STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510084	A. BUILDING: _____ B. WING _____	C 10/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE LISLE IL/AL	1700 ROBIN LN LISLE, IL 60532

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A 000	Initial Comment Facility Reported Incident Survey Conducted: #IL197421 Violations: Section 295.4010 a) d) e) Service Plan Section 295.6010 a) 1) 2) Abuse, Neglect, and Financial Exploitation Prevention and Reporting	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 2 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. 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	A4010		

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A4010	Continued From page 1 295.4000). These requirements are not met as evidenced by: Based on interview and record review, the establishment failed to address a resident's combative behavior exhibited during personal care, failed to ensure interventions are in place in the Service Plan for the combative behavior, and failed to update the Service Plan to address the incident of injury of unknown origin sustained by a resident. The lack of initial interventions to help address the combative behavior contributed to a resident's swelling and bruising to the left hand with diagnosis of fracture of the 5th metacarpal. This failure creates a substantial probability of harm to a resident or residents This applies to 1 of 3 (R1) resident reviewed for an injury of unknown origin incident. The findings include: R1 is a 90-year-old, female resident admitted to the establishment on April 27, 2023, with diagnoses to include unspecified dementia, arthropathy, generalized muscle weakness, unspecified abnormalities of gait and mobility, unspecified lack of coordination, and history of falling. On October 3, 2025, at 1:15 PM, E3 (LPN) and E4 (RN) described R1 as somebody who cannot tell you her name but will turn towards you if you call her. They said R1 is not able to carry on a conversation. R1 is wheelchair bound, combative, and non-compliant. R1 needs two-person assistance with activities of daily living due to her	A4010		

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A4010	Continued From page 2	A4010		

combative behavior especially during care. E3 and E4 said R1 has always been showing combative behavior during personal care especially during dressing, toileting, incontinence care, and bathing. E3 and E4 said R1 could propel herself in her wheelchair. R1 does not wander to other rooms or hallways. The nurses always place her by the nurse's station as she loves to stay there. Both said R1 had an incident of left hand swelling which nobody knew how it happened. All they know is that R1 would fight, scratch, hit, and flail around whenever care is rendered. During other times, outside of personal care, she is usually calm. E3 and E4 said it is a possibility that she hit her hand on something or the wall when she was flailing around as part of her combative behavior during care.

On October 7, 2025, at 11:00AM, E2 (Interim Health and Wellness Coordinator-HWC) said they though R1's swollen left hand was due to cellulitis since it happened suddenly, and it was not there the day before. They only learned it was fracture when x-ray result came out. E2 confirmed R1's MD ordered a new psychotropic medication for her combative behavior.

The establishment's document showed the swelling, warmth, and discoloration to R1's left hand was observed on August 19, 2025. POA and PCP were notified. NP came to assess R1 on August 20, 2025. X-ray was ordered. The result came out on August 20th with diagnosis of fracture of the left fifth metacarpal.

R1's Personal Service Plan dated February 14, 2025, failed to address the combative behavior. The Behavior Management category showed "No behaviors."

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A4010	Continued From page 3 R1's Personal Service Plan dated September 8, 2025, mentioned the combative behavior during care. However, no changes were made to the interventions after the injury of unknown origin and the ensuing fracture that was detected from the x-ray. The additional order of psychotropic medication to help control the combative behavior was not addressed as to what side effects care staff must be aware of, look for and observe, as well as by the care partners to report to the nurse and subsequently to the doctor. E2 (Interim HWC) said, moving forward, she will make sure there will be interventions in place in the service plan showing measures are present to help prevent another incident of injury to R1's hand possibly due to her combative behavior during care. E2 will also make sure there are listed side effects of psychotropics ordered by the doctor for any resident the care partners and nurses will watch for to report to the physician.	A4010		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr This Regulation is not met as evidenced by: Type 3 Violation Section 295.6010 Abuse, Neglect, and Financial Exploitation Prevention and Reporting a) When the establishment has a reasonable belief that a resident has been the victim of abuse, neglect, or financial exploitation, the establishment shall:	A6010		

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A6010	Continued From page 4 1) Notify the Department within 24 hours after receiving the allegation, by contacting the Assisted Living Complaint Registry by telephone, fax, or other electronic means. The establishment shall document this report and maintain documentation on the premises for 12 months after the date of the report. 2) Investigate and develop a written report within 14 days after the initial report. The establishment shall send the written report to the Department within 24 hours after it is completed and shall maintain a copy of the written report on the premises for 12 months after the date of the report. This requirement is not met as evidenced by: Based on interview and record review, the establishment failed to notify the Department, in a timely manner, after an incident of a resident's injury of unknown origin, and failed to develop and send a final written report within 14 days after the initial report. They also failed to follow their own policy regarding reporting of incidents of injury of unknown origin as part of the Abuse Policy. This applies to 1 of 3 (R1) resident reviewed for timely reporting of an injury of unknown origin. The findings include: R1 is a 90-year-old, female resident admitted to the establishment on April 27, 2023, with diagnoses to include unspecified dementia, arthropathy, generalized muscle weakness, unspecified abnormalities of gait and mobility,	A6010		

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A6010	Continued From page 5	A6010		

unspecified lack of coordination, and history of falling.

The establishment's document showed the swelling, warmth, and discoloration to R1's left hand was observed on August 19, 2025. POA and PCP were notified. NP came to assess R1 on August 20, 2025. X-ray ordered. The result came out on August 20th with diagnosis of fracture of the left fifth metacarpal. An investigation was immediately conducted. Staff members were interviewed. The Initial Incident Report was sent to the Department on August 22, 2025 (three days after the injury was initially detected). Final report was sent to the Department on September 12, 2025 (21 days after the initial report).

On October 7, 2025, at approximately 11:00 AM, E2 said she was not able to send the final report within 14 days from the initial report because she was on vacation. As soon as she got back from vacation and found out the final report was not yet sent to the Department, she immediately sent the report on September 12, 2025.

The establishment's Incident Report Policy with effective date of October 10, 2019, showed, "The community should conduct a thorough investigation, and appropriate corrective actions and interventions planned for immediate implementation...Incidents described should be reported to the Department's Online Incident Reporting System within 24 hours of the incident."

The establishment's Abuse, Neglect & Exploitation Policy with effective date of October 2010 showed, "External Reporting/Notification c. Report to the Department of Public Health, Assisted Living Complaint Registry (1) The Executive Director, or designee, in consultation

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A6010	Continued From page 6 with the Regional Director, should report known or suspected abuse, neglect or misappropriation and all allegations of abuse, neglect to the Department of Public health (217-782-4977), Assisted Living Complaint registry (800-252-4343) within 24 hours after receiving the allegation b) A written report shall be developed within 14 days after the initial report. The establishment shall send the written report to the Department of Public Health within 24 hours after it is completed."	A6010		