STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510189	A. BUILDING: _____ B. WING _____	C 09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARVESTER PLACE	150 SOUTH FRONTAGE ROAD BURR RIDGE, IL 60527

(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 IL196560. VIOLATION - 295.6000 a) 13)	A 000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 2 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; Based on record review and interviews, the establishment failed to prevent the theft of narcotic medications for one (R1) of three sampled residents. This failure creates a substantial probability of harm to a resident or residents. Findings include: According to the pharmacy packing slip form and pharmacy prescription summary, R1 had two 30 tablet packets (total of 60 tablets) of Hydrocodone / Apap 5 - 325 mg delivered on 7/10/25 for an order to take one tablet twice daily as needed for pain.	A6000		

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A6000	Continued From page 1 On 9/7/25 at 11:15 A.M., E1 (Executive Director) stated that on 7/15/25 it was brought to E1's and E2's (Clinical Services Director) attention that there was a discrepancy with R1's narcotic count. Through their investigation, they noticed that on 7/14/25, E3 (LPN) had hand written a new controlled drug receipt / record / disposition form for R1 that noted only 28 Hydrocodone / Apap 5 - 325 mg tablets. When E3 was questioned about the reason, E3 said that on the morning of 7/14/25 she accidentally tore the original form so she hand wrote a new one. E1 stated that E1 and E2 went through the shredder and found the original form, pieced it back together and it noted there was actually 58 total tablets not 28. So a full sheet of 30 Hydrocodone / Apap 5 - 325 mg tablets were missing and E3 had falsified a legal document. E3 denied taking any medications, but when interviewing the E4 (LPN) that worked the night shift just prior to E3 working on 7/14/25, E4 stated there were two sheets totaling 58 tablets. E1 stated that even though they know R1's sheet of 30 Hydrocodone / Apap 5 - 325 mg tablets were taken, they did not actually catch E3 in the act. So they cannot say 100% that E3 was the one that stole the medications. E1 stated that they did terminate E3's employment for falsifying legal documents. E1 stated that they notified the local police about the incident but no arrests were made. On 9/8/25 at 10:20 A.M., E2 confirmed that she assisted in the investigation into R1's missing sheet of 30 tablets of Hydrocodone / Apap 5 -325 mg. E2 stated that after their investigation and interviewing all the nurses that were responsible for the narcotics at the time in question, it was determined that E3 was the one last one to handle the medications when they went missing,	A6000		

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A6000	Continued From page 2 was the one who tore up the original form that noted a total of two sheets (58 tablets), and was the one who falsified R1's legal document by falsely noting a total of only 28 tablets. E3 would not respond to phone calls for interview. E3's Community Personnel Action Form confirms that E3's employment was terminated on 7/18/25.	A6000		