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 08/18/2025

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

(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 Original investigation of FRI IL 195747. Violation - 295.6000 a) 13)	A 000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: General 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 interviews, the establishment neglected to transfer one of three sampled residents in an appropriate manner resulting in a fall. The establishment also neglected to provide requested care to one of three sampled residents. (R1) Findings include: On 8/17/25 at 7:50 P.M., Z1 (R1's Son) stated that on the morning of 6/14/25, he received a call from staff saying R1 had fallen and they were	A6000		

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A6000	Continued From page 1	A6000		

going to send R1 to the hospital. Z1 told them he would come in and take R1 to the hospital if that was needed. Z1 stated that when he arrived, R1 was sore but not injured so he didn't go to the hospital. Z1 stated that R1 proceeded to tell him that at around 5:00 A.M., he had called for help to the bathroom. E4 (Caregiver) came into the room and ended up just yanking on R1's hand to get him out of bed. Z1 stated that R1 said that this cause him to fall to the ground. Z1 stated that E4 got R1 back into bed but R1 wanted to get up for the day. E4 told R1 that he can not get up at this time and would have to wait until 6:30 A.M. when the next shift came on. E4 told R1 not to press his call light again until 6:30 A.M.. R1 then pressed his call light at 6:25 A.M., and E4 came into R1's room and "scolded" R1, telling him not to press his light until after 6:30 A.M.. Z1 told a couple of the caregivers on day shift about the incident and they said that was typical behavior from E4. Z1 stated he informed facility management about this incident by email.

R1's current Service Plan notes that R1 is alert to person, place, and time.

On 8/17/25 at 11:10 A.M., R1 stated that on the morning in question (6/14/25) around 5:00 A.M., he had pressed his call light for assistance. E4 came in his room and ended up yanking on R1's hand to get him out of bed. R1 said that this caused R1 to fall to the floor. R1 said that E4 got him back in bed and then refused to help him get up for the morning. R1 said that E4 told him not to press his call button again until after 6:30 A.M.

On 8/17/25 at 10:45 A.M., E2 (Health and Wellness Director) stated that they were informed of E4's behavior through email from Z1. E2 stated that through their investigation, they determined

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A6000	Continued From page 2 that E4's behavior of pulling R1 up by the hand causing the fall and refusing to help R1 was inappropriate. E2 stated that E4's employment was terminated due to this. Facility's "Corrective Action" report dated 6/30/24 confirms that E4's employment was terminated due to "inappropriate behaviors towards residents" (R1).	A6000		