STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5108250	A. BUILDING: _____ B. WING _____	C 08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE OAK PARK	703 MADISON STREET OAK PARK, IL 60302

(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 Complaint Investigation: IL197049/2587869 Violations: 295.3000a) 295.4010d) 295.6000a)1)6)2)1)3) 295.6010a)1)	A 000		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: GENERAL VIOLATION Section 295.3000 Personnel Requirements, Qualifications and Training a) The establishment shall have staff sufficient in number with qualifications, adequate skills, education and experience to meet the 24 hour scheduled and unscheduled needs of residents and who participate in ongoing training to serve the resident population. (Section 35(a)(3) of the Act) This requirement is not met as evidenced by: Based on interview and record review, the establishment failed to ensure employees uphold their Standards of Conduct found in their Employee Handbook affecting one (R2) of two resident reviewed for this requirement. Findings include: According to R2's Face sheet, R2 is 95 years old	A3000		

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A3000	Continued From page 1	A3000		

resident of the Memory care unit since 5/22/23. R2's diagnoses include but not limited to Unspecified Dementia without behavioral disturbance, Essential Hypertension.

R2's Illinois Health and Service Evaluation dated 7/29/25 documented R2 has Severe impairment on short term memory and moderate impairment for long term memory, unable or communicate or receive information; unable to follow instructions.

On 8/21/25 at 10:19am and at 3:53pm, R2 was observed in the activity room, asleep with walker nearby her. According to multiple staff, R2 is non-interviewable due to poor cognitive function.

On 8/21/25 at 11:27am, Z1 (Agency Nurse) said, she was called by staff to help with R2. R2 was on the floor. Z1 indicated, the staff woke up R2 so they can change her incontinence pad. R2 refused to get up, as it was 2am in the morning. Z1's notes dated 8/19/25 indicated, "The CNA explained that they had attempted to change the resident incontinence brief, but she refused and subsequently sat down on the floor." Z1 said, E6 (Certified Nursing Assistant) called her up because E5 (Resident Assistant) refused to help her get R2 off the floor. Z1 indicated that there was an issue between the two staff during R2's care. "The reason why (R2) sat on the floor was because (E6) was being mean and being impatient with (R2). When she sat on the floor, (E5) refused to help change her and get (R2) off the floor. So, (E6) called me up to come upstairs to help, because (E5) was not helping her. (E5) came downstairs and explained what was going on , (E6) was calling her the B word. And when I asked (E6) , she said, she has been the one changing everybody, and (E5) was not helping ..."

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A3000	Continued From page 2 On 8/21/25 at 1:10pm, E4 (Business Office Manager) said, E5 and E6 were arguing in front of the residents, that was why both staff were suspended. On 8/22/25 at 11:39am, E6 said, she wanted to change R2 on the bed, as R2 was sleeping and it was around 1:00am, and they had to wake up R2. E5 wanted to walk R2 to the bathroom. E6 also said, E5 wanted to "double diaper" R2. According to "Employee Handbook" dated January 2024 stated in part; Standards of Conduct As a company that operates with core values of Respect, Integrity, Teamwork and Excellence ... Upholding these values is not just an expectation; its collective commitment from every employee ...It's the expectation of the Company that all employees bear the responsibility of contributing to a positive, safe and productive work environment ...	A3000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: General Violation Section 295.4010 Service Plan d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change,	A4010		

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A4010	Continued From page 3	A4010		

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 is not met as evidenced by:

Based on interview and record review, the establishment failed to follow service plan intervention for one (R1) resident resistive to care, resulting to R1's combative behavior towards staff. This deficient practice affected one of two residents reviewed for service plan and has the probability to affect all residents.

Findings include:

R1 is 59 years old, a resident of the Memory care unit. R1 moved to the community on 7/31/24.
R1's diagnoses include but not limited to Dementia, and Essential Hypertension.
On 8/21/25 at 10:22am, R1 was observed walking without any mobility devices in the hallway. Upon approach, R1 appeared to have well-kept appearance, alert, oriented x1, surveyor asked how he was, R1 mumbled some words, talking non sensical. E3 (Memory Care Director) joined surveyor and R1 in the hallway. E3 confirmed R1 is oriented x1.
R1's Illinois Health and Service Evaluation dated 5/8/25 documented R1 has Severe impairment on short and long term memory, unable or communicate or receive information; unable to follow instructions.

Staffing schedule indicated, E5 (Resident Assistant), E6 (Certified Nursing Assistant-CNA), E7 (CNA) and Z1 (Agency Nurse) were on duty on August 19,2025 night shift (10:30pm-6:30am). This particular incident (per R1's incident detail) occurred approximately around 1:00am.

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A4010	Continued From page 4 On 8/21/25 at 1:58pm, E5 (Resident Assistant) said on 8/19/25 she was working with E6 (CNA), completing rounds for incontinence care. E5 described R1 as some who have "a lot of anxiety". E6 said, they will do "soilers" first because E6 wanted to take a nap. E5 said, they worked together until they reached R1's room, R1 was in a recliner, R1 refused to be changed, at first both staff tried to take off R1's pants but R1 was pulling it up. Both staff attempted to remove R1's pants, R1 continued to resist until R1 became aggravated. E5 said, she told E6 they need to leave and come back later but E6 refused and persisted until R1 became combative. R1 swung at staff. E5 said, "With full force, she tried to push or shove (I don't know the difference) putting hands on him, she pushed him onto the bed, he got up from the bed, and it was back and forth, by the 3rd time, that was when they started with the fist .... He had his closed fist and then he went to go hit her, she has like a half fist, she ended up hitting him on the chest area not full force, he ended making a fist. She ended up telling him on his face, he was in her face, "get the f..k out, fu ....g b ...h". She pointed, "that's why you piss on yourself, you grown ass man and you piss on yourself". They were shoving each other." On 8/22/25 at 11:39am, E6 (CNA) said R1 was on the chair, E5 woke him up. E5 said, (R1) we are going to change you, he stood up, E5 immediately snapped his pants off." E6 said, E5 did not approached R1 gently. E6 said, she gave R1 cookies, E5 took away the cookies from R1, R1 swung at E5, "He tried to hit (E5), (E5) said, "I don't wanna do this, I did not sign up for this, so I said, "we are going to come back to him", and that was what we did."	A4010		

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A4010	Continued From page 5 On 8/21/25 at 12:31pm, E3 (Memory Care Director) was asked, are you supposed to grab or push a resident? E3 said, "No, he needed assistance to be changed, his way of refusing was more like he is pushing or pulling back his pant. " E3 said, "I expected them to give them, to have time for themselves, stay away. Did the staff follow this expectation? "To my understanding no, it was not done". On 8/21/25 at 10:22am, E8 (CNA) said, R1 resist care, and when resisting, back off and go back later. If still resisting, report to the nurse. R1's Service Plan with activation date of 5/10/25 indicated; 01.Diagnoses *Dementia- increased problems communicating or finding words, increased anxiety, agitation, and irritability. 05.Psychosocial. Staff to step back and move away from resident ensuring resident safety first giving him a few minutes and re-approach in a gentle kind manner. Current behavior type-occasional infrequent aggression towards staff during ADL care.	A4010		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: GENERAL 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	A6000		

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A6000	Continued From page 6 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: 1) The right to live in an environment that promotes and supports each resident's dignity, individuality, independence, self-determination, privacy, and choice and to be treated with consideration and respect; 2) The right to respect for bodily privacy and dignity at all times, especially during care and treatment; 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 ensure a resident was free from abuse and follow their Abuse Police and procedure, affecting one (R1) of two residents reviewed for abuse and has the probability to affect all residents. Findings include: An onsite visit was conducted on 8/21/25. R1 is 59 years old, a resident of the Memory care unit. R1 moved to the community on 7/31/24. R1's diagnoses include but not limited to Dementia, and Essential Hypertension. On 8/21/25 at 10:22am, R1 was observed walking without any mobility devices in the hallway. Upon approach, R1 appeared to have	A6000		

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A6000	Continued From page 7	A6000		

well-kept appearance, alert, oriented x1, surveyor asked how he was, R1 mumbled some words, talking non sensical. E3 (Memory Care Director) joined surveyor and R1 in the hallway. E3 confirmed R1 is oriented x1.

R1's Illinois Health and Service Evaluation dated 5/8/25 documented R1 has Severe impairment on short and long term memory, unable or communicate or receive information; unable to follow instructions.

Staffing schedule indicated, E5 (Resident Assistant), E6 (Certified Nursing Assistant-CNA), E7 (CNA) and Z1 (Agency Nurse) were on duty on August 19,2025 night shift (10:30pm-6:30am). This particular incident (per R1's incident detail) occurred approximately around 1:00am.

On 8/21/25 at 1:58pm, E5 (Resident Assistant) said on 8/19/25 she was working with E6 (CNA), completing rounds for incontinence care. E5 described R1 as someone who have "a lot of anxiety". E6 said, they will do "soilers" first because E6 wanted to take a nap. E5 said, they worked together until they reached R1's room, R1 was in a recliner, R1 refused to be changed, at first both staff tried to take off R1's pants but R1 was pulling it up. Both staff attempted to remove R1's pants, R1 continued to resist until R1 became aggravated. E5 said, she told E6 they need to leave and come back later but E6 refused and persisted until R1 became combative. R1 swung at staff. E5 said, "With full force, she tried to push or shove (I don't know the difference) putting hands on him, she pushed him onto the bed, he got up from the bed, and it was back and forth, by the 3rd time, that was when they started with the fist .... He had his closed fist and then he went to go hit her, she has

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A6000	Continued From page 8	A6000		

like a half fist, she ended up hitting him on the chest area not full force, he ended making a fist. She ended up telling him on his face, he was in her face, "get the f..k out, fu ....g b ...h". She pointed, "that's why you piss on yourself, you grown ass man and you piss on yourself". They were shoving each other." E5 stated that whatever she narrated to surveyor was the description of the incident reported to the on duty nurse (Z1). E5 said, she did not want to work with E6 for the remainder of the shift. E5 worked on the second floor with E7, while E6 remained on the 4th floor with R1.

On 8/21/25 at 3:34pm, E7 (CNA) said, "They (R1 and E6) were fist fighting that was what (E5) told me. (E5) was very upset, she told me to call the nurse. I heard (E5) tell the nurse about the fist fight . She told the nurse (Z1), and the nurse told her to make a statement." E7 confirmed she worked with E5 on the second floor.

On 8/21/25 at 11:27am, Z1 (Agency Nurse) denied knowing about the fist fight involving R1. Z1 said, she later learned about the incident from the Director of Nursing later on.

On 8/22/25 at 11:39am, E6 (CNA) said R1 was on the chair, E5 woke him up. E5 said, (R1) "we are going to change you", he stood up, E5 immediately snapped his pants off." E6 said, E5 did not approached R1 gently. E6 said, she gave R1 cookies, E5 took away the cookies, E6 gave R1. R1 swung at E5, "He tried to hit (E5), (E5) said, "I don't wanna do this, I did not sign up for this, so I said, "we are going to come back to him", and that was what we did." E6 confirmed, she stayed on the 4rth floor where R1 was located, and E5 went to the second floor.

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A6000	Continued From page 9 On 8/21/25 at 12:31pm, E3 (Memory Care Director) confirmed receiving the report from E5 describing the incident as "almost like they were wrestling ....she described it as "brawling", no slapping, she described it as pushing, grabbing. " E3 was asked, are you supposed to grab or push a resident? E3 said, "No, he needed assistance to be changed, his way of refusing was more like he is pushing or pulling back his pant. " E3 said, "I expected them to give them (resident0, to have time for themselves, stay away. "Did the staff follow this expectation? "To my understanding no, it was not done". On 8/21/25 at 9:57am, E2 (Wellness Director) said, this abuse allegation was not reported to state agency. E2 said, Abuse is reported to state agency within 24 hours. On 8/22/25 at 12:46pm, E2 said, R1 was sent to the hospital, it is a protocol to have resident checked if there was suspicion of abuse. Per E2 the police were also notified. According to R1's After Visit Summary report form, the hospital, there was no trauma found. R1's Service Plan with activation date of 5/10/25 indicated; 01.Diagnoses *Dementia- increased problems communicating or finding words, increased anxiety, agitation, and irritability. 05.Psychosocial. Staff to step back and move away from resident ensuring resident safety first giving him a few minutes and re-approach in a gentle kind manner. Current behavior type-occasional infrequent aggression towards staff during ADL care. Establishment's Policy and Procedure Manual, Title: Abuse and Neglect. Revision Date:	A6000		

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A6000	Continued From page 10 8/1/2022, stated in part; Policy: ...All reports of suspected abuse will be investigated in a timely manner, with emphasis on protection of the resident after report of an incident ... Purpose: To ensure resident safety. Procedures: 1. Definitions: -Mental Abuse is the willful action or inaction of mental or verbal abuse. This includes but is not limited to ....verbal assault that includes ridiculing, intimidating, yelling, or swearing. -Physical Abuse is the willful act of inflicting bodily injury or physical mistreatment. This includes but is not limited to striking, with or without an object, slapping ...shoving, prodding ... 2. Immediate Response i. The associate alleged to have committed the act of abuse would be immediately removed from duty pending investigation. 9: Reporting b. Alleged or suspected abuse ....should be immediately reported by the Executive Director to the state licensing liaison .... Per E5, E6 and E7's statement, R2 and the alleged perpetrator (E6) were not separated. E6 remained on the floor where R2 was.	A6000		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr This Regulation is not met as evidenced by: GENERAL VIOLATION Section 295.6010 Abuse, Neglect, and Financial Exploitation Prevention and Reporting	A6010		

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A6010	Continued From page 11 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. These requirements are not met as evidenced by: Based on interview and record review the establishment failed to notify the Department, an allegation of abuse affecting one (R1) of two residents reviewed for abuse. Findings include: According to R1's Face sheet, R1 is 59 years old, a resident of the Memory care unit. R1 moved to the community on 7/31/24. R1's diagnoses include but not limited to Dementia, and Essential Hypertension. On 8/21/25 at 10:22am, R1 was observed walking without any mobility devices in the hallway. Upon approach, R1 appeared to have well-kept appearance, alert, oriented x1, surveyor asked how he was, R1 mumbled some words, talking non sensical. According to R1's incident detail, this incident occurred on 8/19/25 at approximately 1:00am. On 8/21/25 at 1:58pm, E5 (Resident Assistant)	A6010		

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A6010	Continued From page 12 said on 8/19/25 she was working with E6 (Certified Nursing Assistant-CNA), completing rounds for incontinence care. E5 said, R1 did not want to have his pull ups changed. E5 and E6 attempted several times to take R1's pants off. R1 resisted until he became aggravated and combative. E5 said, "With full force, she (E6) tried to push or shove (I don't know the difference) putting hands on him (R1), she pushed him onto the bed, he got up from the bed, and it was back and forth, by the 3rd time, that was when they started with the fist. E5 said, R1 had a closed fist and went to hit E6. E6 had a "half fist", hitting R1 on the chest area, not full force. R1 was on E6's face saying, "get the f ... out, fu ....g bi ...h" E5 said, E6 told R1, "That's why you piss on yourself. You grown ass man, and you piss on yourself." E5 said she believes E6's action was physically and verbally abusive, even though R1 will not remember it later. On 8/21/25 at 9:57am, E2 (Wellness Director) said, this abuse allegation was not reported to state agency. E2 said, Abuse is reported to state agency within 24 hours.	A6010		