STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510483	A. BUILDING: _____ B. WING _____	C 03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE POINT PLACE	5701 W 101ST OAK LAWN, IL 60453

(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 Compliant Investigation Survey IL00198901/25911948- Substantiated IL00198829/25911746- Substantiated 295.2050 a) b) 295.4010 d) Facility Reported Incident Survey IL00199140- Substantiated 295.2050 a) b) 295.4010 d)	A 000		
A2050	Section 295.2050 Incident and Accident Reporting This Regulation is not met as evidenced by: General Violation Section 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. These requirements were not met as evidenced by:	A2050		

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A2050	Continued From page 1 Based on record review, and interview, the establishment failed to submit incident report to the Illinois Department of Public Health (IDPH) within the required time frame for two (R1, R2) of three residents reviewed. This has the probability to affect R1,R2 and other residents. The findings include: On 02/26/26 (9:36 AM), the establishment's Facility Reportable Incident (FRI) reports were presented and reviewed. R1's medical record showed R1 moved into the establishment on 1/23/2024, resided in the memory care unit, and had multiple diagnoses, including but not limited to Schizophrenia, CKD Stage 3, Hypertension, Dementia, Vitamin Deficiency. R1's Incident Report, date of incident 11/4/2025, Incident Report was sent on 11/6/2025, was not reported to the Department within 24 hours of the occurrence. R2's medical record showed R2 moved into the establishment on 11/1/2024, resides in the memory care unit, and has multiple diagnoses, including but not limited to Unspecified Dementia, Hypertensive Heart Disease, Hypertensive Heart disease with Heart Failure, Heart Failure, Constipation by delayed Colonic Transit. R2's FRI report included documentation that R2 fell in the resident's room on 12/15/25. The establishment submitted the report to the IDPH on 12/17/25 (2 days after the incident). The facility failed to report the incident within the	A2050		

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A2050	Continued From page 2 required time frame. During an interview with E2/Nurse Management on 02/26/26 at 1:10 PM, E2 stated, the Service Plan "should be updated after every incident... The facility should submit incident reports to the state "within a 24-hour period of the incident." During the same interview, E2 confirmed the report was not submitted within the required time frame.	A2050		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: General 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) This requirement was not met as evidenced by: Based on record review, observation and interview, the establishment failed to ensure the Service Plan was reviewed and updated to meet the safety needs of the residents. This was found in two (R1, R2) of three resident records reviewed. This failure has the probability to affect R1, R2 and other residents.	A4010		

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A4010	Continued From page 3 Findings include R1's medical record showed R1 moved into the establishment on 1/23/2024, resided in the memory care unit, and had multiple diagnoses, including but not limited to Schizophrenia, CKD Stage 3, Hypertension, Dementia, Vitamin Deficiency. R1's progress Notes dated 11/4/2025 at 7:11PM- indicated that R1 was observed laying on the floor and bleeding from forehead, this writer called rapid respond immediately, while trying to assess R1 for pulses, R1 was verbally responsive, and pulses present at this time. rapid response came in to transfer R1 to local hospital. R1's Service Plan, dated 11/12/2025, showed R1 was independent for transfers and mobility. R1's service plan addressed R1 as a fall risk and had no previous falls. R1's Service Plan also indicates that R1 was a wanderer. No intervention in place as how R1 was supervised for safety. R1's Mini Mental State Examination (MMSE) dated 10/3/2025 indicated a Total Score: 7 Points out of 30 possible points. This score places R1as Severe Cognitive Impairment. Records also indicated that R1 was alert and Oriented X1. On 2/26/2026 at 11:46AM, E3 (Cook) said that "It was after dinner around 7:30sh I was cleaning up, I was coming down the hallway, I saw R1 on the floor in the first floor dining room, I thought he was lying down on the floor, when I get close to him, I saw red fluid coming from the side of R1's head, not sure if it was the right or the left side, I called for help using the walkie talkie, nurse from the first floor, one of the Aides, then the second	A4010		

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A4010	Continued From page 4	A4010		

floor nurse assisted to stop the bleeding. R1 was close to the table, his feet were under the table. Dinner is from 4:30-5:30PM. I can't tell how long R1 has been on the floor, but it was a big puddle of blood.

On 2/26/2026 at 1:25PM, E7 (Former Licensed Practical Nurse) said R1 walked independently, R1 was independent for almost all his ADLS, except for bathing, R1 needs assistance with bathing. E7 said that R1gait was steady, he was a wanderer, will walk around. E7 said that it is the standard for the memory care to check residents every 15 minutes, if the R1 was not in activities, staff were supposed to check on him if they didn't see him around. Two staff can't go to break/lunch at the same time, there should be at least 2 caregivers monitoring the residents, making sure they are safe."

The EHR (Electronic Health Record) of R2 was reviewed on 02/26/26 (11:15 AM). The last progress note for R2 was dated "01/31/26".

On 02/26/26, reviewed the establishment's incident reports of R2 that included: 12/22/24 "observed on floor... own apartment: Bedroom... resident was sitting on the floor with blood on him, unresponsive.... assessed LOC and origin of bleeding, call l911, informed DON, POA, and NR..."; 08/21/25 "Unwitnessed Fall... COMMON AREA: Hallway... Staff observed resident sitting on the floor. Head to toe assessment performed. Resident transferred back to chair... Resident transferred to w/chair. Family/NP/Manager notified..."; and 12/14/25 "Unwitnessed Fall... OWN APARTMENT: Bathroom... " The resident reported that he fell "somewhere over there". When staff asked him how he got back in bed, the resident responded he had no idea. Staff

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A4010	Continued From page 5 "phoned 911 for transport, paramedics arrived to transport resident to Christ for further evaluation". On 2/26/2026 at 11:40AM R2's Service Plan was reviewed and contained documentation the Plan was initiated on 11/01/24 and last reviewed on 05/02/25. The Service Plan included, R2 had "mild confusion, and required "stand-by assistance" The Service Plan lacked documentation that the Plan was reviewed and revised after the 12/22/24, 08/21/25, and 12/14/25 fall incidents. On 02/26/26 (12:40 PM - 12:44 PM) R2 was observed in the hallway on route to his apartment in a wheelchair. Surveyor asked R2 if could ask him some questions, R2 replied, "Yes". Observed R2 stand-up from the wheelchair and ambulate to the bathroom inside During an interview with E2 (Nurse Management) on 02/26/26 at 1:10 PM, E2 stated, the Service Plan "should be updated after every incident..." During the same interview, E2 confirmed the establishment failed to review and update the Service Plan of R2 to meet his safety needs.	A4010		