STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL5106197	A. BUILDING: _____ B. WING _____	C 10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD PLACE	1879 CHESTNUT AVE GLENVIEW, IL 60025

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A 000	Initial Comment Complaint Investigation 2599365/ IL197759 - Unsubstantiated Facility Reported Incident 9/28/25 IL197851 - 295.6000a)13) and 295.6010a)1)	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 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; 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; These requirements were not met as evidenced by: Based on interview and record review the facility failed to protect residents' rights to be free from sexual abuse by another resident. This applies to 3 of 3 residents (R2 and R3) reviewed for abuse in the sample of 3. This failure resulted in 2 residents being sexually	A6000		

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A6000	Continued From page 1	A6000		

abused (R2,R3) and has the probability to cause severe harm to a resident or residents.

The findings include:

On 10/8/25 at 10:08 AM, E9 (Licensed Practical Nurse) said she was taking care of R1 on 9/28/25. E9 said R1 was sitting next to R2. E9 said she observed R1, "Caressing" R2's back and upper thigh. E9 said R2 told R1 to stop and R1 did not stop until E9 intervened. E9 said she took R1 to his room after the incident with R2. E9 added that when she was walking with R1 to his room, R1 placed both of his hands on R3's breasts over R3's clothing and started to move his hands around on R3's breast. E9 said R1's contact with R2 and R3 was not incidental. E9 said R1's contact with R2 and R3 would be considered sexual abuse.

R1's progress note dated 9/28/25 showed R1 was observed sitting next to a female resident holding her legs and feeling her legs. E9 informed R1 he should not be touching another resident. The same note showed while E9 was walking with R1, R1 grabbed a female resident's breast.

On 10/8/25 at 11:00 AM, E2 (Director of Nursing) said R1's contact with R2 and R3 was inappropriate touching and violated R2 and R3' body.

R1's Resident Centered Care Plan with a start date of 5/4/25 showed R1 had a history of inappropriate sexual touching towards other residents.

R2's Resident Package dated 1/9/24 showed no resident shall be deprived of any rights nor shall a resident forfeit the right not to be sexually,

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A6000	Continued From page 2 verbally, physically or emotionally abused, humiliated, intimidated, or punished. R3's Resident Package dated 1/28/25 showed no resident shall be deprived of any rights nor shall a resident forfeit the right not to be sexually, verbally, physically or emotionally abused, humiliated, intimidated, or punished. The facility's Abuse, Fraud, and Wrongdoing policy dated 8/20 showed the community takes all reasonable steps to prevent resident abuse and neglect.	A6000		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr This Regulation is not met as evidenced by: Type 3 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:	A6010		

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A6010	Continued From page 3	A6010		

Based on interview and record review the facility failed to notify the Illinois Department of Public Health of an allegation of abuse within 24 hours for 3 of 3 residents (R1,R2 and R3) reviewed for abuse in the sample of 3.

The findings include:

On 10/8/25 at 10:08 E9 (Licensed Practical Nurse) said she was taking care of R1 on 9/28/25 when R1 was sitting next to R2. E9 said she observed R1, "Caressing" R2's back and upper thigh. E9 said R2 told R1 to stop and R1 did not stop until E9 intervened. E9 said she took R1 to his room after the incident with R2. E9 added that when she was walking with R1 to his room, R1 placed both of his hands on R3's breasts over R3's clothing and started to move his hands around on R3's breast. E9 said R1's contact with R2 and R3 was not incidental. E9 said R1's contact with R2 and R3 would be considered sexual abuse. E9 said she notified management, including the Director of Nursing, of the incident.

R1's progress note dated 9/28/25 showed R1 touched a female resident's leg and another female resident's breasts. The same note indicated the Director of Nursing, Executive Director, and Human Resources were notified.

A Communication Result Report for a fax machine showed an Incident Report regarding the events described by E9 that occurred on 9/28/25 was faxed to the Illinois Department of Public Health (IDPH) on 10/1/25 (3 days after the incident occurred).

On 10/8/25 at 11:00, E2 (Director of Nursing) said incidents should be reported to IDPH within 24 hours. E2 said she reported the incident with R1,

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A6010	Continued From page 4 R2, and R3 to IDPH on 10/1/25. E2 said the incident was reported outside of the 24 hour window.	A6010		