STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510128	A. BUILDING: _____ B. WING _____	07/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGES OF NEW LENOX, COTTAGE #5	1031 S CEDAR RD NEW LENOX, IL 60451

(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 Annual Licensure Survey 295.2050 Incident and Accident Reporting a) b) 295.4010 Service Plan d)	A 000		
A2050	Section 295.2050 Incident and Accident Reporting This Regulation is not met as evidenced by: Type 2 Violation 295.2050 Incident and Accident Reporting a) b) a) An establishment shall report to the Department any serious incident or accident. For the purposes of this Section, "serious" means any incident or accident that causes physical or emotional harm or injury to a resident. A change in an individual's (resident's) condition that is due to health or medical decline is not a reportable incident or accident. b) The report shall be made by contacting the Department of Public Health Division of Assisted Living via email at DPH.LTCAL@illinois.gov or as requested by the Department within 24 hours after the occurrence of the incident or accident. This requirement was not met as evidenced by: Based on document review and interview, the establishment failed to ensure incidents resulting in injury were reported to the Illinois Department of Public Health (IDPH). This was found in 2 of 3 (R1 and R2) resident records reviewed, and this failure creates a substantial probability of harm to residents.	A2050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510128	A. BUILDING: _____ B. WING _____	07/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGES OF NEW LENOX, COTTAGE #5	1031 S CEDAR RD NEW LENOX, IL 60451

(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
A2050	Continued From page 1 Findings include: R1 is a 74-year-old that moved into the establishment on 1/19/26 and resides in memory care. R1's health record was reviewed on 7/29/26 at 7:45 AM. Diagnoses include but not limited to Progressive Supranuclear Palsy, Shuffling Gait/Imbalance, Urinary Frequency, and Frequent Falls. The Internal incident report dated 2/4/26 (2:57 PM) contained; on 2/4/26 at 2:18 PM, staff found R1 on the bathroom floor. When questioned R1 stated, while attempting to use the bathroom R1 "fell forward and hit his head on the corner of the wall in his bathroom. Upon evaluation, his nurse notes a round, hard lump to the posterior left of his head. Resident states that pain is localized to the area and rates it a 5/10." (0 equal no pain to 10 that equal severe pain). R1 was transported to the hospital. This incident was not reported to IDPH. R3 is an 88-year-old that moved into the establishment on 10/28/25 and resides in memory care. R2's health record was reviewed on 7/29/26 at 12:30 PM. Diagnoses include but not limited to Dementia, Peripheral Vascular Disease, Glaucoma, and Prostate Cancer. The establishment's internal incident report dated 5/29/26 (9:45 AM) contained R1 reported to staff, "I fell backwards and hit the back of my head and hurt my left ankle". The nurse observed a "large bump to posterior head, and flinching when left ankle assessed". Emergency Medical Services was called and R1 was transported to the hospital. This incident was not reported to IDPH. During an interview with E1 (Executive Director) and E3 (Licensed Nurse/ Nursing Supervisor) on	A2050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510128	A. BUILDING: _____ B. WING _____	07/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGES OF NEW LENOX, COTTAGE #5	1031 S CEDAR RD NEW LENOX, IL 60451

(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
A2050	Continued From page 2 7/30/26 from 11:45 AM to 12:59 PM, the above findings were reviewed and confirmed. During the same interview this writer asked E1 (Executive Director) and E3 (Licensed Nurse/ Nursing Supervisor) whether the incidents indicated above were reported to IDPH, if so to please provide the reports. As of 7/30/26, the establishment failed to provide any documentation that the incidents indicated above, involving R1 and R2, were reported to IDPH.	A2050		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 2 Violation 295.4010 Service Plan d) 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) This requirement was not met as evidenced by: Based on document review and interview, the establishment failed to ensure the service plans were effectively revised to prevent falls and/or injury. This was found in 2 of 3 (R1 and R2) resident records reviewed, and this failure creates a substantial probability of harm to residents. Findings include:	A4010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510128	A. BUILDING: _____ B. WING _____	07/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGES OF NEW LENOX, COTTAGE #5	1031 S CEDAR RD NEW LENOX, IL 60451

(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 R1 is a 74-year-old that moved into the establishment on 1/19/26 and resides in memory care. R1's health record was reviewed on 7/29/26 at 7:45 AM. Diagnoses include but not limited to Progressive Supranuclear Palsy, Shuffling Gait/Imbalance, Urinary Frequency, and Frequent Falls. R1's record contained nursing notes that either R1 fell or was found on the floor with or without injuries. On 12/8/25 (swelling to right head and elbow), 1/28/26, 2/4/26 (injury of "a round, hard lump to the head", complaints of pain, and transported to the hospital), 2/9/25, 2/10/26, 2/14/26 (lacerations to forehead and nose, sent to hospital, diagnosis of a fractured nose with sutures to nose, and glue to forehead laceration), 2/24/26, 4/17/26, twice on 4/17/26 (6:39 PM and 10:22 PM), 4/29/26, 5/22/26 (laceration to right upper lip), 5/29/26 (struck head, taken to hospital), and 7/4/26. R1's service plan dated 7/8/26 included R1 has a fair attention span, require the assistance of 1 person for transfers and mobility, with staff to provide most or all effort for pivoting and sit-to-stand efforts. R1 was identified as having a risk for with fall precautions with interventions for staff to: Offer routine toileting, observe for side-effects of medications, reinforce limitations, remind frequently to ask for help and how to ask for help, involve in activities or put favorite show/movie on the television, ensure fall mat is in place and hospital bed in lowest position, ensure R1 is comfortable and transfer to a recliner or dining chair if not comfortable in a wheelchair, monitor more closely due to "increased impulsivity", perform status checks four (4) times per shift with frequent safety checks during each shift. Morning safety checks included R1 is appropriately dressed, wear appropriate non-skid	A4010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510128	A. BUILDING: _____ B. WING _____	07/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGES OF NEW LENOX, COTTAGE #5	1031 S CEDAR RD NEW LENOX, IL 60451

(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 4	A4010		

shoes, personal hygiene is done, toileting is completed, nutrition and hydration are promoted, activities encouraged throughout the day, room is clean and free of clutter, and blinds are open. Night safety checks included R1 is comfortable in bed, appropriate night clothes on, blinds closed, bed in lowest position, room properly lit, personal items and call pendant within reach. As of 7/29/26, R1's service plan lacked effective interventions to prevent falls and ensure R1 is safe from injuring self.

R2 is an 88-year-old that moved into the establishment on 10/28/25 and resides in memory care. R2's health record was reviewed on 7/29/26 at 12:30 PM. Diagnoses include but not limited to Dementia, Peripheral Vascular Disease, Glaucoma, and Prostate Cancer. R2's record contained nursing notes that either R2 fell or was found on the floor with or without injuries: On 12/8/25 (swelling to right head and elbow), 2/19/26 (hit head during the fall), 4/3/26, 5/29/26 (head injury large bump to posterior head and complaints of left ankle pain), 6/2/26 (R2 reported continued pain in left leg, left arm and stomach that started after fall on 5/29/26 with old bruising). 6/22/26 (hit right side of head and knee). On 6/22/26, R2 was admitted to a hospital for "evaluation and management of possible T7 and T8 compression fractures", R2 now require a two-person assist with all activities of daily living. As of 7/3/26, R2 remains in an inpatient rehabilitation facility with no plans for discharge at present.

R2's service plan dated 6/3/26 contained documentation that R2 required stand-by assistance with all transfers, use a walker for all mobility needs, staff to ensure R2 wear non-skid shoes while ambulating and assistive device is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510128	A. BUILDING: _____ B. WING _____	07/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGES OF NEW LENOX, COTTAGE #5	1031 S CEDAR RD NEW LENOX, IL 60451

(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 5 utilized properly at all times. R2 educated on using the call pendant, R2 was transferred from Cottage 2 (assisted living) to Cottage 5 (memory care) on 6/3/26 for closer supervision and assistance. Yet, R2 continued to fall with the last fall resulting in injury and an undetermined inpatient stay. R2's service plan lacked effective interventions to prevent falls and injury. During an interview with E1 (Executive Director) and E3 (Licensed Nurse/ Nursing Supervisor) on 7/30/26 from 11:45 AM to 12:59 PM, the above findings were reviewed and confirmed.	A4010		