STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510036	A. BUILDING: _____ B. WING _____	C 01/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT BOLINGBROOK	351 LILY CACHE LANE BOLINGBROOK, IL 60440

(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 IL198957 295.2000 a)c)2)3)4) 295.2050 a)b)c) 295.4010 a) 295.6000 a)13)	A 000		
A2000	Section 295.2000 Residency Requirements This Regulation is not met as evidenced by: Type 1 Violation Section 295.2000 Residency Requirements a) No individual shall be accepted for residency or remain in residence if the establishment cannot provide or secure appropriate services, if the individual requires a level of service or type of service for which the establishment is not licensed or which the establishment does not provide, or if the establishment does not have the staff appropriate in numbers and with appropriate skill to provide such services. (Section 75(a) of the Act) c) A person shall not be accepted for residency if: 2) The person is not able to communicate their needs in any manner and no resident representative residing in the establishment, and with a prior relationship to the person, has been appointed to direct the provision of services;	A2000		

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A2000	Continued From page 1 3) The person requires total assistance with 2 or more activities of daily living; 4) The person requires the assistance of more than one paid caregiver at any given time with an activity of daily living; This requirement was NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to recogize a residents need for higher level of care for one resident (R1) out of three residents reviewed for residency requiremenst. This failure cause severe harm to a resident and creates a substantial probability of severe harm to other residents. Finding include: R1 was admitted to the facility on 11/25/24. R1's service plan dated 11/26/24 documents R1 as needing physical assistance with bathing, dressing, oral hygiene, mobility, is bedbound and has periods of time where she can not communicate her needs. On 1/23/26 at 8:35 am, R1 observed lying in bed with her meal on the bedside table. R1 was asked questions, but only smiled and nodded and did not verbally respond to any questions asked. On 1/23/26 at 8:48 am, E4, Caregiver, stated that R1 is bedbound and eats all her meals in her room. E4 was asked how long she's been bedbound and if she gets out of bed. E4 stated "(R1) has been bedbound since she got here. The only time got her out of bed was to shower. It took 2 caregivers to transfer (R1) because she	A2000		

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A2000	Continued From page 2	A2000		

used to be able to at least stand and pivot when we transferred her. She wasn't able to take a step, but she was able to at least bare weight."
E4 was asked how much assistance R1 needed with cares such as bathing, dressing, oral hygiene, eating and moving around the facility. E4 stated "(R1) needs pretty much total assist. We have to wash and dress her because she really can't move her arms. She isn't able to do it on her own. We also have to brush her teeth for her. She is able to eat on her own though. She's bedbound so she really doesn't go anywhere, when we did take her to the shower, we had to push her (wheelchair) because she couldn't propel herself." E4 stated that R1 has been bedbound and needed almost total assist in all areas of ADLs since her admission. E4 was asked about R1's fractured leg on 12/9/25. E4 stated that she was the one that discovered R1's injury on 12/9/25, but she noticed something was wrong with R1's leg on 12/8/25. E4 stated that she doesn't know how it happened and R1 can't communicate what happened.

R1's hospital records dated 12/9/25 documents, "Chief Complaint: Leg Injury (Pt with right lower leg injury. Pt was found by caregiver in bed with a pool of blood around right leg. Pt is bedbound and complete care at facility. Pt is A&Ox1 (baseline). Right leg splinted by EMS, bleeding controlled). Type I open displaced comminuted fracture of shaft of right fibula, initial encounter."
On 1/23/26 at 11:12 AM, R1'a POA stated "I have a theory on how it happened. Since my mom can't walk, they stand her up and pivot her into the wheelchair. I think her leg got stuck when they moved her and it broke. I said something to the doctor at the hospital and he said it's a possibility given the type and location of the fracture."

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A2000	Continued From page 3 On 1/23/26 at 12:30 PM, E2, Wellness Director, verified that R1 was not on hospice at the time of her admission and stated that she just went on hospice when she returned to the facility on 12/14/25. E2 verified that R1 has been bedbound and needing total assist with several areas of her ADLS.	A2000		
A2050	Section 295.2050 Incident and Accident Reporting This Regulation is not met as evidenced by: Type 1 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. c) A copy of the report shall be maintained by the establishment for one year after the date of the incident or accident. This requirement was NOT MET as evidenced	A2050		

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A2050	Continued From page 4 by: Based on observsation, interview and record review, the facility failed to report an injury of unkown origin for one resident (R1) out of three residents reviewed for injuries. This failure caused a delay in assessment and investigation that creates a substantial probability of severe harm to a resident. Findings include: R1's service plan dated 11/26/24 documents R1 as needing physical assistance with bathing, dressing, oral hygiene, mobility, is bedbound and has periods of time where she can not communicate her needs. On 1/23/26 at 8:35 am, R1 observed lying in bed with her meal on the bedside table. R1 was asked questions, but only smiled and nodded and did not verbally respond to any questions asked. On 1/23/26 at 8:48 am, E4, Caregiver, stated that R1 is bedbound. E4 was asked how long she's been bedbound and if she gets out of bed. E4 stated "(R1) has been bedbound since she got here. The only time got her out of bed was to shower. It took 2 caregiver to transfer (R1) because she used to be able to at least stand and pivot when we transferred her. She wasn't able to take a step, but she was able to bare weight." E4 was asked about R1's fractured leg on 12/9/25. E4 stated that she was the one that discovered R1's injury on 12/9/25 and stated "I used to be able to transfer (R1) by myself. I'm probably the only one that was able to do it. About a week prior (E4 looked at the calendar), it was 12/2, I noticed that R1 wasn't able to bare weight on her right leg like she used to. I noticed there was somehting	A2050		

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A2050	Continued From page 5	A2050		

wrong with her right leg. I reported it to the (E6,Nurse). Then on 12/8/25, I was assigned to (R1) and when I was transfering her, I noticed she still had an issue withg that right leg. It looked out of place, it was bent. I reported it to (E6,Nurse) again. When I came in on 12/9/25, it was about 7:30 am, I grabbed (E5, caregeiver) to help me transfer (R1) becuase she wasn't able to stand on that leg. We walked into the room and when I pulled back the covers, there was a huge pile of blood in the bed. I immediatley went and got (E6, Nurse)."

On 1/23/26 at 9:51 am, E6, Nurse, stated that she doesn't remember R1's leg injury being reported the week of 12/2, but does remember the injury being reported to her on 12/8. E6 stated she reported the injury of unkown origin to E2, Wellness Director.

R1's hospital records dated 12/9/25 documents, "Chief Complaint: Leg Injury (Pt with right lower leg injury. Pt was found by caregiver in bed with a pool of blood around right leg. Pt is bedbound and complete care at facility. Pt is A&Ox1 (baseline). Right leg splinted by EMS, bleeding controlled). Type I open displaced comminuted fracture of shaft of right fibula, initial encounter."

On 1/23/26 at 10:30 aM, E2, Wellness Director, verified she was informed of R1's leg injury on 12/8/25, but did not investigate it or report it becauce the family refused to have her treated. E2 stated she did report the 12/9/25 leg fracture.

R1's medical record does not document R1's POA or physician was notified.

On 1/23/26 at 11:12 AM, R1'a POA stated that she was never notified on an injury on 12/8/26

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A2050	Continued From page 6 and would have had her mother sent to the hospital had she been informed.	A2050		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 1 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. This requirement was NOT MET as evidenced by: Based on interview and record review, the facility failed to add the transfer status of a resident (R1) for three residents reviewed for service plans. This failure creates the substantial probability of severe harm to a resident or residents. Findings include: R1 was admitted to the facility on 11/25/24. R1's service plan dated 11/26/24 documents R1 as needing physical assistance with bathing, dressing, oral hygiene, mobility, is bedbound and has periods of time where she can not	A4010		

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A4010	Continued From page 7	A4010		

communicate her needs. R1's service plan does not indicate how R1 transfers.

On 1/23/26 at 8:35 am, R1 observed lying in bed with her meal on the bedside table. R1 was asked questions, but only smiled and nodded and did not verbally respond to any questions asked.

On 1/23/26 at 8:48 am, E4, Caregiver, stated that R1 is bedbound and eats all her meals in her room. E4 was asked how long she's been bedbound and if she gets out of bed. E4 stated "(R1) has been bedbound since she got here. The only time got her out of bed was to shower. It took 2 caregiver, but (R1) used to be able to at least stand and pivot when we transferred her. She wasn't able to take a step, but she was able to bare a weight." E4 was asked how much assistance R1 needed with cares such as bathing, dressing, oral hygiene, eating and moving around the facility. E4 stated "(R1) needs pretty much total assist. We have to wash and dress her because she really can't move her arms. She isn't able to do it on her own. We also have to brush her teeth for her. She is able to eat on her own though. She's bedbound so she really doesn't go anywhere, when we did take her to the shower, we had to push her (wheelchair) because she couldn't propel herself." E4 stated that R1 has been bedbound and needed almost total assist in all areas of ADLs since her admission. E3 was asked about R1's fractured leg on 12/9/25. E4 was asked about R1's fractured leg on 12/9/25. E4 stated that she was the one that discovered R1's injury on 12/9/25 and stated "I used to be able to transfer (R1) by myself. I'm probably the only one that was able to do it. About a week prior (E4 looked at the calendar), it was 12/2, I noticed that R1 wasn't able to bare weight on her right leg like she used to. I noticed there

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A4010	Continued From page 8 was somehting wrong with her right leg. I reported it to the (E6,Nurse). Then on 12/8/25, I was assigned to (R1) and when I was transfering her, I noticed she still had an issue withg that right leg. It looked out of place, it was bent. I reported it to (E6,Nurse) again. When I came in on 12/9/25, it was about 7:30 am, I grabbed (E5, caregeiver) to help me transfer (R1) becuase she wasn't able to stand on that leg. We walked into the room and when I pulled back the covers, there was a huge pile of blood in the bed. I immediatley went and got (E6, Nurse)." R1's hospital records dated 12/9/25 documents, "Chief Complaint: Leg Injury (Pt with right lower leg injury. Pt was found by caregiver in bed with a pool of blood around right leg. Pt is bedbound and complete care at facility. Pt is A&Ox1 (baseline). Right leg splinted by EMS, bleeding controlled). Type I open displaced comminuted fracture of shaft of right fibula, initial encounter." On 1/23/26 at 11:12 AM, R1'a POA stated "I have a theory on how it happened. Since my mom can't walk, they stand her up and pivot her into the wheelchair. I think her leg got stuck when they moved her and it broke. I said something to the doctor at the hospital and he said it's a possibility given the type and location of the fracture." On 1/23/26 at 12:30 PM, E2, Wellness Director, verified R1 was a 2 person stand and pivot transfer, but it was not added to the service plan.	A4010		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by:	A6000		

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A6000	Continued From page 9 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 This requirement was NOT MET as evidenced by: Based on interview and record review, the facility failed to assess and address a resident's injury of unkown injury for one resiednt (R1) out of three residents reviewed for accident/incident. This failure resulted in R1 being left in bed for an unkown time frame with an open fracture and bleeding to the right leg. This failure also creates a substantial probability of severe harm or death to a resident or residents. Findings include: R1's service plan dated 11/26/24 documents R1 as needing physical assistance with bathing, dressing, oral hygiene, mobility, is bedbound and has periods of time where she can not communicate her needs. R1's service plan does not include how she transfers. On 1/23/26 at 8:35 am, R1 observed lying in bed with her meal on the bedside table. R1 was asked	A6000		

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A6000	Continued From page 10	A6000		

questions, but only smiled and nodded and did not verbally respond to any questions asked.

On 1/23/26 at 8:48 am, E4, Caregiver, stated that R1 is bedbound. E4 was asked how long she's been bedbound and if she gets out of bed. E4 stated "(R1) has been bedbound since she got here. The only time got her out of bed was to shower. It took 2 caregiver to transfer (R1) because she used to be able to at least stand and pivot when we transferred her. She wasn't able to take a step, but she was able to bare weight." E4 was asked about R1's fractured leg on 12/9/25. E4 stated that she was the one that discovered R1's injury on 12/9/25 and stated "I used to be able to transfer (R1) by myself. I'm probably the only one that was able to do it. About a week prior (E4 looked at the calendar), it was 12/2, I noticed that R1 wasn't able to bare weight on her right leg like she used to. I noticed there was somehting wrong with her right leg. I reported it to the (E6,Nurse). Then on 12/8/25, I was assigned to (R1) and when I was transfering her, I noticed she still had an issue withg that right leg. It looked out of place, it was bent. I reported it to (E6,Nurse) again. When I came in on 12/9/25, it was about 7:30 am, I grabbed (E5, caregeiver) to help me transfer (R1) because she wasn't able to stand on that leg. We walked into the room and when I pulled back the covers, there was a huge pile of blood in the bed. I immediately went and got (E6, Nurse). The fracture is the same place I reported the leg injury the day prior."

On 1/23/26 at 9:50 am, E5, Caregiver, stated "On 12/9/25 around 7:30-8 am, (E4) came and got me and asked if I could help transfer (R1) because (R1) had been having issues over the last few days baring weight on her right leg. When I went in there with (E3), she pulled the covers off (R1)

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A6000	Continued From page 11	A6000		

and there was blood pooled all over the bed. It was really bad. (E3) ran to get the nurse and I left the room."

On 1/23/26 at 9:51 am, E6, Nurse, stated that she doesn't remember R1's right leg injury being reported the week of 12/2, but does remember the injury being reported to her on 12/8. E6 stated she reported the injury of unkown origin to E2, Wellness Director. E6 stated that she looked at the leg on 12/8 and noted that it was swollen and it wasn't completely aligined.

R1's hospital records dated 12/9/25 documents, "Chief Complaint: Leg Injury (Pt with right lower leg injury. Pt was found by caregiver in bed with a pool of blood around right leg. Pt is bedbound and complete care at facility. Pt is A&Ox1 (baseline). Right leg splinted by EMS, bleeding controlled). Type I open displaced comminuted fracture of shaft of right fibula, initial encounter."

On 1/23/26 at 10:30 aM, E2, Wellness Director, verified she was informed of R1's leg injury on 12/8/25, but did not investigate it or report it becauce the family refused to have her treated. E2 verified they did not assess or address R1's injury when notified on 12/8/25.

R1's medical record does not document R1's POA or physician was notified.

On 1/23/26 at 11:12 AM, R1'a POA stated that she was never notified on an injury on 12/8/26 and would have had her mother sent to the hospital had she been informed.

On 1/24/26 at 9:30 AM, Z1, Paramedic, stated "When we arived on the scene, (R1) had an open fracture to her right leg. She had a laceration

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A6000	Continued From page 12 where the bone poked through the skin and there was apporximatley 400 ml of blood in the bed. Given the size of the laceration and the amount of dried blood, I would guess she had been laying there like that for about 4 hours."	A6000		