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A 000	Initial Comment Complaint Investigation IL199679 295.3000e)2)c) 295.3020c)5) 295.4010a)d)e) 295.6000a)13) 295.6010a)1)2)b)1-7)c) Complaint Investigation IL199595 295.1070a)c)11)d) 295.4010a) 295.7000f)1)2) Facility Reported Incident IL200042 and IL200043 - No deficiencies	A 000		
A1070	Section 295.1070 Annual on-Site Review and Complaint Procedure This Regulation is not met as evidenced by: Violation Section 295.1070 Annual On-Site Review and Complaint Investigation Procedures a) The Department will conduct an annual unannounced on-site visit at each assisted living and shared housing establishment to determine compliance with the applicable licensure requirements and standards as set forth in the Act and this Part. Additional visits may be conducted without prior notice to the assisted living or shared housing establishment. (Section 110(a) of the Act) c) The review shall address the following issues:	A1070		

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A1070	Continued From page 1 11) Incident and accident reports that are required to be submitted to the Department. d) An establishment shall not restrict or hamper access by Department staff to the building, residents or designated records required to conduct routine or periodic review or investigations. A resident may limit access to their private dwelling space to reviewers, except if suspected violations exist that may pose a threat to the resident's or others' health, safety or well-being. A resident may also elect to limit access to themselves and their records, except as required as a condition of payment for publicly funded housing and/or services. Based on interview and record review, the facility failed to grant the state agency access to R4's complete medical record for review during a complaint investigation. The facility also failed to provide a a copy of an abuse investigation to the state agency during an abuse investigation for one resdients (R3). These failures impeded the state surveyor's ability to conduct a complete and thorough investigation. Findings include: 1. On 5/1/26, at 9:38 AM, E2, Health and Wellness Director, was asked for the facility reportables from 10/1/25 to 5/1/26, access to the resident's medical records, and R4's 10/8/25 incident investigation. E2 stated, "I don't know if I have R4's medical record. She's been discharged, so her medical records are in storage. I'll have to see if I can get access." E2 asked this surveyor what was needed from R4's medical record. E2 was informed that the surveyor needed, at a minimum, R4's physician	A1070		

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A1070	Continued From page 2	A1070		

assessment, physician orders, cognitive evaluation, service plan, progress notes, fall risk assessment, establishment contract, orientation and any information pertaining to R4's reportable, injury and hospitalization.

On 5/1/26 at 12:04, this surveyor received requested medical records for R1 and R2, but did not recieve medical record for R3-R8. This surveyor asked where the other resident's medical records were at. E2 stated "I have them here (Holding a stack of medical records). I'm making copies for you. The only one I don't have yet is (R4)."

On 5/1/26, at 1:59 PM, E2 was asked if she was able to locate R4's medical record. E2 stated she is still looking for R4's medical record since they were put in storage when R4 discharged on 10/8/25.

On 5/2/26 at 7:10 AM, E2 stated that she was unable to get R4's medical record because they're locked in E1's, Executive Director, office and she doesn't have access to the office. E2 stated E1 is on benefit time and is unavailable. E2 was informed that if the facility is unable to produce resident records upon request during a complaint investigation, the facility would be in violation. E2 stated "Well, I can get you the progress notes and FAST (Functional Assessment Staging of Alzheimer's Disease) that's all I have access to."

On 5/2/26 at 10:30 AM, E2 handed this surveyor resident documentation. Review of the documentation handed to this surveyor shows R4's progress notes and FAST assessment. No other documentation provided. E2 stated "That's all I can get for (R4)."

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A1070	Continued From page 3 On 5/2/26 at 12:00 PM, E2 stated "I might be able to get (R4's) service plan. I contacted IT to see if they can help me print R4's service plan since she's discharged. We keep the service plans on a different system." On 5/2/26 at 12:20 PM, E2 handed this surveyor R4's service plan and stated "I was able to get the service plan. What I gave you is all I have access to." On 5/2/26 at 12:30 PM, review of documentation of R4's medical records recieved by the facility include the progress notes, FAST assessment, service plan and 10/8/26 reportable without investigation. This surveyor was not given any additional medical records for R4 during the course of the suvey. 2. On 5/1/26 at 9:38 am, E2, Health and Wellness Director, was asked for the facility reportables from 10/1/25-current. E2 was also told this surveyor would like to see the complete investigations for R3's allegation of theft. E2 was asked if she knew anything about $600 dollars missing from R3. E2 stated "I was told it was $250 and then later told a different amount. I talked to the family, and they said (R3) never had any money in his room. (R3) has changed the amount that's missing a couple times." On 5/2/26 at 9:25 am upon reviewing the facility provided reportables from 10/1-5/1/26 There is no reportable for R3's allegation of theft. The requested documents also do not include an investigation or progress note of the incident. E2 was again asked for R3's reportable and investigation of his allegation of theft.	A1070		

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A1070	Continued From page 4 On 5/2/26 at 10:02 am, R3 stated that he had 2 wallets that went missing. One wallet had $167 and the other wallet had $200. He stated that he keeps the wallets on his chair next to the bed. One day he noticed his wallet missing. He called his family and they had him call the bank immediately because he had credit cards in the wallet. He said the bank put a stop on his account and his family notified the police. He stated a week later, one of his wallets was found under his bed, but the money and one credit card was missing. R3 stated he notified E10, LPN of the missing wallets and she told him that he needed to report it to the administration. He stated he spoke to E2 about the missing wallet. On 5/2/26 at 10:12 AM, E10, LPN stated that R3 told her that he had $600 dollars missing. E10 stated "I told (R3). "I'm just a nurse. You need to report that to E1, Executive Director and E2." (R3) told me he thinks it was the nurse with braids coming down, but I told him that he needs to let the admin know that because I don't know who that is. They go through so many people working here, it's hard to keep track of who is who. The turnover rate here is bad." " E10 was asked if she knew if R3 reported it to administration, if she had reported it to administration, or if she documented that R3 told her about the missing money. E10 stated that she did not report it to administration and said she assumes R3 did because E1 and E2 know about it. On 5/2/26 at 10:30 AM, E2 handed this surveyor R3's missing money abuse investigation, but did not have a reportable. When E2 handed this surveyor the abuse investigation, E2 stated that she can not give this surveyor a copy of the investigation as it's an internal document and is	A1070		

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A1070	Continued From page 5 not allowed to give a copy to IDPH. E2 was questioned why the facility will not give this surveyor a copy of the abuse investigation in order to complete the investigation, E2 stated "I was told by my Regional not to." On 5/3/26, this surveyor completed the investigation and the facility did not provide a copy of R3's requested financial abuse investigation.	A1070		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: Type 2 Violation Section 295.3000 Personnel Requirements, Qualifications and Training e) A file shall be maintained for each employee containing the following: 2) Documentation of: C) Ongoing training; Based on interview and record review, the facility failed to maintain an employees ongoing training to include abuse prevention and reporting. This failure creates a substantial probability of harm to a resident or residents. Findings include: R3's facility investigation dated 1/15/26, documents R3 reached out to community	A3000		

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A3000	Continued From page 6	A3000		

representative and reported a staff member took his wallet, credit cards and $250 dollars from his room.

On 5/2/26 at 10:02 am, R3 stated that he had 2 wallets that went missing. One wallet had $167 and the other wallet had $200. He stated that he keeps the wallets on his chair next to the bed. One day he notice his wallet missing. He called his family and they had him call the bank immediately because he had credit cards in the wallet. He said the bank put a stop on his account and his family notified the police. He stated a week later, one of his wallets was found under his bed, but the money and one credit card was missing. R3 stated he notified E10, LPN of the missing wallets and she told him that he needed to report it to the administration. He stated he spoke to E2 about the missing wallet.

On 5/2/26 at 10:12 AM, E10, LPN stated that R3 told her that he had $600 dollars missing. E10 stated "I told (R3). "I'm just a nurse. You need to report that to E1, Executive Director and E2." (R3) told me he thinks it was the nurse with braids coming down, but I told him that he needs to let the admin know that because I don't know who that is. They go through so many people working here, it's hard to keep track of who is who. The turnover rate here is bad." " E10 was asked if she knew if R3 reported it to administration, if she had reported it to administration, or if she documented that R3 told her about the missing money. E10 stated that she did not report it to administration and said she assumes R3 did because E1 and E2 know about it.

On 5/2/26 at 11:19 am, E2 was informed that R3 reported the missing money to E10, but E10 did

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A3000	Continued From page 7 not report it and instead told R3 to report it to administration. E2 confirmed E10 should have reported R3's allegation to administration. On 5/2/26 at 12:00 PM, E2 was asked for E10's abuse training. E2 logged onto her laptop and stated "I'm looking at (E10)'s training and it doesn't look like she completed her abuse training in the last year. Let me check and I'll be back." On 5/2/26 at 12:38 pm E2 stated she is not able to find E2's abuse training. E2 stated "There should be a paper sign in sheet for an in-person abuse training HR did, but I don't know where it is. I think it's locked in the HR office and I don't have access to that office. I was told that if we get written for it, we'll just dispute it and submit the in-service when we find it. " E2 was asked if she knows when the abuse training was completed E2 stated she was not for sure.	A3000		
A3020	Section 295.3020 Employee Orientation and Ongoing Training This Regulation is not met as evidenced by: Type 2 Violation Section 295.3020 Employee Orientation and Ongoing Training c) Each manager and direct care staff member shall complete a minimum of 8 hours of ongoing training, applicable to the employee's responsibilities, every 12 months after the starting date of employment. The training shall include:	A3020		

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A3020	Continued From page 8 5) Abuse and neglect prevention and reporting requirements Based on interview and record review, the facility failed to privide an employees ongoing training to include abuse prevention and reporting. This failure creates a substantial probability of harm to a resident or residents. Findings include: R3's facility investigation dated 1/15/26, documents R3 reached out to community representative and reported a staff member took his wallet, credit cards and $250 dollars form his room. On 5/2/26 at 10:02 am, R3 stated that he had 2 wallets that went missing. One wallet had $167 and the other wallet had $200. He stated that he keeps the wallets on his chair next to the bed. One day he notice his wallet missing. He called his family and they had him call the bank immediately because he had credit cards in the wallet. He said the bank put a stop on his account and his family notified the police. He stated a week later, one of his wallets was found under his bed, but the money and one credit card was missing. R3 stated he notified E10, LPN of the missing wallets and she told him that he needed to report it to the administration. He stated he spoke to E2 about the missing wallet. On 5/2/26 at 10:12 AM, E10, LPN stated that R3 told her that he had $600 dollars missing. E10 stated "I told (R3). "I'm just a nurse. You need to report that to E1, Executive Director and E2." (R3) told me he thinks it was the nurse with braids coming down, but I told him that he needs	A3020		

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A3020	Continued From page 9 to let the admin know that because I don't know who that is. They go through so many people working here, it's hard to keep track of who is who. The turnover rate here is bad." " E10 was asked if she knew if R3 reported it to administration, if she had reported it to administration, or if she documented that R3 told her about the missing money. E10 stated that she did not report it to administration and said she assumes R3 did because E1 and E2 know about it. On 5/2/26 at 11:19 am, E2 was informed that R3 reported the missing money to E10, but E10 did not report it and instead told R3 to report it to administration. E2 confirmed E10 should have reported R3's allegation to administration. On 5/2/26 at 12:00 PM, E2 was asked for E10's abuse training. E2 logged onto her laptop and stated "I'm looking at (E10)'s training and it doesn't look like she completed her abuse training in the last year. Let me check and I'll be back." On 5/2/26 at 12:38 pm E2 stated she is not able to find E2's abuse training. E2 stated "There should be a paper sign in sheet for an in-person abuse training HR did, but I don't know where it is. I think it's locked in the HR office and I don't have access to that office. I was told that if we get written for it, we'll just dispute it and submit the in-service when we find it. " E2 was asked if she knows when the abuse training was completed E2 stated she was not for sure.	A3020		
A4010	Section 295.4010 Service Plan	A4010		

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A4010	Continued From page 10	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.

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).

Based on interview and record review, the facility failed to update a residents service plan with noted behaviors for three residents (R5, R7 and R8), failed to add interventions post fall for two residents (R7 and R8) and failed to add interventions to prevent further abuse for two resident (R5 and R8). This failure resulted in continued falls for R7 and R8 and creates a substantial probability of severe harm to a resident or residents.

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Findings include:

1. R7 admitted to the facility on 2/21/23 with a diagnosis of Parkinson's and Dementia. R7's FAST Functional Assessment Staging of Alzheimer's Disease documents a score of 7 indicating severe cognitive decline/severe Dementia.

R7's medical record documents the following falls 10/14/25, 10/18/25, 10/25/25, 12/5/25, 12/24/25, 2/14/26, 2/21/26, 2/26/26, and 4/12/26.

R7's service plan does not contain the mentioned falls or fall interventions.

On 5/1/26 at 7:39 AM, E5, CNA, stated there are currently 3 employees assigned to the memory care unit with a nurse that goes back and forth. There's no issues with staffing, but there are residents that need close monitoring like R7 because she stands up a lot.

On 5/1/26 at 7:46 AM, E6 Caregiver, was asked about staffing. E6 stated the only issue with staffing that they run into is someone always needs to keep a close eye on the residents. E6 stated they have to keep a close eye on R7 because she likes to stand up a lot.

On 5/1/26 at 1:25 PM, E2, Health and Wellness Director, was asked where R7's falls are located on the service plan. E2 stated that R7 really doesn't have falls, she slides herself out of the wheelchair or bed onto the floor. E2 was asked where that's at in the service plan. E2 looked over R7's service plan and was unable to find the updated fall interventions or behaviors interventions to address R7 falling or sliding onto the floor. E2 said they did increase R7's toileting

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time, but again could not find the update on the service plan. E2 stated that there may be interventions written on the back of the original service plan. E2 stated that sometimes the nurses or managers will hand write updates and interventions on the back of the service plan and then she updates it electronically. This surveyor asked where she got the copies she gave this surveyor and E2 stated "It was from the original copy in her chart, but it may not have copied the writing on the back. I only copied one side. I'll go check real quick." This surveyor told E2 "I'll go with you and check." This surveyor followed E2 to the physical hard chart in the nurse's office. The charts did not have the service plans. E2 stated "I think I left them in the other office when I made copies." This surveyor then followed E2 to another area of the building where the original service plans were at. The service plans were reviewed front and back. R5, R6, R7 and R8's service plan do not contain any hand written notes anywhere on the service plan other than what was previously given to this surveyor. E2 verified the service plans don't have any updates written on them.

2. R8 admitted to the facility on 7/30/25 and resides in the memory care unit. R8's FAST Functional Assessment Staging of Alzheimer's Disease documents a score of 7 indicating severe cognitive decline/severe Dementia.

R8's medical record documents R8 had a fall on 3/29/26, 3/28/26 and 2 falls on 3/19/26.

R8's progress note dated 12/13/25 documents "Note Text: RA on duty reported to writer, that resident slapped another resident at the dining room table. Resident was immediately removed from the table. writer asked resident why she

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BROOKDALE ORLAND PARK	16051 S LAGRANGE RD ORLAND PARK, IL 60467

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A4010	Continued From page 13	A4010		

slapped the other resident she stated "I don"t know." Writer explained lo resident that it is inappropriate to slap anyone resident. Resident just nodded her head. The psychiatric (Nurse Practitioner) was called and he gave new orders to increase the risperdal from 0.25mg BID to 0.5 mg BID and if she continues this behavior resident should be sent out for geriatric psych evaluation. POA was updated and agreed. HWC was made aware also."

R8's progress note dated 2/6/26 documents "Note Text: (ADON aware, Psychiatrist aware) -1800 Observed resident leaving her room with a metal fork. neutral affect. Politely asked if she wanted me to put it away for her, and calmly reached for 1t. Resident stabbed the knife towards me and this writer had to quickly back up, very suddenly angry/agitated affect "I'm not going back to (MD)". Backed up and gave her more space, as she was walking towards me to get closer. Watched her from a distance to give some space. then at 1810 got assistance in taking the fork from her with another staff member. She attempted to hit us with the fork but not in a stabbing motion this time. Fork taken successfully. Resident appears less agitated al 2035. Will continue to monitor."

On 5/1/26 at 7:43 AM, E5 CNA, stated R5 likes to get close to residents due to anxiety and feels comfort when she holds onto them. E5 stated that R8 doesn't like it and gets irritated with R5 and smacks her and stated "We have to keep a close eye on them. (E5 pointed to the common area were R5 and R8 are sitting. R5 is sitting in a chair separated from R8.) We have to make sure (R5) doesn't get to close and try to hold (R8)."

On 5/1/26 at 7:46 AM, E6 Caregiver, stated that

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R8 does get irritated with R5 and smacks her, but R5 is the only one she does that with, so they have to make sure they stay separated. E6 was asked why. E6 stated "(R5) likes to get close and hold the other residents hand and (R8) doesn't like it, so she'll smack (R5). It's why we have to make sure the two stay seperated."

On 5/1/26 at 7:55 AM, E7 CNA, stated that R8 does hit R5 because R5 irritates R8. R5 likes to be close to the residents and can grab their arm or hand. When R5 does it to R8, R8 will smack R5, so they have to keep an close eye on both of them. E7 was asked how many times R8 has smacked R5. E7 stated "I think a few times."

R8's incident report dated 12/13/25 documents "Resident observed slapping another resident in the dining room. When asked what happened resident stated, "I don't know why I did it." No other documentation into R8's abuse investigation was given to this surveyor during the course of the investigation.

R8's service plan does not document any behaviors, falls or interventions.

On 5/1/26 at 12:20 PM, E2. Health and Wellneess Director, was asked where R5 and R8's behaviors and the intervention to keep the two seperated are. E2 stated "It should be under the cognitive/Psychosocial section." With E2 present, R5 and R8's service plan was reviewed and they do not contain this information. E2 was asked why it's not on the service plan. E2 said "I know it's only happened 1 maybe 2 times. It might be in the progress notes."

On 5/1/26 at 1:25 PM, . E2 was aked where the new interventions are supposed to go. E2 stated

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"They go in the comments at the bottom of each section." E2 then stated "There may be interventions written on the back of the service plan." This surveyor asked where she got the copies she gave this surveyor and she said "It was from the original copy in her chart, but it may not have copied the writing on the back. I only copied one sided. I'll go check real quick." This surveyor told E2 "I'll go with you and check." This surveyor followed E2 to the physical hard chart in the nurse's office. The charts did not have the service plans. E2 stated "I think I left them in the other office when I made copies." This surveyor then followed E2 to another area of the building where the original service plans wera at. The service plan was reviewed front and back. R5 and R8's service plan do not have any hand written notes anywhere on the service plan outside of the copies given to the surveyor. E2 verified the service plans don't have anything written on them.

On 5/1/26 at 1:41pm E2 confirmed that R8 doesn't have any updates to address behaviors or interventions following R8's physical abuse on R5. E2 was asked where the interventions go when there's a fall or behavior. E2 stated "Service plan updates are in the comment section at the bottom of each section." E2 confirmed that R5, R6, R7 and R8 don't have any updates and stated "This is one of the things I'm trying to educate the nurse managers on. They have to update the comments section of the service plan."

3. R5 admitted to the facility on 8/16/23 with a diagnosis of dementia. R5's FAST Functional Assessment Staging of Alzheimer's Disease documents a score of 7 indicating severe cognitive decline/severe Dementia.

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A4010	Continued From page 16	A4010		

On 5/1/26 at 7:43 AM, E5 CNA, stated R5 likes to get close to resident due to anxiety and feels comfort when she holds onto them. E5 stated that R8 doesn't like it and gets irritated with R5 and smacks her and stated "We have to keep a close eye on them. (E5 pointed to the common area were R5 and R8 are sitting. R5 is sitting in a chair separated from R8.) We have to make sure (R5) doesn't get to close and try to hold (R8)."

On 5/1/26 at 7:46 AM, E6 Caregiver, stated that R8 does get irritated with R5 and smacks her, but R5 is the only one she does that with, so they have to make sure they stay separated. E6 was asked why. E6 stated "(R5) likes to get close and hold the other residents hand and (R8) doesn't like it, so she'll smack (R5). It's why we have to make sure the two stay seperated."

On 5/1/26 at 7:55 AM, E7 CNA, stated that R8 does hit R5 because R5 irritates R8. R5 likes to be close to the residents and can grab their arm or hand. When R5 does it to R8, R8 will smack R5, so they have to keep an close eye on both of them. E7 was asked how many times R8 has smacked R5. E7 stated "I think a few times."

R5's progress note dated 12/13/25 documents "Resident was slapped by another resident at the dining room table. No redness or injury noted at this time and resident denies pain or discomfort."

On 5/1/26 at 1:41pm E2 confirmed that R5 doesn't have any updates to address behaviors or interventions following R8's physical abuse on R5.

On 5/2/26, E9 Memory Care Manager, was asked about R5's behavior of holding other residents.

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A4010	Continued From page 17 E9 stated that R5 has anxiety it help her when she's close to or holding other resident. E9 was asked about the incident between R5 and R8 and what interventions the facility put in place to keep R5 safe. E9 stated "I told the staff they need to keep (R5) and (R8) seperated." E9 was asked where this information is at on the service plan. E9 stated "We put the updates in the comments section." E9 was given R5's service plan and asked where it says to keep R5 away from R8 or other residents. E9 looked at the R5's service plan and verified it's not in the service plan.	A4010		
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; Based on observation, interview and record review, the facility failed to prevent a resident (R5) from being physically abused by R8 and failed to implement any interventions to prevent further occurances from happening. This failure resulted in R5 being slapped be R8 and creates a	A6000		

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substantial probability of severe harm to a resident or residents.

Findings include:

R8 admitted to the facility on 7/30/25 and resides in the memory care unit. R8's FAST Functional Assessment Staging of Alzheimer's Disease documents a score of 7 indicating severe cognitive decline/severe Dementia.

R8's progress note dated 12/13/25 documents "Note Text: RA on duty reported to writer, that resident slapped another resident at the dining room table. Resident was immediately removed from the table. writer asked resident why she slapped the other resident she stated "I don"t know." Writer explained lo resident that it is inappropriate to slap any one resident. Resident just nodded her head. The psychiatric (Nurse Practitioner) was called and he gave new orders to increase the risperdal from 0.25mg BID to 0.5 mg BID and if she continues this behavior resident should be sent out for geriatric psych evaluation. POA was updated and agreed. HWC was Made aware also."

R8's progress note dated 2/6/26 documents "Note Text: (ADON aware, Psychiatrist aware) -1800 Observed resident leaving her room with a metal fork. neutral affect. Politely asked if she wanted me to put it away for her, and calmly reached for 1t. Resident stabbed the knife towards me and this writer had to quickly back up, very suddenly angry/agitated affect "I'm not going back to (MD)". Backed up and gave her more space, as she was walking towards me to get closer. Watched her from a distance to give some space. then at 1810 got assistance in taking the fork from her with another staff

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A6000	Continued From page 19	A6000		

member. She attempted to hit us with the fork but not in a stabbing motion this time. Fork taken successfully. Resident appears less agitated al 2035. Will continue to monitor."

On 5/1/26 at 7:43 AM, E5 CNA, stated R5 likes to get close to resident due to anxiety and feels comfort when she holds onto them. E5 stated that R8 doesn't like it and gets irritated with R5 and smacks her and stated "We have to keep a close eye on them. (E5 pointed to the common area were R5 and R8 are sitting. R5 is sitting in a chair separated from R8.) We have to make sure (R5) doesn't get to close and try to hold (R8)."

On 5/1/26 at 7:46 AM, E6 Caregiver, stated that R8 does get irritated with R5 and smacks her, but R5 is the only one she does that with, so they have to make sure they stay separated. E6 was asked why. E6 stated "(R5) likes to get close and hold the other residents hand and (R8) doesn't like it, so she'll smack (R5). It's why we have to make sure the two stay seperated."

On 5/1/26 at 7:55 AM, E7 CNA, stated that R8 does hit R5 because R5 irritates R8. R5 likes to be close to the residents and can grab their arm or hand. When R5 does it to R8, R8 will smack R5, so they have to keep an close eye on both of them. E7 was asked how many times R8 has smacked R5. E7 stated "I think a few times."

R8's incident report dated 12/13/25 documents "Resident observed slapping another resident in the dining room. When asked what happened resident stated, "I don't know why I did it." No other documentation into R8's abuse investigation was given to this surveyor during the course of the investigation.

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A6000	Continued From page 20 R5 and R8's service plan does not document any behaviors or interventions to keep the two seperated or how the facility will prevent further incidents of R8 physically abusing R5. On 5/1/26 at 12:20 PM, E2. Health and Wellneess Director, was asked where R5 and R8's behaviors and the intervention to keep the two seperated are. E2 stated "It should be under the cognitive/Psychosocial section." With E2 present, R5 and R8's service plan was reviewed and they do not contain this information. E2 was asked why it's not on the service plan. E2 said "I know it's only happened 1 maybe 2 times. It might be in the progress notes." On 5/1/26 at 1:25 PM, . E2 was aked where the new interventions are supposed to go. E2 stated "They go in the comments at the bottom of each section." E2 then stated "There may be interventions written on the back of the service plan." This surveyor asked where she got the copies she gave this surveyor and she said "It was from the original copy in her chart, but it may not have copied the writing on the back. I only copied one side. I'll go check real quick." This surveyor told E2 "I'll go with you and check." This surveyor followed E2 to the physical hard chart in the nurse's office. The charts did not have the service plans. E2 stated "I think I left them in the other office when I made copies." This surveyor then followed E2 to another area of the building where the original service plans wera at. The service plan was reviewed front and back. R5 and R8's service plan do not have any hand written notes anywhere on the service plan outside of the copies given to the surveyor. E2 verified the service plans don't have anything written on them.	A6000		

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A6000	Continued From page 21 On 5/1/26 at 1:41pm E2 confirmed that R5 and R8 don't have any updates to address behaviors or interventions following R8's physical abuse on R5 and stated "This is one of the things I'm trying to educate the nurse managers on. They have to update the comments section of the service plan."	A6000		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr This Regulation is not met as evidenced by: Type 1 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. 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.	A6010		

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A6010	Continued From page 22 b) A written report of the investigation conducted pursuant to subsection (a)(2) shall contain at least the following: 1) Dates, times, and description of the alleged abuse, neglect or financial exploitation; 2) Description of any injury to the resident; 3) Description of any change in the resident's physical, cognitive, functional, or emotional condition; 4) Any actions taken by the licensee; 5) A list of individuals and agencies interviewed or notified by the establishment; 6) Names of witnesses to the alleged abuse, neglect, or financial exploitation; and 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. c) Establishment employees and volunteers are obligated to report abuse, neglect, or financial exploitation of a resident to the establishment management and to the Department. Based on interview and record review, the facility failed to report an allegation of financial exploitatoin to IDPH and staff failed to notify the abuse coordinator of an allegation of abuse for one resident (R3). The facility also failed to report injuries of unkown origin to IDPH for one resident (R8) and failed to notify the IDPH of a resident to	A6010		

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resident abuse between R5 and R8. This failure hinders the stated ability to investigate an allegation of abuse and injury of unkown origin which can cause continued non-compliance and creates a substantial probability of severe harm to a resident or resident.

Findings include:

1. R3 admitted to the facility on 7/7/25 and is alert and oriented times 3 with mild forgetfullness.

On 5/1/26 at 9:38 am, E2, Health and Wellness Director, was asked for the facility reportables from 10/1/25-current. E2 was also told this surveyor would like to see the complete investigations for R3's allegation of theft. E2 was asked if she knew anything about $600 dollars missing from R3. E2 stated "I was told it was $250 and then later told a different amount. I talked to the family, and they said (R3) never had any money in his room. (R3) has changed the amount that's missing a couple times."

On 5/2/26 at 9:25 am upon reviewing the facility provided reportables from 10/1-5/1/26 There is no reportable for R3's allegation of theft. The requested documents also do not include an investigation or progress note of the incident. E2 was again asked for R3's reportable and investigation of his allegation of theft.

On 5/2/26 at 10:02 am, R3 stated that he had 2 wallets that went missing. One wallet had $167 and the other wallet had $200. He stated that he keeps the wallets on his chair next to the bed. One day he notice his wallet missing. He called his family and they had him call the bank immediately because he had credit cards in the wallet. He said the bank put a stop on his account

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and his family notified the police. He stated a week later, one of his wallets was found under his bed, but the money and one credit card was missing. R3 stated he notified E10, LPN of the missing wallets and she told him that he needed to report it to the administration. He stated he spoke to E2 about the missing wallet.

On 5/2/26 at 10:12 AM, E10, LPN stated that R3 told her that he had $600 dollars missing. E10 stated "I told (R3). "I'm just a nurse. You need to report that to E1, Executive Director and E2." (R3) told me he thinks it was the nurse with braids coming down, but I told him that he needs to let the admin know that because I don't know who that is. They go through so many people working here, it's hard to keep track of who is who. The turnover rate here is bad." " E10 was asked if she knew if R3 reported it to administration, if she had reported it to administration, or if she documented that R3 told her about the missing money. E10 stated that she did not report it to administration and said she assumes R3 did because E1 and E2 know about it.

On 5/2/26 at 10:30 AM, E2 handed this surveyor R3's missing money abuse investigation,, but did not have a reportable. When E2 handed this surveyor the investigation, E2 stated that she can not give this surveyor a copy of the investigation as it's an internal document and is not allowed to give a copy to IDPH. E2 was asked why the allegation of theft was not reported to IDPH, E2 did not answer and only shrugged. E2 stated R3's family notified the police and when they came out, they gave the police a copy of R3's contract that states the facility is not responsible for any lost or stolen items. E2 stated they told R3 and family that the signed contract states they are not

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A6010	Continued From page 25	A6010		

responsible for any lost or stolen items, and they encourage the residents to keep valuables in a lock box.

On 5/2/26 at 11:19 am, E2 was informed that R3 reported the missing money to E10, but E10 did not report it and instead told R3 to report it to administration. E2 confirmed E10 should have reported R3's allegation to administration.

On 5/2/26 at 12:40 PM, E2 was asked who the abuse coordinator is. E2 stated E1. E2 was asked why E1 did not report R3's allegation of missing money. E2 stated "I don't know."

2. R8 admitted to the facility on 7/30/25 and resides in the memory care unit. R8's FAST Functional Assessment Staging of Alzheimer's Disease documents a score of 7 indicating severe cognitive decline/severe Dementia.

R8's progress note dated 11/3/25 documents "Bruise noted on the side of resident's left eye. She says she thinks she hit it, but she is not a reliable informant. Resident denies pain, will continue to monitor."

R8's progress note dated 12/13/25 documents "Note Text: RA on duty reported to writer, that resident slapped another resident at the dining room table. Resident was immediately removed from the table. writer asked resident why she slapped the other resident she stated "I don"t know." Writer explained lo resident that it is inappropriate to slap anyone resident. Resident just nodded her head. The psychiatric (Nurse Practitioner) was called and he gave new orders to increase the risperdal from 0.25mg BID to 0.5 mg BID and if she continues this behavior resident should be sentout for geriatric psych

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	ASL510088	A. BUILDING: _____ B. WING _____	C 05/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ORLAND PARK	16051 S LAGRANGE RD ORLAND PARK, IL 60467

(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
A6010	Continued From page 26	A6010		

evaluation. POA was updated and agreed. HWC was Made aware also."

R8's progress note dated 2/6/26 documents "Note Text: (ADON aware, Psychiatrist aware) -1800 Observed resident leaving her room with a metal fork. neutral affect. Politely asked if she wanted me to put it away for her, and calmly reached for 1t. Resident stabbed the knife towards me and this writer had to quickly back up, very suddenly angry/agitated affect "I'm not going back to (MD)". Backed up and gave her more space, as she was walking towards me to get closer. Watched her from a distance to give some space. then at 1810 got assistance in taking the fork from her with another staff member. She attempted to hit us with the fork but not in a stabbing motion this time. Fork taken successfully. Resident appears less agitated al 2035. Will continue to monitor."

R8's progress noted dated 2/14/26, documents "CNA reported that resident has bruise to right buttock and right hand swollen. Hand not painful to touch not warm. Resident using the hand to pick up objects doesn't seem to be painful. The resident put on the list to see (MD) this week. Family and (MD) notified."

On 5/2/26 at 10:30 AM, E2 was asked why the incident of R8 slapping R5 on 12/13/25 was not reported, E2 stated "I gave it to you. It's in the pile of reportables." This surveyor went through the stack again with E2 present and there is no reportable for the resident-to-resident abuse. E2 stated "Oh, it must have been misplaced. I do the reportables by month. Let me have someone check the binder."

On 5/2/26 at 12:20 PM, E2 returned with a

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A6010	Continued From page 27 reportable sheet for R8's resident-to-resident abuse and verified she gave this surveyor all facility reportables from 10/1/25 to 5/1/26. R8's reportable does not document it was reported to IDPH. The facility reportables given to surveyor also do not contain a report or investigation for R8's injuries of unkown origin. During the course of the survey, the State Agency that recieves and tracks facility reported incidents, verified that the incident of R8 slapping R5 on 12/13/25 was not reported.	A6010		
A7000	Secton 295.7000 Resident Records This Regulation is not met as evidenced by: Violation Section 295.7000 Resident Records f) The following resident records and supporting documents shall be made available for on-site inspection by the Department upon request at any time: 1) Service delivery contracts and related documents executed by each resident or resident's representative, including, but not limited to, negotiated risk agreements; 2) Records supporting compliance with each individual contract and with this Part Based on interview and record review, the facility failed to provide complete medical records for one resident R4, out of eight residents reviewed during a complaint investigation.	A7000		

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A7000	Continued From page 28 Findings include: On 5/1/26, at 9:38 AM, E2, Health and Wellness Director, was asked for the facility reportables from 10/1/25 to 5/1/26, access to the resident's medical records, and R4's 10/8/25 incidnet investigation. E2 stated, "I don't know if I have R4's medical record. She's been discharged, so her medical records are in storage. I'll have to see if I can get access." E2 asked this surveyor what was needed from R4's medical record. E2 was informed that the surveyor needed, at a minum, R4's physician assessment, physician orders, cognitive evaluation, service plan, progress notes, fall risk assessment, establishment contract, orientation and any information pertaining to R4's reportable, injury and hospitalization. On 5/1/26 at 12:04, this surveyor received requested medical records for R1 and R2, but did not recieve medical record for R3-R8. This surveyor asked where the other resident's medical records were at. E2 stated "I have them here (Holding a stack of medical records). I'm making copies for you. The only one I don't have yet is (R4)." On 5/1/26, at 1:59 PM, E2 was asked if she was able to locate R4's medical record. E2 stated she is still looking for R4's medical record since they were put in storage when R4 discharged on 10/8/25. On 5/2/26 at 7:10 AM, E2 stated that she was unable to get R4's medical record because they're locked in E1's, Executive Director, office and she doesn't have access to the office. E2 stated E1 is on benefit time and is unavailable.	A7000		

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A7000	Continued From page 29 E2 was informed that if the facility is unable to produce resident records upon request during a complaint investigation, the facility would be in violation. E2 stated "Well, I can get you the progress notes and FAST (Functional Assessment Staging of Alzheimer's Disease) that's all I have access to." On 5/2/26 at 10:30 AM, E2 handed this surveyor resident documentation. Review of the documentation handed to this survey shows R4's progress notes and FAST assessment. No other documentation provided. E2 stated "That's all I can get for (R4)." On 5/2/26 at 12:00 PM, E2 stated "I might be able to get (R4's) service plan. I contacted IT to see if they can help me print it since she's discharged. We keep the service plans on a different system." On 5/2/26 at 12:20 PM, E2 handed this surveyor R4's service plan and stated "I was able to get the service plan, but what I gave you is all I have access to." On 5/2/26 at 12:30 PM, review of documentation of R4's medical records recieved by the facility include the progress notes, FAST assessment, service plan and 10/8/26 state reportable without investigation. This surveyor was not given any additional medical records for R4 during the course of the suvey.	A7000		