STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510081	A. BUILDING: _____ B. WING _____	C 08/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HOFFMAN ESTATES	1515 BARRINGTON RD HOFFMAN ESTATES, IL 60169

(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 Investigation of Facility Reported Incident of 7/20/2025/IL196528 Section 295.2050 Incident and Accident Reporting	A 000		
A2050	Section 295.2050 Incident and Accident Reporting This Regulation is not met as evidenced by: Type 3 Violation Section 295.2050 Incident and Accident Reporting 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. c) A copy of the report shall be maintained by the establishment for one year after the date of the incident or accident.	A2050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510081	A. BUILDING: _____ B. WING _____	C 08/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HOFFMAN ESTATES	1515 BARRINGTON RD HOFFMAN ESTATES, IL 60169

(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 These requirements are not met as evidenced by: Based on observation, interview, and record review the facility failed to report a resident fall with injury and failed to report the incident within 24 hours for 1 of 3 residents (R1) reviewed for falls in the sample of 3. Findings include: R1 's Incident Report, date of occurrence 7/20/2025, was reported to the state surveying agency on 7/23/2025 at 10:14 AM. The report showed, as a result of the fall, R1 was sent to the emergency room and was admitted with diagnosis of old odontoid fracture and weakness. On 8/15/2025 at 10:54 AM, E1 stated E1 is off on weekends. The facility does not have nursing coverage for Assisted Living residents after 5 pm weekdays or on the weekends and that the reason the incident was not reported within the required time frame was because for every reportable incident, the corporate consultant has to approve the report to be sent. For this incident, the corporate consultant did not give approval to send report to the state surveying agency until July 23, 2025, 72 hours after the incident. E1 presented an email affirming that E1 had sent the report for approval to the corporate consultant on 7/21/2025 and was not approved until 7/23/2025. R2's Incident Report, date of occurrence 7/12/2025, was reported to the state surveying agency on 7/17/2025 at 11:22 AM. The report documents that R2 attempted to go to the bathroom unassisted and was found on the floor. R2 was sent to the emergency room on	A2050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510081	A. BUILDING: _____ B. WING _____	C 08/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HOFFMAN ESTATES	1515 BARRINGTON RD HOFFMAN ESTATES, IL 60169

(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 7/12/2025 returned to the establishment. E1 stated that E1 was on vacation at that time and E2, Independent Living Health and Wellness Coordinator, was covering for her, was the one who sent the report. R3's Incident Report, date of occurrence, 5/26/2025, was reported to the state surveying agency on 5/28/2025 at 11:10 AM. The report documents that R3 slipped and fell while trying to get some water to drink and was observed wearing socks without non skid shoes. R3 was sent to the hospital and sustained right femur fracture.	A2050		