STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510088	A. BUILDING: _____ B. WING _____	C 05/09/2025

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
A 000	Initial Comment Complaint Investigation Survey#2594013/IL191877-substantiated	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 2 Violation Section 295.4010 Service Plan 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). This requirement was not met as evidenced by: Based on observation interview and record review the establishment failed to update and revise a resident's service plans after a fall incidents including a fall with injury. This applies to 1 of 3 residents (R2) reviewed for falls in the sample of 3. The findings include: 1. R2's electronic medical record (EMR) printed last 4/9/25 documents R2's move in date at the facility last 2/16/22 with diagnoses that include vascular dementia, anxiety and failure to thrive. The Facility Reported Incident (FRI) dated 4/30/25 time of incident as 6:30 AM, documents	A4010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510088	A. BUILDING: _____ B. WING _____	C 05/09/2025

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
A4010	Continued From page 1	A4010		

"[R2]was observed lying supine on the floor next to her bed with bleeding lacerations to the left eye. Resident unable to remember what happened. First Aide to left eye laceration completed, full body assessment completed, 911 was called and resident was transferred to hospital for evaluation. Diagnosis: Left eye laceration, left hip fracture."

R2's hospital record dated 5/1/25 documents: discharged diagnosis: closed left hip fracture, fall, head injury. Follow up appointment to the provider.

On 5/9/25 at 9:30 AM, R2 was in bed, with eyes open looking around. R2's left forehead was noted to have sutures. R2's daughter (Z2) at bedside. Z2 stated "mom fell and broke her left hip. She also hit the left side of her face. Mom did not undergo any surgery, the hospital doctor said she might not make it. She continues to be on Hospice, now on bedrest since the fall incident. We are just making her comfortable."

On 5/9/25 at 11:32 AM, E4 (License Practical Nurse-LPN) said she was R2's Nurse last 4/30/25. R2 was found on the floor in her room. R2's head was bleeding. R2 was sent out to the hospital via 911. While at the hospital, R2 was diagnosed to have a left hip fracture and laceration to left side of forehead. R2 came back to the facility last 5/1/25, already on hospice, comfort care, with sutures to left forehead. Family did not want any surgery to fix R2's left hip fracture.
E4 said R2 has a video surveillance in the room, the video recording last on 4/30/25 was reviewed-R2 got up from her bed, ambulated towards the bathroom, she lost balance and fell hitting the left side of her face.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510088	A. BUILDING: _____ B. WING _____	C 05/09/2025

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
A4010	Continued From page 2 On 5/9/25 at 12:45 PM, E6 (Certified Nursing Assistant-CNA) said she was R2's CNA last 4/30/25. Prior to R2's fall, E6 (CNA) said she checked on R2, opened R2's door, peeked on R2, R2 was in bed. Approximately 15 minutes later, she was told R2 fell and R2 was bleeding. R2 was sent out to the hospital. E6 said she was not sure if R2 was a fall risk resident. Review of R2's service plan dated 4/10/25 documents "most recent falls 3/23/25 and 3/24/25" R2's service plan did not include any fall interventions to the falls: on 3/23/25-R2 was climbing out of her broda chair, before a staff could reach the resident, she slid down the side of the broda chair down to the floor. Resident has a cut over her left eye. R2's service plan did not include any fall interventions on R2's fall dated 3/24/25-R2 fell in her room. Video surveillance show R2 was getting out of bed, R2 fell on her floor mat R2's service plan did not include the latest fall on 4/30/25 (fall with injury) when R2 sustained a left hip fracture and laceration to left eyebrow. The same service plan did not list any fall interventions to R2's latest fall. On 5/9/25 at 2:45 PM, E2 (Wellness Director) said the Service Plan should be updated and new fall interventions should be put into place to minimize falls. E1 (Executive Director) said it's been recognized that there was a lot to work on regarding residents Service Plans,. E1 said the Wellness Director (E2) and Wellness Consultant (E3) have	A4010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510088	A. BUILDING: _____ B. WING _____	C 05/09/2025

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
A4010	Continued From page 3 been working on reviewing and updating residents service plans,. The facility policy on Falls Management dated 1/2025 states f. Service Plan is reviewed for potential fall interventions and updated as necessary.	A4010		