STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL5105884	A. BUILDING: _____ B. WING _____	C 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MODENA GREEN OAKS	29330 NORTH WAUKEGAN ROAD GREEN OAKS, IL 60044

(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/ FRI INVESTIGATION 201696, 201596, 201230 295.6000 Resident Rights cited a)1)13)	A 000		
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: 1) The right to live in an environment that promotes and supports each resident's dignity, individuality, independence, self-determination, privacy, and choice and to be treated with consideration and respect. 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor. These requirements were not met: Based on observation, interview, and record review, the facility failed to protect a resident from abuse by an employee. This involves 1 of 3 residents reviewed (R1). This failure creates a substantial probability of severe harm to a resident or resident.	A6000		

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A6000	Continued From page 1 Findings include: R1 moved into the facility on 2/28/26 with following diagnoses Dementia, psychosis, Alzheimer's disease major depressive disorder, hypertension, diabetes mellitus, anxiety, asthma. Per incident accident reportable dated 4/10/26 it was brought to E1 (Executive Director) attention by family of R1. R1was handled inappropriately during care on 4/9/26 by E4 (Caregiver). Once this issue was brought to E1's attention E4 was placed on suspension (4/10/26) and investigation was started immediately. On 5/12/26 E1 (Executive director) noted that on 4/10/26 Z1 (wife) of R1 also his POA called and informed E1 that on 4/9/26 E4 was handling R1 during incontinent care inappropriately. Z1 told E1 while watching the video in R1's room she was alarmed how E4 was treating R1 during incontinence care. E4 found an irritated spot on R1's buttock and called the nurse into the room to check on it. Nurse proceeded to tell E4 to put barrier cream on the area. While E4 was applying the cream R1 was pushing E4's hand away from the sore area on the buttock, eventually E4 was redirecting R1 but with no success so he pushed him over almost on his stomach so he could complete the task. Z1 felt that R1 was handled roughly. Z1 forwarded the video of the incident to E1. E1 noted she watched the video and agreed with Z1 that E4 was inappropriate by pushing him over on his stomach while giving care. 5/13/26 Interviews from E5, E7 (caregivers) noted that they never had the opportunity to work with E4 because they worked days and E4 works PM shift.	A6000		

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A6000	Continued From page 2 5/13/26 10:30AM phone interview with E8 noted he worked with E4 on the PM shift. One-time E4 got frustrated with a resident R2 who wouldn't listen to him and when E8 entered the room to see what was going on, E4 stormed out, but returned in a few minutes after getting his composure. That was the only time he saw E4 get upset with a resident 5/13/26 E1 1:30PM (Executive Director) E2 (Assistant Director of Nursing) before 4/10/26 did not hear of any issues with E4. Once we received the video of R1 from his POA, E4 an investigation started immediately on E4, E1 and E2 started their investigation by interviewing staff in the Memory Care unit and conclusion was from the video obtained from Z1 that E4 was being rough with R1 during incontinence care. E1 explained that the facility does not accept this type of behavior towards residents. E4 was terminated from his job on 4/10/26. Policy Procedure for Abuse, Neglect, Exploitation: Policy: Resident abuse, neglect and exploitation are prohibited. Should any resident experience abuse (by staff, residents, family, or others) or when abuse is suspected, staff and volunteers are required to immediately provide notification to person/agencies as described in this policy. Staff will not be terminated nor reprimanded for reporting suspected or actual cases of resident abuse. The term abuse as used in this policy also includes, but in not limited to, neglect, abandonment, exploitation and any other form of abuse. Solera Employee Handbook. All employees are required to treat residents with the utmost care and respect. Aggressive or abusive behavior is strictly prohibited and grounds for immediate	A6000		

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A6000	Continued From page 3 termination.	A6000		