STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510244	A. BUILDING: _____ B. WING _____	C 06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY CIRCLE	3659 WEST 99TH STREET CHICAGO, IL 60655

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A 000	Initial Comment Complaint Investigation IL202307 295.6000 a)13) 295.6010 a) 1) c)	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 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; This requirement was NOT MET as evidenced by: Based on observation, record review and interview, there is reasonably suspicion to conclude that the establishment failed to ensure a resident was free of being a victim of physical abuse. This involves 1 of 3 residents reviewed (R1). This failure creates a substantial probability of severe harm to a resident or residents. Findings Include: R1 is a 65 year old resident who has diagnoses including anxiety disorder, multi system	A6000		

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A6000	Continued From page 1	A6000		

degeneration of the autonomic nervous system and spasmodic torticollis. R1 is assessed to be oriented to person, time and place.

On 6/29/26 at approximately 3:30pm, R1 was observed in her room, seated in a recliner. R1 appeared very frail but was alert and oriented to person, time and place. R1 said she remembered the incident of the CNA (E1) slapping her one buttock. R1 said this happened early morning and during care and that E1 is no longer caring for her. R1 couldn't explain why she didn't want E7 (Nurse) to tell someone about this incident.

The initial abuse allegation report dated 6/6/26 shows the following:
On 6/6/26 at 10:15am, Z1 (POA/power of attorney) requested to speak with a staff nurse and reported the alleged abuse incident. R1 alleges on Thursday night (6/4/26) that night staff E1 CNA (certified nurse aide) rendered perineal care and slapped R1's butt. Investigation initiated. E1 (CNA) was identified and was suspended. Head to toe assessment completed by floor nurse (E4). No injury reported.

On 6/6/26 E4 notified E2 (Executive Director) of the allegation of abuse. E4 conducted a head to toe assessment. No injuries noted.

During the investigation it was learned that R1 relayed that she reported the incident to E7 (RN) on Friday June 5th but instructed her "not to say anything. "During interview on 6/6/26 E7 confirmed receiving report from R1 that E1 slapped her buttocks. R1 asked E7 not to say anything to anyone.

On 6/29/26 at 3:17pm via telephone E7 (RN) stated, "I work 2 to 10:30 shift. We were just

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A6000	Continued From page 2 chatting then R1 asked who's on tonight? And that's when R1 started about the E1 CNA and then R1 said E1 slapped her. I asked R1 where. R1 said , her bottom. R1 is pretty alert for the most part. I think I said something like did she want me to say something. R1 said don't say anything. I'm not sure if she was afraid (of retaliation). R1 didn't seem upset when she told me. R1 said I hope she doesn't do it again."	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 a) 1) c) 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 months after the date of the report. c) Establishment employees and volunteers are obligated to report abuse, neglect, or financial exploitation of a resident to the establishment management and to the Department.	A6010		

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A6010	Continued From page 3	A6010		

This requirement was not met as evidenced by:

Based on observation, record review and interviews, establishment staff failed to report an allegation of physical abuse to management staff and did not follow the establishment's abuse policy and procedure for reporting allegations of abuse. The allegation was not made known to the establishment until over 24 hours later.
This was found in 1 of 3 residents reviewed (R1).

This failure creates a substantial probability of severe harm to a resident or residents.

Findings include:

R1 is a 65 year old resident who has diagnoses including anxiety disorder, multi system degeneration of the autonomic nervous system and spasmodic torticollis. R1 is assessed to be oriented to person, time and place.

The initial abuse allegation report dated 6/6/26 shows the following:
On 6/6/26 at 10:15am, Z1 (POA/power of attorney) requested to speak with a staff nurse and reported the alleged abuse incident. R1 alleges on Thursday night (6/4/26) that night staff E1 CNA (certified nurse aide) rendered perineal care and slapped R1's butt. Investigation initiated. E1 (CNA) was identified and was suspended. Head to toe assessment completed by floor nurse (E4). No injury reported.

The written statement submitted from E8 (CNA) shows that on 6/6/26, E8 was in R1's bedroom making the bed. Z1 (POA/power of attorney) came up to E8 and told E8 about the situation R1

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A6010	Continued From page 4	A6010		

described to her. Z1 asked E8 how to call someone. E8 used her work phone to call the assisted living nurse (E4, LPN) who was on shift.

On 6/6/26 E4 notified E2 (executive director) of the allegation of abuse. E4 conducted a head to toe assessment. No injuries noted.

During the investigation it was learned that R1 relayed that she reported the incident to E7 (RN) on Friday June 5th but instructed her "not to say anything. "During interview on 6/6/26 E7 confirmed receiving report from R1 that E1 slapped her buttocks. R1 asked E7 not to say anything to anyone.

On 6/29/26 at 3:17pm via telephone E7 (RN) stated, "I work 2 to 10:30 shift. We were just chatting then R1 asked who's on tonight? And that's when R1 started about the E1 CNA and then R1 said E1 slapped her. I asked R1 where. R1 said , her bottom. R1 is pretty alert for the most part. I think I said something like did she want me to say something. R1 said don't say anything. I'm not sure if she was afraid (of retaliation). R1 didn't seem upset when she told me. R1 said I hope she doesn't do it again."

On 6/29/26 at approximately 3:30pm, R1 was observed in her room, seated in a recliner. R1 appeared very frail but was alert and oriented to person, time and place. R1 said she remembered the incident of the CNA (E1) slapping her one buttock. R1 said this happened early morning and during care and that E1 is no longer caring for her. R1 couldn't explain why she didn't want E7 to tell someone about this incident.

The establishment's Abuse, Neglect and/or Misappropriation of Resident Funds or Property

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A6010	Continued From page 5 and Exploitation Prohibition policy and procedure shows the following: E. Reporting Response Allegations, suspicion and substantiated findings of abuse, neglect or misappropriation of resident funds/property will be reported according to the State specific guidelines for reporting. 1. Reporting Timing: Staff will report incidents and /or alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property immediately to the Administrator/designee.	A6010		