STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510405	A. BUILDING: _____ B. WING _____	C 09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW FALLS	1681 WILLOW CIRCLE DRIVE CREST HILL, IL 60403

(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 IL00197541 IL00197444 295.2000 a) 295.6000 a) 13) 295.6010 a) 1)	A 000		
A2000	Section 295.2000 Residency Requirements This Regulation is not met as evidenced by: Type 1 Violation Section 295.2000 Residency Requirements a) No individual shall be accepted for residency or remain in residence if the establishment cannot provide or secure appropriate services, if the individual requires a level of service or type of service for which the establishment is not licensed or which the establishment does not provide, or if the establishment does not have the staff appropriate in numbers and with appropriate skill to provide such services. (Section 75(a) of the Act) This requirement is not met as evidenced by: Based on interview and record review this establishment failed to ensure resident meets residency requirements for one resident (R1) of three resident reviewed. This failure results in R1's inappropriate sexual behavior of self exposure. This failure has the probability of affecting all	A2000		

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A2000	Continued From page 1	A2000		

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

Findings include:

R1's medical record showed R1 moved into the establishment on 4/25/2025, resided in the memory care unit, and had multiple diagnoses, including but not limited to Essential Hypertension, Dementia, Osteoarthritis, Type 2 Diabetes Mellitus, Syncope and Collapse, History of Falling, Constipation, Hyperlipidemia, Gastro-Esophageal Reflux Disease.

R1's Service Plan, dated 4/27/24, showed R1 was independent, with the use of a wheelchair, for transfers and mobility. R1's service plan addressed R1 is independently on almost all expects of Activities of Daily Living (ADLS). The resident has a behavior problem r/t inappropriate behavior due to the disease process (Dementia Diagnosis).
GOAL: Eliminate or significantly reduce the frequency and intensity of the inappropriate sexual behaviors.

R1's Progress Notes indicated: 9/15/2025- Resident attempted to come into hallway with only depend on.

On 9/16/2025 at 12:01PM, E5 (Certified Nursing Assistant/CNA) said," R1 is usually grumpy, tries to take off depend and show private area. Behaviors have been reported to the nurse; they know about it."

On 9/16/2025 at 12:02PM, E6 (Caregiver)said ," R1 tries to show private area, likes to be in wheelchair wearing only depends."

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A2000	Continued From page 2 On 9/16/2025 at 1:16PM, E3 (Resident Care Coordinator/Scheduler) said,"R1 has sexually acting behavior, exposing self and laughing about it. R1does it for fun. If R1 gets aggravated, will expose self." On 9/16/2025 at 1:48PM, E2 (Director of Nursing) said,"R1 expresses self sexually and that this behavior is not appropriate."	A2000		
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 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 This requirement was not met as evidenced by: Based on interview and record review the establishment failed to ensure residents are free form Verbal abuse for one resident (R3) from three resident reviewed for abuse. This failure	A6000		

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A6000	Continued From page 3	A6000		

resulted in R3 being yelled at by an employee (E4).
This failure has the probability to affect all 86 residents in this establishment. This failure creates a substantial probability of severe harm to a resident or residents.

Findings include:

R3 is 80-year-old. Per Face sheet R3 moved into this establishment on 2/26/2023 and resides in the Assisted Living Unit. R3 diagnoses include but not limited to Chronic Kidney Disease, Stage 3, Malignant Neoplasm of Prostate, Lumbosacral Plexus Disorder, Spondylolisthesis, Radiculopathy, Lumbar Region, Venous Insufficiency, Lymphedema, Personal History of Thrombophlebitis, Persona; History of Pulmonary Embolism, Chronic Diastolic (Congestive) Heart Failure.

During an abuse investigation to this establishment on 9/16/2025, E2 (Director of Nursing/DON) stated E4 (Caregiver) was suspended due to using profanity in front of residents. When requested the investigation for this incident ,E2 said that E2 was still investigating and that the only statement E2 had so far was the one from R3.

On 9/17/2025 at 9:54AM, E3 (Caregiver) said "I was coming into the facility and E4 (Caregiver) was there, we look at each other and E4 all of a sudden said don't give a fuc* about you rolling your eyes, if you want, we can do all that. R3 was present .E4 started cursing like we were out on the street, this is a working place. E4 sent me a text I think it was Monday, when I was off. The text said, let me know when you are off work, bitc*."

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A6000	Continued From page 4 R3 said "Last weekend I had to pick up my own garbage and take it all the way to the front desk. Caregiver (E4) came to R3 very upset and raising E4 voice at R3 . R3 told E4 to stop yelling at R3. This made R3 very upset."	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 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. These requirements were not met as evidenced by: Based on interview and record review, the establishment failed to ensure incident report for alleged sexual/ mental abuse were reported to the Department within 24 hours of occurrence. This involves 1 of 3 residents reviewed (R1).	A6010		

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A6010	Continued From page 5 This failure has the probability to affect all residents in the facility. This failure creates a substantial probability of severe harm to a resident or residents. Findings include: On 9/16/2025 at 2:18PM, E12 (Registered Nurse/RN) said," E4 (Caregiver) reported that last Saturday on 9/13/2025, E3 (Resident Care Coordinator/Scheduled) was sexually abusing R1. E12 said that E2 (Director of Nursing) was called immediately." E2 was instructed to provide the initial incident report for review. E2 did not provide the Initial Incident Report. When asked again, E2 said," Is still investigating. The initial report should be sent to the department within 24 hours." On 9/16/2025 at 2:47PM, E2 (Director of Nursing) said," didn't send the initial report to IDPH because the investigation is ongoing."	A6010		