initiated an investigation to identify the root cause of the incident. V3 said she interviewed the staff and R1, and concluded that R1 stood up and lost her balance after both V9 and V10 (CNAs) left the dining area unsupervised. V3 said staff were expected to remain in the dining room until the last resident was assisted to ensure the safety of all residents. V9's (CNA) communication action documents dated 5/27/2026 said that On 5/26/2026, the employee failed to properly communicate to the other staff that she was going to leave the Dining room to take another resident from the dining room to her room. The documents also noted that if a resident requires supervision during meals in the dining room, staff must inform another staff member before stepping away to assist or toilet another resident, ensuring continued supervision in the dining area.On 6/09/2026 at 2:40 PM, V12 (Medical Physician) said she was R1's medical provider and aware of her high-fall risk due to her multiple risk factors. V12 said she expects the facility staff to follow their fall policy and R1's plan of care to ensure she is being monitored safely. 2. The EMR showed R2 had multiple diagnoses, including a history of stroke with left side hemiplegia, kyphosis, osteoarthritis, general muscle weakness, abnormal gait, impaired mobility, and left upper extremity contracture. R2's MDS dated [DATE], said she was cognitively intact. The MDS also said R2 required partial to moderate assistance with transfers and was dependent on staff for her showering needs. R2's EMR also said she was at risk for falls due to her comorbidities.On 6/09/2026 at 10:15 AM, R2 was in her room, sitting in her wheelchair. R2's left arm and hand were severely contracted both were in a fixed position. R2 had yellowish bruising to her left lateral forearm. R2 said the bruising was from her fall on 5/23/2026 when V11 (Certified Nurse Assistant/CNA) was assisting her to bed after her shower. R2 said she was transferred to the hospital and had sustained a fracture on her left ninth rib. R2 proceeded to raise the left side of her shirt and had scattered purple bruising and a white dermal-pain patch over her lateral rib area. R2 said she required staff assistance with her stand-pivot transfers due to her left side weakness. R2 continued to say that on the evening of 5/23/2026, after her shower, V11 dried her in the bathroom located in her room and applied a hospital gown, then proceeded to wheel her next to her bed to transfer her into bed. R2 said she did not believe V11 was attempting to further dry her back but rather placing her hands around her trunk area to transfer her, and when she stood up barefoot, her left foot slid, and she fell. R2 said V11 was unable to brace her fall because she did not use a gait belt. R2's witnessed fall incident report dated 5/23/2026 said that at 7:10 PM, R2 was observed on the floor next to her bed with V11 (CNA) beside her. R2 reported, My foot got stuck on the carpet. R2's progress note dated 5/24/2026 at 1:40 AM said R2 was being monitored after her fall incident and now reporting increased pain 9/10 to left forearm and left rib cage. R2's physician was updated and ordered R2 to be transferred to the hospital for further evaluation.R2's progress note dated 5/24/2026 at 8:36 AM said R2 returned from the hospital and was (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	diagnosed with a closed fracture of the left rib. The note also said R2 was further assessed and had approximately 2.3 cm x 8.5 cm bruise/discoloration noted under her left breast, and approximately 3.1 cm x 13.3 cm discoloration noted to the left rib cage area.On 6/09/2026 at 12:40 PM, V11 (CNA) said she had showered R2 on 5/23/2026, and afterwards had wheeled and positioned her next to her bed. V11 said she intended to continue to dry R2's back prior to proceeding with her transfer to bed. V11 confirmed R2 was barefoot, and a gait belt was not applied during the task. V11 said she was not ready to transfer R2, and when R2 leaned forward, she started to slide off the shower chair and fell on her left side. V11 said she believed her cueing was off when rendering care to R2, and the fall could have been prevented if she had communicated clearly with R2 regarding the task. R2's care plan said she was at risk for falls and included multiple interventions, including evaluate Resident's environment to identify factors known to increase risk for falls and assist with ambulation and transfers, utilizing therapy recommendations.On 6/09/2026 at 1:35 PM, V3 (Nursing Supervisor) said she responded to R2's fall incident. V3 said when she arrived at R2's room, she was on the floor next to her bed, barefoot and wearing a gown. V3 said R2 did not have a gait belt in place. V3 said R2 reported she fell from the shower chair, and V11 originally also reported that R2 fell during the transfer. V3 said she initiated an investigation to identify the root cause of the incident and reinterviewed V11 because it was unclear if R2 slid off the shower chair when leaning forward as later reported by V11. V3 continued to say that V11 was expected to prioritize the safety of R2 when rendering her care, including during bath care and transfers. V3 said she further educated V11 after the incident about ensuring non-skid socks and a gait belt were applied prior to transferring a resident, and to clearly communicate with the resident when rendering care. V11's (CNA) communication action documents dated 5/26/2026 said that On 5/23/2026, the staff had performed transfer without a gait belt and failed to clearly communicate the task with the resident to avoid miscommunication. The documents also noted that staff were to use a gait belt at all times when transferring residents who required one or two person assistance.On 6/09/2026 at 2:40 PM, V12 (Medical Physician) said R2 was at risk for falls due to her medical conditions and required staff assistance with her care. V12 said she expected the facility staff to provide a safe environment when rendering care and transferring residents as per the facility's policy to ensure the safety of residents.The facility's Falls and Fall Risk Managing undated policy said that based on previous evaluations and current data, the staff would identify interventions related to the resident's specific risks and causes to try to prevent a resident from falling and try to minimize complications from falling. Fall risk factors would be evaluated, which included cognitive impairment, gait and balance disorders, lower extremity weakness, and unsafe or absent footwear. The facility would systematically evaluate and implement Resident-Centered interventions for the management of fall risks and falls. The facility expects staff to identify, implement, and prioritize relevant interventions to try to minimize the serious consequences of falling.