STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510115	A. BUILDING: _____ B. WING _____	C 12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENDALE OF MOKENA	21536 SOUTH WOLF ROAD MOKENA, IL 60448

(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 (FRI) #198638 (11/3/25) 295.4010 a)d)e) 295.6000 a) 13)	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: TYPE 1 VIOLATION - REPREAT VIOLATION - Section 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. d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, 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) e) The service plan shall be reviewed and revised if necessary immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000). This requirement is not met as evidenced by:	A4010		

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A4010	Continued From page 1 Based on record review, observations and interviews the establishment failed to develop and implement interventions to address residents care needs. These failures affected 2 of 2 residents reviewed for cognitive impairment, wandering, aggressive behavior and Activities of Daily Living (ADLs). These failures affected R1 and R2 but has the probability to affect all residents in this memory care unit. These failures create a substantial probability of severe harm to a resident or residents. Findings include: R1 was admitted to the establishment 10/26/22 with diagnoses including Alzheimer's, and Anxiety Disorder. R1 resides in the Memory Care Unit. 11/3/25 Incident Report and Progress Notes document R1 was found on the floor after he was pushed by R2. Review of R1's 11/3/25 Progress Note (PN) showed documentation of the resident having wandered into R2's apartment and being pushed out of R2's room by R2 and falling onto the floor. R1 complained of right leg pain immediately, was transferred to the hospital and admitted with a diagnosis of right femur fracture. On 11/24/25 at 10:00AM E1 and E2 stated R1 has a history of wandering and had wandered into other resident ' s rooms. E1 stated R1 had wandered into R2 ' s apartment. R2 pushed R1 out of his apartment causing R1 to fall and break his right femur. E1 stated R1 had wandered into R2's apartment. R2 kept saying the "kid" wandered into R2's room. R2 told E1 he kept asking R1 to leave. R2	A4010		

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A4010	Continued From page 2	A4010		

was seen on video pushing R1 out of his apartment , R1 stumbled backward, fell and fractured his femur. Both residents have diagnoses and live in Memory Care.

Staff interviewed stated R1 does wander.

R1's service plan (SP) dated 8/25/25 documented the resident had awareness issues and needed supervision due to his inability to recognize and avoid potentially harmful situations, needed hands on staff assistance to ambulate, had severely impaired orientation, severe wandering with a history of getting lost, was combative with redirection and identified behavior management as an issue but doesn't identify the behaviors R1 exhibits. R2's SP failed to develop and implement interventions to address these identified problem areas.

R2 was admitted to the establishment 7/31/25 with diagnoses that includes Vascular Dementia.

Review of an incident report dated 11/3/25 documented R2 admitted having pushed R1 onto the floor when R1 tried to enter his apartment.

R2's PN dated 11/3/25 documented the same information regarding R1 being found on the floor after R2 admitted he pushed R1 out of his room.

Initial Psychiatric Evaluation dated 11/4/25 documented R2 had a history of psychiatric hospitalization due to aggression and behaviors and mentions R2's altercation with two other residents (other resident not identified), including pushing R1 out of R2's room. When evaluated R2 couldn't remember the incident.

The evaluator documented R2 had a history of

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A4010	Continued From page 3 hospitalization due to his aggression and behaviors. R2 was assessed and found to have an irritable mood, forgetfulness and poor engagement, irritable and uncooperative, slow, disorganized, unable to specify frustrations, poor judgement, impaired memory forgetful and poor insight. Staff was to use redirection, distraction, activities and supportive living and recommended transfer to the hospital if aggression recurs due to risk of harm to self or others. On 11/24/25 at 10:00am E1 (Executive Director) and E2 (Director of Health Services) admitted R2 had pushed R1 who fell. The incident was seen on video when reviewed. Staff interviewed stated R2 does become irritable and aggressive. R2's SP dated 9/9/25 identified the residents' poor judgment, long and short-term memory impairment, problems with mood and depression, but doesn't identify what moods the resident has, identified mild impairment with his orientation and history of wandering. The SP doesn't address or identify the types of the resident's aggression, nor does the SP have interventions developed and implemented to address these problems and wasn't revised with interventions developed and implemented to address the problem areas identified by the psychiatric evaluator.	A4010		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: TYPE 1 VIOLATION	A6000		

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A6000	Continued From page 4 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 is not met as evidenced by: Based on record review and interviews the establishment failed to monitor the aggression of one resident with a history of aggression (R2) to ensure the safety of one resident (R1) in the sample of 2 reviewed for abuse. This failure creates a substantial probability of severe harm to a resident or residents. Findings include: R1 was admitted to the establishment 10/26/22 with diagnoses that included Alzheimer's. Review of R2's record documented the resident was confused and wanders, sometimes into other resident's rooms. R2 was admitted to the establishment 7/31/25 with diagnoses including Vascular Dementia. Review of R2's record showed documentation showing prior to admission to this establishment the resident had been hospitalized due to aggression. On 11/24/25 incident reports were reviewed and	A6000		

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A6000	Continued From page 5	A6000		

showed an incident report dated 11/3/25 documenting R2 pushed R1 onto the floor causing R1 to fall. R1 sustained a right femur fracture as a result of being pushed.

Review of R1's and R2's record's Progress Notes showed documentation dated 11/3/25 that also documented R1 was pushed to the floor by R2 who admitted he'd pushed R1 out of R2's apartment.

R1's record also documented the resident complained of pain after the fall, was unable to stand on his right leg, was transferred to the hospital and diagnosed with a right femur fracture.

On 11/24/25 at 10:00am E1 (Executive Director) and E2 (Director of Health Services) admitted R2 had pushed R1 who fell. The incident was seen on video when reviewed.

On 11/24/25 at 3:15pm E2 stated R2 didn ' t go out to the hospital for a psychiatric/behavioral evaluation after pushing R1 onto the floor.

E1 and E2 stated R1 has a history of wandering and had previously wandered into other resident's rooms.

E1 stated on 11/3/25 R1 had wandered into R2's apartment. When asked what happened R2 kept saying the "kid" wandered into R2's room. R2 told E1 he kept asking R1 to leave. R2 was seen on video pushing R1 out of his apartment , R1 stumbled backward, fell and fractured his femur.

On 12/8/25 at 1:00PM Z1 stated after the incident with R1 Z1 asked R2 what happened and R2 gave the same statement regarding R1

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coming into R2 ' s apartment and R2 pushed R1 out of his apartment. R1 does wander but isn ' t aggressive.

Z1 stated R2 remained in the community after pushing R1 to the floor. The resident does have a history of aggression, is unable remember specifics but said it's depending on how he ' s feeling; it varies. The resident shows more irritability but not physical aggression since 11/3/25.

R2 was described as alert to person and " kind of knows where he is " .

On 11/24/25 at 2:00PM Z2 stated R2 has been aggressive before and sometimes R2 won ' t let others sit at his table with him at meals and will try to forcibly remove them. R2 has thrown salad bowls at caregivers. If someone wanders into his apartment staff has seen him forcibly remove the other resident. R2 screams, yells, and will throw items at residents during meals.

On 11/24/25 at 2:10PM Z3 described R1 as sweet and doesn ' t bother anyone, he walks and doesn ' t get into trouble.

Z3 went on to describe R2 ' s behavior ... " he ' s something else " . Today (11/24/25), he was angry with another resident because he felt she was standing too close to him. R2 " kicks butt " . This morning he got angry because he didn ' t get a fork with his silverware. He " pretty much " stays in his room except at meals.

When interviewed 12/8/25 at 1:00PM Z4 stated after breakfast 11/3/25 staff sat R1 in the dining room. Z4 later saw R1 laying on the floor outside R2 ' s apartment. When staff stood R1 off the

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A6000	Continued From page 7 floor he complained of right leg pain. Staff sat the resident in a chair and EMS (Emergency Medical Service) was called and transferred R1 to the hospital. Z4 stated the employee had never seen R2 being aggressive but has heard of instances of his aggression. On 11/3/25 R2 hadn ' t been aggressive initially. The resident didn ' t receive and prn medication. R2 remained in the establishment on E2 ' s instructions who said she ' d have a psychiatric evaluation done. R2 did remember at first pushing R1 but later didn ' t remembeer the incident. On 12/8/25 this surveyor called E1 and E2 to re request R1 and R2 ' s cognitive assessments and asked them to be emailed to this surveyor at the Illinois Department of Public Health (IDPH). E1 presented an initial psychiatric evaluation dated 11/4/25 for R2 and a psychiatric follow up dated 12/2/25 for R1. The establishment wasn't able to present a current cognitive assessment for R1couldn't present a cognitive assessment R2 conducted for R2 before or after the resident's admission. Review of the establishment's Resident Abuse policy failed to list the procedure required by IDPH when there is suspected or actual abuse. There is no instruction regarding separating the abused from the abuser, protection of the abused resident, and didn't address any actions the establishment is to take regarding the abuser.	A6000		