STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510497	A. BUILDING: _____ B. WING _____	C 11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STORYPOINT BOLINGBROOK	370 N WEBER ROAD BOLINGBROOK, IL 60440

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A 000	Initial Comment Complaint Investigation IL198610 295.2000 a) 1) 2) 3) 4) 5) 6) 295.6000 a) 1) 13) 295.6010 a) 1) 2) 4) 7)	A 000		
A2000	Section 295.2000 Residency Requirements This Regulation is not met as evidenced by: Type 1 Violation Section 295.2000 a) 1) 2) 3) 4) 5) 6) 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) c) A person shall not be accepted for residency if: 1) The person poses a serious threat to themselves or to others; 2) The person is not able to communicate their needs in any manner and no resident	A2000		

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A2000	Continued From page 1 representative residing in the establishment, and with a prior relationship to the person, has been appointed to direct the provision of services; 3) The person requires total assistance with 2 or more activities of daily living; 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; 6) The person has a severe mental illness, which for the purposes of this Section means a condition that is characterized by the presence of a major mental disorder as classified in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision DSM-5-TR, where the individual is a person with a substantial disability due to mental illness in the areas of self-maintenance, social functioning, activities of community living and work skills, and the disability specified is expected to be present for a period of not less than one year, but does not mean Alzheimer's disease and other forms of dementia based on organic or physical disorders. Nothing in this Section is meant to prohibit an individual with a diagnosis of depression from living in an establishment so long as the resident	A2000		

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A2000	Continued From page 2 is not substantially disabled in the areas of self-maintenance, social functioning, activities of community living, and work skills. These requirements were not met as evidenced by: Based on record review and interviews , the establishment failed to ensure one resident met the requirements for admission. This failure involves 2 of 3 residents (R1,R2) reviewed. This failure resulted in (R1) being struck by (R2) multiple times in the face. This failure has the substantial probability to cause severe harm to all residents in the memory care community. Findings include: R2 is a 74 year old resident who moved into the establishment 10/3/25. R2 has diagnoses including unspecified Dementia, Delirium due to know physiological condition, unspecified Psychosis, Dysthymic disorder, Mild cognitive impairment and Metabolic Encephalopathy. R2 has a history of alcohol dependence with withdrawal with perceptual disturbance. The incident and accident report dated 10/9/25 at 10:45pm shows R2 was found in the hallway moving furniture from his room. A small hematoma was noted to the front left side of R2's scalp and a small laceration noted to the right hand. R2 appeared confused and in danger of harming himself and others. 911 called due to mental status. R2 was transported to a local hospital.. The hospital diagnosis was dementia with behavioral disturbances. The incident accident report dated 11/16/25	A2000		

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A2000	Continued From page 3	A2000		

shows Z2 (Private Care Giver) reported while sitting at the dining room table, R2 was trying to hit her in her stomach. R2 was in a standing position at a dining room table. R2 looked at R1 and proceed to punch R1 in the face multiple times. E4 (LPN) tried to assist R2 out of the dining room. E4 and other staff managed to remove R2 from the dining room and hold R2 until the paramedics arrived. R2 was transferred to a local hospital.

On 11/20/25 at 12:05pm E1 (Executive Director) stated, "R2 will not be returning to the community due to safety concerns. The first time R2 was sent out to the hospital because he moved his furniture into the hallway and pulled the air conditioning cover off the wall. Staff was not able to redirect R2's behavior. R2 was sent out to a behavior health hospital. When R2 came back from the hospital, he was on hospice. We had a discussion with R2's wife. She wanted R2 to return to the community. I told her the only way R2 could return was to have a 24 hour caregiver. R2 had a 24 hour caregiver up to the day of the incident. What may have prompted R2 was maybe the Z2 may have startled R2. R2 was becoming more aggressive, showed more exit seeking behavior and restlessness."

On 11/20/25 at 1:10pm E6 (Care Aide) said R2 had a private caregiver. They usually work 12 hours.

The service plan creation date 10/3/25 shows R2 requires assistance with bathing, dressing, grooming, toileting and evacuation/emergency. Under Reasoning, R2 also requires assistance with redirection due to occasional confusion, deficits in judgement wandering or exit seeking, etc.

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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 These requirements were not met as evidenced by: Based on record review and staff interviews, the establishment failed to ensure that one resident was free from physical abuse. This failure involves 2 of 4 residents (R1,R2) reviewed. This failure resulted in (R1) being the victim of physical abuse from (R2). This failure has the substantial probability to cause severe harm to all residents in the memory care community. Findings include: R1 is a 91 year old resident who resides in the memory care unit. R1 has diagnoses including dementia, anxiety disorder and mild cognitive impairment.	A6000		

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R2 is a 74 year old resident who moved into the memory care unit 10/3/25. R2 has diagnoses including unspecified Dementia, Delirium due to known physiological condition, Alcohol dependence with withdrawal with perception disturbance, unspecified psychosis and mild cognitive impairment.

The incident accident report dated 11/16/25 shows Z2 (Private Care Giver) reported while sitting at the dining room table, R2 was trying to hit her in her stomach. R2 was in a standing position at a dining room table. R2 looked at R1 and proceed to punch R1 in the face multiple times. E4 (licensed pratical nurse/LPN) and other staff managed to remove R2 from the dining room and hold R2 until the paramedics arrived. R2 was transferred out toa local hospital.

The progress note for R1 and R2 dated 11/16/2025 confirms what was documented in the inicident accident report.

On 11/20/25 the following employees who work in the memory care unit were interviewed and stated the following:

-12:05pm E1 (Executive Director) stated, "R2 will not be returning to the community due to safety concerns. The first time R2 was sent out to the hospital was because R2 moved his furniture into the hallway and pulled the air conditioning cover off the wall. Staff not able to redirect R2's behavior. R2 sent out to behavior health hospital. When R2 came back from the hospital, he was on hospice. We had a discussion with R2's wife. She wanted R2 to return to the community. I told the wife the only way R2 could return was to have a 24 hour caregiver. R2 had a 24 hour caregiver up to the day of the incident. R2 was becoming

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A6000	Continued From page 6	A6000		

more aggressive, more exit seeking behavior and restlessness."

-12:55pm E2 (LPN, Wellness Director) stated, "I was at home that day. I got a call from E3 (LPN). E3 said R2 made contact with R1. R2 was swinging at R1. 911 was called. The staff made sure the other residents were safe. I've only been here 2 weeks, but I know that R2 is a likeable person. R2 seems to do best in a small environment, not noisy. I really didn't get to know R2.

As far as R1, she does best with yes and no questions. I saw her on Monday. R1's upper lip and face were a little red. No bruises or black eye. R1 doesn't seem any different. No changes noted in R1's behavior or demeanor. I've asked the staff to keep closer watch on R1."

-12:40pm E3 (LPN, Director of Connect Point) stated, "this was at our Thanksgiving brunch. This happened around 12:30pm/12:45pm: I didn't witness the exact incident. I heard the commotion in the memory care unit in the dining room. Everything happened so fast. R2 was being aggressive, reaching out for R1.We tried to get R2 out of the dining room. R2 hit R1 in her head and face. I was helping to get R2 away. Z2 was in the dining room with R2. R2 was walking with Z2. R1 wasn't crying. R1 seemed fine. A family member of another resident came and sat by R1. Z1 who lives about 5 minutes away came to see R1. The paramedics evaluated R1. Z1 didn't want R1 sent out. Z1 wanted hospice to assess R1."

-12:50pm E4 (LPN, Memory Care Unit Nurse) stated, "it was the Thanksgiving brunch . R2 has had a caregiver since coming back from the psych hospital. Z2 was on break. R2 was

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A6000	Continued From page 7	A6000		

pleasant. Z2 came back and said R2 was trying to hit her in the stomach, I came over, R2 was standing up. R2 was already in defensive mode. R2 looked at R1 who was seated next to him eating her meal. R2 punched R1 several times. We were able to get R2 out of the dining room. We got R2 to sit on the floor. One police officer came first, then the paramedics. R2 was still being combative when they arrived. I've never seen R2 combative like that. R2 was always pleasant, anxious sometimes but not combative. R1 was ok. R1 said I'm ok. R1 had a small cut to her lip. Z1 came and hospice came to assess R1."

-1:10pm E5 (LPN, Memory Care Unit Nurse) stated, "we were having a Thanksgiving brunch, Everything seemed to be going well. There wasn't any commotion at the time. R2 was siting next to R1 eating. R2 was seated to R1's right. Z2 was seated by R2. R2 stood up and started hitting R1 in the face. R1 doesn't really talk. There were no words, R2 just started hitting R1. Staff tried to get R2 to stop and tried to protect R1. R1 seems ok, no change in her condition. R2 was sent out right away. I was the one that called 911.

-1:15pm E6 (Resident Aide, Memory Care Unit) stated, "this happened towards the end of the brunch. We were starting to pass out dessert. We (E4, E7 (Resident Aide)) were standing in the doorway. R2 was agitated with Z2. We saw R2 stand up. R1 was drinking water, R2 knocked the cup out of R1's hand. R1's wheelchair was locked so I couldn't move R1 right away so I put my arm around her face so R2 couldn't hit R1 again. I took the brunt of the hits on my arm. R2 only hit R1 once. Everything happened so fast. I knew I wanted to protect R1. R1 seemed ok after the incident. Z1 sat with R1. On Monday morning

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A6000	Continued From page 8 R1's lip was swollen but R1 didn't have any bruises to her face. Hospice did come out to see R1. Z2 new that day, I had not seen Z2 before. The caregivers usually work 12 hours. E3, E4 and E8 (Resident Aide) got R2 out of the dining room and lowered R2 to the floor." The service plan creation date 10/3/25 shows R2 requires assistance with bathing, dressing, grooming, toileting and evacuation/emergency. Under Reasoning, R2 also requires assistance with redirection due to occassional confusion, deficits in judgement, wandering or exit seeking, etc.	A6000		
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: 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.	A6010		

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A6010	Continued From page 9 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. b) A written report of the investigation conducted pursuant to subsection (a)(2) shall contain at least the following: 4) Any actions taken by the licensee; 7) If the abuse, neglect, or financial exploitation is substantial, a description of the action to be taken by the establishment to prevent the abuse, neglect or financial exploitation from occurring in the future. These requirements were not met as evidenced by: Based on record review and staff interviews, the establishment failed to notify the Department within 24 hours after receiving the allegation of resident to resident physical abuse involving 2 residents (R1, R2). This failure has the probability to affect all residents in the memory care unit. Findings include:	A6010		

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A6010	Continued From page 10	A6010		

R1 is a 91 year old resident who resides in the memory care unit. R1 has diagnoses including unspecified dementia, anxiety disorder and mild cognitive impairment.

R2 is a 74 year old resident who moved into the memory care unit 10/3/25. R2 has diagnoses including unspecified Dementia, Delirium due to known physiological condition, Alcohol dependence with withdrawal with perception disturbance, unspecified psychosis and mild cognitive impairment.

On 11/20/25 the establishment presented an incident accident report dated 11/16/25 that shows Z2(Private Care Giver) reported R2 was trying to hit her in her stomach. R2 was in a standing position at a dining room table. R2 looked at R1 and proceed to punch R1 in the face multiple times. E4 (licensed practical nurse /LPN) and other staff managed to remove R2 from the dining room and hold R2 until the paramedics arrived. R2 was transferred out to a local hospital.

This incident accident report does not indicate if it was an initial and or final report. There was no confirmation attached to to show the incident report was sent to the department within 24 hours after completion.

On 11/20/25 at 2:55pm E2 (licensed practical nurse,wellness director) was asked if the incident accident report was sent to the department. E2 said the report was sent directly to the portal. E2 said she would see if she could print out a confirmation as proof.

On 11/24/25 at 1:35pm during the exit conference, E1 (executive director) was asked if the incident accident report was sent to the

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A6010	Continued From page 11 department. E1 said he thought the report was sent to the department. However, when E1 looked in the IDPH (Illinois Department of Public Health) portal. E1 stated, "I only see confirmation for the incident involving R2 dated 10/9/25. I don't see the one for 11/16/25. E2 walked into E1's office during this time. E1 asked E2 asked if the incident report was sent to the department. E2 said yes, the incident report was sent in that Monday (11/17/25). However the establishment was not able to present proof the incident report was sent in to the department portal within the required 24 hour time period.	A6010		