STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL5108201	A. BUILDING: _____ B. WING _____	C 05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOTUS SENIOR LIVING LLC	4601 WEST YORKHOUSE ROAD WADSWORTH, IL 60083

(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 Facility Reported Incident 5/10/2026 / IL201934 Violations: 295.6000a)13) 295.6010a)1)2)	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: 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; These requirements are not met as evidenced by: Based on interview and record review, the establishment failed to keep a resident free from abuse. This applies to 1 of 3 (R1) reviewed for abuse reporting in the sample of 3. This failure creates a substantial probability of severe harm to a resident or resident. Findings include:	A6000		

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A6000	Continued From page 1 On 5/26/2026 at 11:39AM, E3 (Certified Nursing Assistant - CNA) said on 5/19/2026 she went into [R2's] room to get [R1] for his shower. E3 said [R1] initially refused the shower and [R2] tried to intervene and grabbed [R1's] wrist. E3 said she wouldn't say [R2] grabbed [R1] hard, but it was a grip and couldn't pull away. E3 said she could tell [R1] doesn't like being grabbed. E3 said she reported the event to E4 (Unit Manager). On 5/26/2026 at 1:59PM, E5 (Licensed Practical Nurse - LPN) said a CNA reported [R2] was yelling and [R1] was in his room slamming doors. E5 said she reported it to [E2 - Wellness Director] and [E2] instructed her to put a note in the computer. E5's Progress Note for R1 from 5/17/2026 at 11:12AM, states [E6 - Caregiver] reported to her that [R2] was yelling through the monitor telling [R1] to lay down. [R1] was getting upset and was slamming doors. [E6] states that it's harder to handle [R1] when [R2] yells at him. . . On 5/26/2026 at 11:26AM, E10 (LPN) said she was called to the memory care unit because [R2] want [R1] to go to bed. E10 said she saw [R1] and he didn't want to go to bed. E10 said she called [Z2 - R1's Sister] and [Z2] stated [R1] needed to go to bed. E10 said she and [R1] tried for 30 minutes to get [R1] to bed. E10 said [R2] was giving [R1] instructions that night and was speaking loudly. E10 said [R1] still refused to get ready for bed. E10 a resident can be asked but their answer is honored. E10 said the way we are taught, the residents still have rights, and we don't force residents to do anything. E10 said that is not how residents talk to other residents.	A6000		

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A6000	Continued From page 2 E10's Progress Note for R1 from 5/20/2026 at 11:01PM, writer was called to memory care in regards to [R1] not wanting to go to bed and [R2] stating [R1] needs to go to bed. . . states [E2] was notified of the situation. . . On 5/26/2026 at 11:02AM, E2 said residents should communicate respectfully, there shouldn't be verbal aggression or agitation just respectful communication with each other. E2 said residents shouldn't be putting their hands on each other. The establishment provided Abuse, Neglect, and Exploitation policy dated 6/1/2025 states, . . . Resident abuse, neglect, and exploitation are prohibited . . .	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	A6010		

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A6010	Continued From page 3 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. These requirements are not met as evidenced by: Based on interview and record review, the establishment failed to report abuse to the Department within 24 hours after the report was made. This applies to 1 of 3 (R1) reviewed for abuse reporting in the sample of 3. This failure creates a substantial probability of severe harm to a resident or resident. Findings include: On 5/26/2026 at 11:39AM, E3 (Certified Nursing Assistant - CNA) said on 5/19/2026 she went into [R2's] room to get [R1] for his shower. E3 said [R1] initially refused the shower and [R2] tried to intervene and grabbed [R1's] wrist. E3 said she wouldn't say [R2] grabbed [R1] hard, but it was a grip and couldn't pull away. E3 said she could tell [R1] doesn't like being grabbed. E3 said she reported the event to E4 (Unit Manager). On 5/26/2026 at 1:59PM, E5 (Licensed Practical Nurse - LPN) said a CNA reported [R2] was yelling and [R1] was in his room slamming doors. E5 said she reported it to [E2 - Wellness Director] and [E2] instructed her to put a note in the computer. E5's Progress Note for R1 from 5/17/2026 at	A6010		

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A6010	Continued From page 4	A6010		

11:12AM, states [E6 - Caregiver] reported to her that [R2] was yelling through the monitor telling [R1] to lay down. [R1] was getting upset and was slamming doors. [E6] states that it's harder to handle [R1] when [R2] yells at him.

On 5/26/2026 at 11:26AM, E10 (LPN) said she was called to the memory care unit because [R2] want [R1] to go to bed. E10 said she saw [R1] and he didn't want to go to bed. E10 said she called [Z2 - R1's Sister] and [Z2] stated [R1] needed to go to bed. E10 said she and [R1] tried for 30 minutes to get [R1] to bed. E10 said [R2] was giving [R1] instructions that night and was speaking loudly. E10 said [R1] still refused to get ready for bed.

E10's Progress Note for R1 from 5/20/2026 at 11:01PM, writer was called to memory care in regards to [R1] not wanting to go to bed and [R2] stating [R1] needs to go to bed. . . states [E2] was notified of the situation. . .
On 5/26/2026 at 11:02AM, E2 said staff should report allegations of abuse immediately to herself and [E1]. E2 said an investigation should be started and [the Department] should be notified.

The establishment failed to provide documentation the Department was notified, or an investigation was completed on 5/17/2026, 5/19/2026, and 5/20/2026.

The establishment provided Abuse, Neglect, and Exploitation policy dated 6/1/2025 states, . . . reporting of any suspected, alleged, or witnessed abuse will be completed according to state reporting requirements . . .