STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510040	A. BUILDING: _____ B. WING _____	C 11/09/2025

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AUTUMN LEAVES OF ORLAND PARK	8021 151ST STREET ORLAND PARK, IL 60462

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A 000	Initial Comment Facility Reported Incident Investigation: Facility Reported Incident of 10/18/2025/IL198420 - 295.2050a)b), 295.4010a)c)	A 000		
A2050	Section 295.2050 Incident and Accident Reporting This Regulation is not met as evidenced by: Type 3 Violation 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. This requirement was NOT MET as evidenced by: Based on interview and record review the facility failed to report to Illinois Department of Public within the required timeframe a change in condition for one (R1) of three residents reviewed for accident/injury.	A2050		

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A2050	Continued From page 1 Findings include: R1 is a 96-year-old with diagnosis not limited to: Memory disorder, Fulsteen-26/30 -early Alzheimer's, Coronary atherosclerosis of native coronary artery, STENT LAD, Essential Hypertension, Hernia Inguinal repair, Herniated lumbar, intervertebral disc. According to R1's face sheet printed 11/8/2025, R1 was admitted to Assisted Living on 4/1/2024. Facility's initial/final report to state agency documents in part: Incident date: 10/18/2025, On duty nurse was preforming wellness check and heard resident (R1) yell, "I just fell" I just fell" Resident was alert with no loss of consciousness. Nurse observed resident sitting on his buttocks in front of his door holding back of his head. R1 stated I am okay; I just lost my balance and fell. Description of Action Taken by establishment as a Result of Incident/Accident: On duty nurse assessed and noted actively bleeding from back of resident head. Pressure applied and VS (vital signs) taken. 911 called, resident was transferred to local hospital. R1 Diagnosis Scalp Laceration. Resident returned back to the community same day, appears stable with no bleeding to back of head. Four staples applied, intact. Staples to be removed in 10 days. Service plan updated. Fax Notification to IDPH shows incident/accident was reported on 10/22/2025 at 9:30pm E2, Licensed Practical Nurse (LPN) Nursing and Incident note Fall (unwitnessed) for R1 dated 10/18/25 at 10:55am documents in part: On duty nurse was rounding and heard R1 yell, I just fell I just fell. Nurse immediately responded and observed R1 sitting in front of his door holding	A2050		

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A2050	Continued From page 2	A2050		

back of his head, bleeding actively with no loss of consciousness. R1 stated, " I am okay, I just loss my balance and fell. Pressure applied to back of head with clean towel. R1 denied pain or discomfort. No s/s of distress noted. 911 called and R1 was transferred to local hospital for further eval and treatment. R1 returned back to community same day appears stable with no bleeding to back of head. Four staples intact and patent to scalp laceration to be removed in 10 days.

On 11/7/2025 at 1:41pm R1 lying in bed, aware and able to answer simple questions. R1 stated, he is okay and knows how to push pendant if he needs help. R1 stated, he is eating his meals and remembers when he fell. R1 stated, I just fell. I slipped on the floor, and I did not hurt myself. I have not had any other falls and I use my walker.

On 11/7/2025 at 2:04pm E2, Licensed Practical Nurse (LPN) stated, I took care of R1 on 10/18/2025 and I remember when he fell on 10/18/2025. I was in his room doing rounds and he was in bed and in the process of getting up. I left his room, and I heard a bang or thud, and he was on the floor. It was right before lunch. R1 can walk but is declining. He used to have a steady gait but lately was using a walker. He knows what is going on, just declining. I believe R1 was grabbing his watch off the nightstand, and he lost his gait and stumbled towards the door. He hit his head on the doorknob. When he stumbled, he hit his head on doorknob. He was trying to get up when I entered room. He told me he hit his head and said he was okay. He felt blood and said he did not need to go to hospital. I was able convince him to go to hospital. I do document in computer, so oncoming nurse knows what took place. I did head to toe assessment and did not note any

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A2050	Continued From page 3	A2050		

other injury. He only had a head injury no complaints of anything else. He had four staples to remove 7-10 days. No new orders did assessment again when he returned, and no complaint of pain and he was happy to be back. E1, Executive Director reports incident to state. I just fill out the incident report and they close out and submit to whoever it needs to be submitted to.

On 11/8/2025 at 12:04pm E1 stated in part, I am familiar with R1 and the incident that occurred on 10/18/2025. If a resident falls, the nurse assesses and determines if they need to go to the hospital. When R1 fell the nurse called me and said when he was rounding, he heard R1 say he fell. R1 was sitting on the floor with his hand on his head. E2 saw he was bleeding on his head and put pressure on it. R1 was conscious and stated he lost his balance and was fine. E2 noticed he was bleeding on the back of his head and called 911 and sent him to the hospital, called the doctor and family and E1. That is the process. R1 said he was going to the bathroom. He has a pendant, but he does not always call and does things himself. His gait is not steady. He always says he is fine. He is confused but able to sometimes make needs known just depends. The nurse does incident report and documentation. I do the reportable. Reportables are done within 24 hours of incident. This was not reported within 24 hours, this is one that I forgot. I still reported it, but it was late on 10/22/2025. It is better to report late than not to report.

Facility Policy Incidents/Accidents, undated documents in part: Procedure: 10. State Reportable Incident Reports must be sent to IDPH within 24 hours of the incident.

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A4010	Continued From page 4	A4010		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 3 Violation 295.4010 Service Plan a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the Act) The establishment shall respect and accept the resident's choices regarding the service plan. c) The service plan shall be signed and dated by all individuals involved in its development. This requirement was NOT MET as evidenced by: Based on interview and record review the facility failed to obtain resident representative signature for one (R1) of three residents reviewed for service plan. This deficient practice affected two residents (R1, R2) reviewed for service plan compliance in a sample of three. Findings include: R2 is an 88-year-old female with diagnosis not limited to: Vascular Dementia, Non-displaced C4 fracture, Falls, Left radial styloid fracture, HX of Super Ventricular Tachycardia (SVT),	A4010		

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A4010	Continued From page 5	A4010		

Hypertension (HTN), Chronic Kidney Disease stage 2 (CKD2), Depression, Gastroesophageal Reflux Disease (GERD, Unsteady gait, Moderate aortic stenosis.

According to R2's face sheet printed 11/8/2025, R2 was admitted to Assisted Living on 5/6/2025.

Service Plan Report dated 8/8/2025 in part shows, Reason: Change of Condition Signatures 1. Resident/POA Name, Relationship, Signature, Date Left Blank.

R3 is a 71-year-old female with diagnosis not limited to: Anxiety, Bipolar Mood Disorder, Schizophrenia, Hyperlipidemia, Essential Tremor, Primary Hypertension, Dementia, Prediabetes

According to R3's face sheet printed 11/8/2025, R2 was admitted to Assisted Living on 3/3/2022.

Service Plan Report dated 10/31/2025 in part shows, Reason: Annual Signatures 1. Resident/POA Name, Relationship, Signature, Date Left Blank.

On 11/8/2025 at 12:04pm E1 (Executive Director) stated, we do service plans annually, pre-admission, with move-in initial service, and change of condition. I do service plan, I educate the family and review with family, then the Power of Attorney (POA) or guardian sign the service plan. I have not seen R3's POA for about 6 months, he has been sick. Sometimes I will send via email and wait for them to respond back. For R2 the daughter comes in at night and the daughter has not signed yet. I have tried to get signatures. If not documented in the medical record means not done. We must follow the regulation. I usually always get my service plans

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A4010	Continued From page 6 signed. Review of medical record for R2 and R3 and no documentation of discussion regarding service plan with R2 and R3's POAs. Facility Policy Service Plan E-130, undated documents in part, Procedure: 1. The Executive Director will ensure that a service plan will be completed under nursing direction upon move-in to the residence, annually, and upon any significant change in condition. The Nurse, Executive Director and the Resident and/or Responsible Party will sign the agreed upon service plan.	A4010		