STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510399	A. BUILDING: _____ B. WING _____	C 03/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEINBERG COMMUNITY	1551 LAKE COOK RD DEERFIELD, IL 60015

(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 IL00200220 is substantiated. 295.6000a)13)	A 000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: General Violatoin Section 295.6000 Resident Rights 295.6000a)13) 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 regulation is NOT MET as evidenced by: Based on interview and record review, the establishment failed to protect a resident from misappropriation of property/exploitation/theft and failed to ensure staff reported suspicion of misappropriation in a timely manner. This involves 1 of 2 residents reviewed (R1). This failure resulted in R1's personal belongings being removed from her apartment after her death by a staff member. Findings include:	A6000		

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R1's medical record showed a move-in date of 02/02/2024 and a date of death of 01/15/2026. R1 previously resided in room 527. Past medical history included but not limited to: mild cognitive impairment, mood affective disorder, chronic pain and personal history of diseases of the musculoskeletal system and connective tissues.

R1's service plan agreement dated 01/10/2026 reads in part: on 01/10/2026, resident was observed with hallucination and confusion. Nurse assessed resident and notified physician. Sent to hospital for further evaluation, Z1 (R1's brother) was notified. On 01/16/2026, resident passed away at the hospital.

Final incident report submitted to Department of Public Health documented initial report of resident (R1) misappropriation of property/theft was sent on 02/03/2026. Continues as investigation with local police department and state's attorney office ...Establishment will file complaint so the incident "will be on record of this terminated employee" (E4).

Investigation report provided by facility on 03/06/2026 documented that on 02/02/2026, a resident assistant (E6) informed E5 (Personal Care Manager) that she observed E4 (Personal Care Staff/Resident Assistant) "going in/and out" of resident's room who had expired (R1) and whose door should have been locked. E6 gave days and times she noticed E4 entering and exiting room. E5 reviewed video footage from the days and times indicated by E6 with another manager. Video footage showed E4 enter R1's room on 01/28/2026, 01/30/2026, and 02/02/2026 at approximately 09:00 PM then exited the room at approximately 09:30 PM with bags then proceeded to put the bags into her vehicle. E4

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re-entered the building and re-entered R1's around 10:30 PM. E4 was then seen again placing bags into her vehicle. After viewing the video footage, E5 reported the incidents to E1 (Executive Director) on 02/02/2026. On 02/03/2026, E1 and E5 met with E4 and asked if E4 had taken any items from a resident's room. Initially, E4 denied the accusation then admitted that R1 had previously told her that she wanted E4 to have an article of clothing. E4 admitted to taking this clothing item. E4 was re-educated that staff are not allowed to take anything from a resident's room whether current or deceased. Polcie were notified and reviewed video footage on-site. Police were provided with R1's face sheet and vacancy form that showed establishment aquired the room as of 01/30/2026, concluding that items were removed from the room initially when they were R1's property and when they were the property of the establishment. E4 was suspended pending investigation. Z1 was contacted and indicated he would review R1's belongings the following day. Inservice was held on 02/05/2026 to review abuse, neglect and financial exploitation (including misappropriation of funds and property) and tips/gratuity policy. E4 was officially terminated on 02/09/2026. On 02/11/2026, during follow-up with police, it was reiterated that the establishment would be pressing charges against E4.

Review of termination form dated 02/04/2026 that was provided by E1 on 03/06/2026 indicated E4 involuntarily resigned and was terminated on 02/09/2026 for "violation of work rules" and "theft".

On 03/06/2026 from 12:22-12:40 PM, E1 (Executive Director) said verbatim during interview regarding R1's incident: E1 was notified

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on 02/03/2026 by E5 (Personal Care Manager) that an anonymous staff member (identified as E6-President Assistant) reported seeing E4 enter room 527 that was previously occupied by R1. She was discharged at the time E4 entered. The room still contained personal belongings such as, clothes, shoes, pictures and costume jewelry. E1 said E4 was first observed by E6 on 02/02/2026 entering R1's room and she reported this to E5 on 02/03/2026. E1 then said an investigation was initiated and upon reviewing video footage, E1 saw E4 enter the room on 01/28, 01/30 and 02/03/2026 at approximately the same time each evening. E1 indicated E4 entered the room at approximately 9:00-930 PM and again at approximately 10:30 PM. E4 exited the room with "large plastic bags on all three dates". E1 indicated she could follow the video footage all the way from the stairways to the employee parking lot where E4 was observed placing the bags into her vehicle. The police were called on 02/03. At 12:32 PM, E1 said after reviewing the footage, she met with E4 and asked whether she took items from any resident's room. At first, E4 denied taking anything then said prior to R1 passing, R1 wanted E4 to have a specific dress shirt before she passed. E4 then admitted to going into R1's room and taking the dress shirt and nothing else. E4 did not indicate what day she entered the room. E1 re-educated E4 on the facility's policy regarding misappropriation/theft that each employee must sign during orientation. E4 was then suspended and escorted out of facility. At 12:35 PM, during this interview, E1 received a call from the local police department. They indicated the case is now closed and E4 was given a local ordinance. At 1239 PM, E1 said that Z1 (R1's brother) started cleaning out her room and removing items on 01/15. The room was vacated on 01/30, and any remaining items

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were donated to the establishment. E1 added that on the first two dates (01/28 & 01/30) that E4 removed items from the room, it was still R1's property but on the last date (02/02/2026), it was the establishments property. Z1 was informed and spoke with the police on 02/04. On 02/05, R1's brother came in and met with E1 and indicated he was concerned with the jewelry for sentimental reasons and had already taken any valuables prior to vacating the room on 01/30/2026.

On 03/06/2026 from 12:53-1:28 PM, E4 (Personal Care Staff/Resident Assistant) said verbatim during interview regarding R1's incident: she no longer works at the facility. Then indicated she was "set up". E4 then said the family took R1's valuable items and gave authority to the facility to throw her remaining items away. The facility takes donated TV's, furniture, etc. and either puts them in the basement or into the facility trash bins then said after she (R1) passed away, several staff members entered her room to clean it up. At 12:58 PM, E4 said when the facility called her, they said there's video footage of her taking bags out of R1's room. At 12:59 PM, E4 said there were clothes inside the bags which she placed into her car then later donated. She added that the facility did not re-educate her on the facility's policy regarding removing items from a resident's room. E4 then said the room was no longer R1's after 02/01 due to her death. E4 added that from 01/15 to 01/31/2026, she did not enter R1's room or remove any bags from the room then indicated after the facility opened the room for cleaning and clearing of the contents is when she entered the room, but she did not recall the date she had entered. E4 said it is common practice for people to go into a room and take home whatever they want. At 1:09 PM, E4 said she told E1 that she

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took clothes from R1's room. Then later received a call and was accused of stealing items. E4 said "they should have made it clear that staff are not allowed to take things from a resident's room because it is considered theft". At 1:12 PM, E4 said when she was first questioned about the incident, she was asked if she took any items from other resident's rooms. E4 said no she did not. E4 then indicated she told management prior to R1's death, she wanted E4 to have a brown dress then donate the remaining clothes to charity. E4 said she did not tell anyone that R1 voiced this to her. E4 then said the first week of February was when she entered R1's room and she had only entered the room once and took out some bags of clothes. E4 didn't recall how many bags she removed. E4 added that she placed the bags into her car then donated them to charity. At 1:19 PM, E4 said she's seen other staff take expensive items from resident rooms like paintings, jewelry, etc. and take them to their cars. E4 added that when a family donates items, certain staff are allowed to take the items from the room for themselves then indicated that E6 told her R1's room was open for donation a few days prior to her going into the room. E6 then said E6 took items the day before she took items, and other staff took items from the room as well. E4 said she was the last person to take items out of R1's room. She added that when a room is open for cleaning, staff are allowed to take items, and whatever is left, will be placed into the dumpster.

On 03/06/2026 from 1:35 - 01:50 PM, E5 (Personal Care Manager) said verbatim during interview regarding R1's incident: She received a complaint by E6 (Resident Assistant) on 02/02/2026 that E6 saw E4 going into R1's room. E6 knew the resident had passed and that E4

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didn't have any business going into the room. E6 saw E4 take a bag out of the room on 02/02. E5 said she reviewed video footage and saw E4 taking bagged items from R1's room then saw her taking the bags out to her car in the back parking lot. She informed E1 on 02/02. On 02/03 E5 and E1 spoke with E4 in person and asked if she took any items a resident's apartment. She denied it. Then she admitted that R1 told her before she expired that R1 wanted E4 to have a dress shirt. E4 admitted going into R1's and taking this item only. E4 was educated that staff are never allowed to remove items from a resident's room, whether current or expired. E4 was informed the police would be called. At 1:42 PM, E5 said a room still belongs to a resident until the vacancy form is completed and signed by the family. R1's vacancy form was signed on 01/30/2026. The apartment belonged to the establishment after 01/30. Any items still in the apartment also belonged to the facility. At 1:45 PM, E5 said housekeeping clean out the resident's room after discharge and any large items are placed in the basement area where staff can put their name on an item if they want it; clothes, shoes, décor, etc. are usually placed into the garbage. E5 added that staff cannot go into a resident's room and take items. If a staff member wants any clothes, shoes, décor, etc., they can take it out of the dumpster. At 1:50 PM, E5 said E1 talked with police and showed them the footage and they came and talked with E4. After police finished speaking with E4, E1 and E5 met with her again. They took E4's name badge and informed her that she was suspended pending investigation then escorted her out. E5 and E1 phoned E4 on 02/05/2026, informed her the investigation was complete and they were going to terminate her employment. E4 was then informed that she had three days to request a

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meeting with the establishment or with the union. E4 then said there was no further contact with E4 after this date.

On 03/06/2026 at 01:58 PM, E6 (Resident Assistant) said verbatim during interview regarding R1's incident: she saw E4 enter R1's room on 01/28/2026 at about 9:30-10:00 PM and again on 01/30/2026 at about the same time. E6 said after she seen E4 enter R1's room, she left the area and went to the first floor and sat by the elevator. On 01/28, she saw E4 come down the stairs with a big, black plastic bag and walked towards the back door that exits to the back parking. E6 said she watched E4 put the bag into her (E4) car. E4 came back into the building and went up to the fifth floor again. E6 said she didn't tell anyone initially because she "wanted to see if she would do it again". At 2:11 PM, E6 said she again saw E4 enter R1's room on 01/30/2026 at about 9:30-10:00 PM. At that same time, one of E6's assigned residents call light was going off. Another staff member asked E6 where E4 was at. E6 said she didn't know where E4 was then E6 went to the first floor. E6 said she saw E4 come downstairs with a small plastic bag on same date, but she couldn't see what was in the bag. E6 added that she still didn't tell anyone that she saw E4 going into R1's room and leaving with bags of stuff. Then said E4 was off on 01/31 and 02/01/2026 but when E4 returned to work on 02/02/2026, E6 worked with E4 again on the fifth floor from 2:30 to 11:00 PM. E6 saw E4 enter R1's room once again at about 9:00-9:30 PM on this date. E6 said she again went downstairs because she didn't want E4 to see her coming out of the room. E6 saw E4 come down the stairs again with a small plastic bag, exit the back door then come back in without the bag. E6 said the following day, 02/03/2026, she went to E5's office

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and told her that she saw E4 go into R1's on 01/28, 01/30 and 02/02/2026. E6 told E5 to check the camera. E6 said staff have previously been told to report any suspicion of abuse or theft to management immediately. E6 then said E4 was called to E5's office then later returned and took her personal bag then left the floor (500). E6 added that E4 didn't work at facility anymore after that day (02/03/26). At 2:27 PM, E6 said staff are not allowed to take any items from a resident's room even if the family doesn't want them. E6 added that she has never taken anything from a resident's room, nor did she take any items from R1's room. E6 also said she never told E4 that R1's room was open, and staff could take stuff.

On 03/06/2026 at 03:01 PM, E7 (Resident Assistant) indicated she has worked at the facility for eleven years and is currently working on the fifth floor. E7 then said she has attended several in-services on abuse and theft, then added that staff are never allowed to remove anything from a resident's room even when donated. She added that donated items moved to the basement can be claimed by staff but never from a resident's room.

On 03/06/2026 at 02:46 PM, E1 indicated she is trying to obtain the police report and will provide to surveyor when received but may not be until Monday (03/09/2026).

On 03/06/2026 at 03:20 PM, E1 acknowledged that the misappropriation of property occurred but the facility had taken proper steps in the investigation. E1 added that she would like this incident to be a part of E4's record so she can't work somewhere else and do this again.

On 03/07/2026 at 05:05 PM, during exit

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conference with E1 (Executive Director), she said her expectation of a staff member who suspects or witnesses abuse, neglect, or theft is to report the incident immediately.

(E1 provided surveillance footage clips for the incident involving R1 and E4. Surveyor attempted to view video clips but was unable due to required security access that was not obtained.)

On 03/09/2026, E1 provided the police report regarding R1's incident that reads in part:

Police Offense Report (case # 2026-00001558) with print date of 03/09/2026 provided be E1 (Executive Director) on same date reads in part: two officers were dispatched to the establishment on 02/03/2026 at approximately 04:45 PM for an investigation regarding a potential theft that was later deemed as burglary. E1 stated to officers that an anonymous employee reported to E5 (Personal Care Manager) on 02/03/2026, seeing E4 enter R1's previous room (527) and exited with bags full of items. Initial review of surveillance footage confirmed the claim and showed E4 had entered and exited said room approximately six different times on various dates. On each time/time, E4 was seen exiting the room with bags that appeared to be full of items. These dates were confirmed as occurring on 01/28, 01/30 and 02/02 between 2100-2230 (9PM-10:30 PM) hours each day. The officers partial video surveillance that showed E4 enter, and exit said room on two separate occasions and seen leaving with plastic bags that appeared full. The contents within the bags could not be determined. Officers were informed by staff that E4 could be seen on additional footage take the stairs to the back of the building where her vehicle was parked after leaving the unit (500).

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A6000	Continued From page 10 Officers then contacted Z1 (R1's brother) who confirmed the property was turned over to the establishment on 01/30/2026. E1 was informed by officers that the establishment would be considered the victim for any additional theft that occurred possession was re-obtained. E1 indicated criminal charges would be filed against E4 because she was not an authorized employee granted access to the unit. E4 was interviewed by officers at establishment. When asked if she had taken any items from said room, E4 indicated she only took a single knee-length brown dress. E4 then said she and R1 were friends and R1 stated to E4 that she could take anything she wanted following her passing. After further questioning by officers, E4 admitted to removing bags of garbage from said room and only the above mentioned dress. E4 was asked if there was other clothing, jewelry, or shoes inside the bag. Initially E4 denied the claim then stated she did take additional articles of clothing which she donated to charity. Officers were provided with a flash drive that contained video footage of E4. Upon viewing the footage, E4 was seen entering said unit empty-handed and exiting with items on 01/28. 01/30, and 02/02/2026. Video also showed E4 checking the unit multiple times to ensure the unit remained unlocked. Footage further showed E4 leaving said room/unit with bags that appeared full, a green and brown tote bag, and a large white handbag on above dates. Further footage showed E4 exiting the room/unit with plastic bags also appeared full, exiting the building, placing items in the trunk of her vehicle then re-entering building empty-handed. On 02/05/2026, Z1 was contacted by phone. This conversation is redacted then documented E1 stating she spoke with Z1 who indicated to her that R1 "has a storage unit he has not visited and the missing jewelry may be located in that unit".	A6000		

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A6000	Continued From page 11 On 02/10/2026, it is noted that Z1 did not want to press charges for the dates prior to vacating room (01/30/2026). On 02/17/2026, officers went to E4's residence and issued her a citation (NT12626) for theft (local ordinance 15-29.2) and was provided with a court date. Per county felony review, there was not enough evidence to continue pursuing a felony charged. Case was closed. Undated Resident's Rights policy provided by facility on 03/06/2026 reads in part, [Establishment] Community for Senior Living shall assure that all residents have the following rights: the right to be free of abuse or neglect or financial exploitation or to refuse to perform labor ... the right to retain and use personal property and a place to store personal items that is locked and secure ... Abuse, Neglect, and Financial Exploitation (including misappropriation of property) Prevention and Reporting policy last revised 02/2026 provided by facility on 03/06/2026 reads in part: to provide prevention and reporting requirements for Abuse, Neglect, and Financial Exploitation in accordance with IDPH (Illinois Department of Public Health) Assisted Living Regulations. In accordance with IDPH Assisted Living Regulations, section 295.6010 includes but not limited to: ... all staff and visitors are obligated to report abuse, neglect, and financial exploitation of a resident to management ...	A6000		