STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510331	A. BUILDING: _____ B. WING _____	C 11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEER PARK VILLAGE SENIOR LIVING	21840 W LAKE COOK ROAD DEER PARK, IL 60010

(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 25111189/IL198584 & 25111382/IL198658 Violations: 25111189/IL198584 - 295.4010d) cited 25111382/IL198658 - 295.6000a)13) & 295.6010a)1)2) cited	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 2 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, 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) These requirements are not met as evidenced by: Based on interview, and record review the facility failed to update service plans with interventions to prevent falls or injuries. This applies to 4 of 6 residents (R3,R4,R5,R6) reviewed in the sample of 7 for service plans. This failure creates a substantial probably of harm to the other residents in the facility. The findings include:	A4010		

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A4010	Continued From page 1 On 11/20/2025 at 12:53PM and 2:19PM, E1 (Executive Director) said the service plan is updated with additional interventions as appropriate, which they usually are. E1 said if they require a change in condition form the Director of Nursing (DON) or Assistant Director of Nursing (ADON) would eval and do a change in condition service plan. E1 said the [E2 - DON] had passed away over the weekend. R3's Incident report dated 11/20/2025 shows he had falls on 9/17/2025, 8/31/2025, 4/18/2025, and 4/1/2025. R3's Service Plan dated 6/26/2025 (last modified date of 9/18/2025) doesn't list dates to when interventions were put into place follow the resident's falls in the 07 Fall Potential category for R3's falls on 8/31/2025 and 4/1/2025. R4's Incident report dated 11/20/2025 shows he had falls on 9/25/2025, 9/17/2025, 8/11/2025, 4/26/2025, and 4/24/2025. R2's Service Plan dated 10/2/2025 (last modified date of 10/2/2025) doesn't list dates to when interventions were put into place following the resident's falls in the 07 Fall Potential category for R4's falls on 4/26/2025, 9/17/2025, and 9/25/2025. R5's Incident report dated 11/20/2025 shows he had falls on 9/12/2025, 8/19/2025, 6/6/2025, and 5/2/2025. R5's Service Plan dated 7/2/2025 (last modified date of 9/13/2025) doesn't list dates to when interventions were put into place following the resident's falls in the 07 Fall Potential category for R4's falls on 8/19/2025 and 6/6/2025. R6's Incident report dated 11/20/2025 shows she had falls on 11/15/2025 (12:15PM & 10:45AM), 11/14/2025, 11/11/2025, 11/5/2025, 11/1/2025, 10/27/2025, 10/26/2025, 9/24/2025, 8/13/2025,	A4010		

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A4010	Continued From page 2 and 8/26/2025. R6's Service Plan dated 5/2/2025, 11/7/2025 (last modified date of 11/15/2025) don't list dates to when the interventions were put into place follow the resident's falls in the 07 Fall Potential category for R6's falls on 8/13/2025 and 11/1/2025. The facility provided Resident Fall policy revised 2/2025 states, . . . It is with the intent of the community to maintain safety after a resident has fallen . . .	A4010		
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; These requirements are not met as evidenced by: Based on observation, interview, and record review the facility failed prevent staff to resident abuse. This applies to 1 of 3 (R7) reviewed in the sample of 7 for abuse. This failure resulted in R7	A6000		

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A6000	Continued From page 3	A6000		

being the victim of physical abuse .
This failure creates a substantial probably of severe harm to the other residents in the facility.

The findings include:

The facility provided the video during the survey onsite.

Video Summary: R7 requests something to put on. E6 (Caregiver) gets a brief or pull-up out of the bathroom. R7 starts to put the pull-up on herself, sitting up on the edge of the bed. E6 assists R7 with putting on a gown. R7 was attempting to grab at something on her right hip/thigh area. R7 states she can't get up. R7 is then seen trying to button her gown. E6 lifts up R7's legs quickly and roughly, dumping R7 back into bed. E6 starts turning R7 in the bed roughly while pulling up the resident's pull-up. E6 is seen holding R7's right knee down with her left hand, while R7 was on her right side. R7 starts telling E6 "stop it," "get out of here," "you are hurting me" and "you hit me." E6 did not stop when R7 asked her to stop. E6 only stopped after she finished getting R7's pull-up back on. R7 was upset in the video and states, "unbelievable" multiple times.

On 11/20/2025 at 3:52PM, E1 (Executive Director) and E3 (Assistant Director of Nursing - ADON) confirmed the resident in the bed was in fact [R7] and the caregiver was [E3] wearing a blue scrub top in the facility provided video.

On 11/20/2025 at 2:19PM, E1 said [R7's] family sent an email stating a caregiver was rough with [R7]. E1 said E2 (Director of Nursing - DON) was on duty on 10/8/2025 and reviewed the video. E1 said she was out of town in Nebraska for a

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A6000	Continued From page 4	A6000		

conference that day. E1 said [E2] had passed away over the weekend.

On 11/20/2025 at 2:35PM, E3 said she did not witness the event but did see the video. E3 said in the video you see [R7] sitting on the edge of the bed. E3 said [E6] appeared burnt out. E3 said [R7] was yelling at [E6] and [E6] lifted her feet up into bed fast. E3 said [E6] pulled out the pad under her. E3 said [E6] stated knock yourself out to [R7] but is unsure what was said prior to that. E3 said they taught [E6] to walk away and have more patience. E3 said staff providing care should be provided reassurance to make them feel safe and should be handled with care.

On 11/20/2025 at 2:40PM, E4 (Memory Care Director) said she handles all non-clinical operations. E4 said she was out of town in Ohama and received a message from E2. E4 said she saw the video on 10/8/2025 with [R7]. E4 said there was some anger that [R7] was expressing with [E6]. E4 said [E6] appeared to be affected by the communication. E4 said she couldn't hear everything that was said in the video due to video quality. E4 said both parties seemed agitated, but the only person that mattered in the room was [R7]. E4 said [E6] told [R7] something along the lines you go ahead and do that or I'm here all day, which is not how we train. E4 said we don't talk to residents like that, and we walk away to a safe space. E4 said if we have empathy fatigue we should walk away.

On 11/20/2025 at 3:53PM, E6 said she was working with [R7] the morning of 10/8/2025.

On 11/20/2025 at 4:31PM, E8 (Operations Director) said she was notified [E6] was being placed on suspension. E8 said it is their policy to

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A6000	Continued From page 5 suspend someone for their next three working shifts. E8 said [E6] was taken off the schedule on Thursday and Friday that week. The Abuse Reporting and Investigation policy revised 2/2025 states, . . . It is the policy of this community that allegations of abuse be reported and thoroughly investigated. . . employees alleged to be involved in the incident will be placed on unpaid administrative leave pending the outcome of any internal investigation into allegations of abuse. . . The Executive Director/Manager or Director of Nursing will report the allegations to the Assisted Living Complaint Registry . . . within 24 hours.	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 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.	A6010		

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A6010	Continued From page 6 2) Investigate and develop a written report within 14 days after the initial report. The establishment shall send the written report to the Department within 24 hours after it is completed and shall maintain a copy of the written report 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 facility failed to notify the state of abuse and failed to send in a written report to the state. This applies to 1 of 3 (R7) residents reviewed for abuse in the sample of 7. These failures create a substantial probably of severe harm to the other residents in the facility. The findings include: On 11/20/2025 at 2:19PM, E1 (Executive Director) said [R7's] family sent an email stating a caregiver was rough with [R7]. E1 said the incident wasn't reported to IDPH (Illinois Department of Public Health). The facility failed to provide documentation or confirmation the abuse allegation or a written investigation was reported to IDPH.	A6010		