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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 Annual Licensure Survey 295.2040a)b)1)c)d)e)h) 295.2060a)b)1)2) 295.3000a)b)e)1)2)B)C)f)1)g)h) 295.3020a)1-6)d)1) 295.3030a)b) 295.3040 295.8000a)1) Facility Reported Incident: #200712 295.2000a)e) 295.6000a)1)5)	A 000		
A2000	Section 295.2000 Residency Requirements This Regulation is not met as evidenced by: TYPE 1 VIOLATION Section 295.2000 Residency Requirements 295.2000a)e) 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) e) Residency shall be terminated in accordance with Section 295.2010 when services available to the resident in the establishment are no longer adequate to meet the needs of the resident. This provision shall not be interpreted	A2000		

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A2000	Continued From page 1	A2000		

as limiting the authority of the Department to require the residency termination of individuals. (Section 75(e) of the Act)

This regulation is NOT MET as evidenced by:

Based on interview and record review, the establishment failed to discharge a cognitively impaired resident that requires extensive supervision to prevent accidents and/or risk of serious injury. This failure applies to one (R1) of seven residents reviewed for this requirement.

This failure resulted in R1 experiencing repeated falls with or without injuries and an increase of safety checks to prevent further fall incidents.

This failure creates a substantial probability of severe harm or death to a resident or residents.

Findings include:

R1's Mini Mental State Exam dated 06/19/2025 (virtual assessment) documented score of 24 which indicates normal to uncertain mild impairment.

R1's face sheet documented a move-in date of 06/23/2025 with a past medical history not limited to glaucoma, hypertension, ataxic gait, urinary tract infection and incontinence, osteoporosis, restless legs syndrome, sleep apnea, and dementia.

Review of R1's incident log from admission to current showed the following:

fall on 07/04/2025 at 2:45 AM where she sustained abrasion to left & right knee; fall on 07/04/2025 at 4:30 PM; observed on floor on

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A2000	Continued From page 2 07/25/2025 with unspecified injury to left leg; fall on 08/12/2025 at 12:15 AM; fall on 08/31/2025 at 9:30 PM; fall on 10/15/2025 at 12:15 AM where she sustained a skin tear to right knee; fall on 10/21/2025 at 11:45 AM with no documented injuries and at 3:30 PM where she sustained a skin tear to right arm; observed on floor on 10/27/2025 at 7:15 PM; fall on 11/18/2025 at 9:00 AM; fall on 01/13/2026 at 5:30 PM; fall on 02/19/2026 at 9:45 AM; observed on floor on 02/2025/26 at 7:30 AM; fall on 03/11/26 at 6:00 AM where she sustained a hematoma to eyebrow; fall on 03/14/2026 at 3:15 AM where sustained injury to left eye. R1's service plan dated 03/16/2026 reads in part: level of assistance for mobility/ambulation: independent, uses walker independently, resident reminded to lock brakes before standing; does not require assistance with using the community response system; requires regularly scheduled safety checks per memory care protocol-every one hour daily; has a history of falls; transferring: independent, resident does not require assistance with transferring; occasional poor judgment. Resident at time may refuse staff assistance with activities of daily living (ADLs); resident has current or history of frequent or difficulty in remembering and using information, requires directions and reminding from others; short and long term memory impairment; observe/monitor for safety checks overnight every thirty minutes. R1's interventions and fall incidents included but not limited to: staff to assist in keeping a clutter free apartment; encourage resident to wear proper footwear; remind resident to ask for assistance as needed;	A2000		

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staff to round on resident per memory care protocol; encourage resident to scoot over to the middle of the bed when laying down.

9/1/25 slid off bed (not indicated on incident log) on to bottom, no injuries. 9/1/25 call to family to bring new blanket as comforter is too slippery.

10/15/25 noted on floor small skin tear to R lower knee. 10/15/25 staff to remind/assist to wear non-skid socks to prevent falls in room at nighttime.

10/21/25 fall while walking and multitasking moving the tissue to side of her walker, lost balance with fall. 10/21/25 staff to remind, put tissues or other objects in pockets, to keep both hands on the walker, new order for therapy received. 10/21/25 3:30 PM, request sent to power of attorney asking if they can purchase a walker tote to go over resident's walker to replace carrying a purse (received 10/22), also reinforced the importance with resident of keeping both hands on walker when she walks.

10/24/25 discoloration to right flank faded, may be from recent fall, undetected at the time of fall (not indicated on incident log). 10/24/25 staff to continue to monitor for safety and remind resident she can pull bathroom cord for assistance.

10/27/25 status post fall, physician in to see resident, new order for physical therapy. Staff to remind resident to get up slowly for transfers.

11/18/25 staff to provide cues while in room providing care, encourage to wait for assistance.

01/13/26 fall after dinner, foot caught on chair, lost balance, no injuries. 1/13/26 intervention for

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A2000	Continued From page 4	A2000		

staff to encourage resident to use proper body mechanics and to get up slowly for independent transfers with rolling walker.

02/19/26 resident had a self-reported fall with bruising noted to right forehead. Resident states she fell and hit her head with her foundation. 02/19/2026 staff to offer assistance to resident with applying makeup.

02/26/26 unwitnessed fall (UWF) near her bathroom while attempting to clean her floor with no shoes on at time of fall. 2/26/26 staff to encourage proper footwear or non-skid sock when out of bed.

03/11/26 self-reported UWF fall while attempted to ambulate herself to the washroom. 3/11/26 resident to continue antibiotics for urinary tract infection (UTI). Staff to offer to toilet every two hours during the day and twice at nighttime.

03/14/26 3:15 AM fall in bathroom complained of dizziness no new injury. 03/14/26 new order for blood pressure monitoring x forty-eight (48) hours and safety checks changed to every thirty (30) minutes.

On 03/25/2026 at 03:06 PM, E2 (Director of Nursing) said "we don't do fall assessments". Incident reports are done post fall and interventions are updated with each fall within twenty-four hours of business.

On 03/25/2026 at 03:08 PM, E21 (Assistant Director of Nursing) said R1 has mild to moderate cognition. E2 added that R1 ambulates independently with a wheeled walker and her safety checks were increased to thirty minutes due to increased falls.

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A2000	Continued From page 5 On 03/26/2026 from 09:08 - 09:28 AM, E17 (Licensed Practical Nurse) said verbatim regarding R1: she is alert to self and is a high fall risk especially when in her room. She always tries to walk without her walker. Is dark in her room at night and she still tries to walk. E17 also added that R1 does not have a call pendant because she doesn't know how to use it. She forgets how to use it due to her dementia. On 03/26/2026 from 09:40 - 09:50 AM E19 (Licensed Practical Nurse) said verbatim regarding R1: is alert but forgets to use her walker at times. I would say she is a fall risk. Has had previous falls. Her safety checks are either every one hour or thirty minutes, not sure. During exit conference on 03/30/2026 from 12:00 PM - 12:26 PM with E1 (Executive Director), E2 (Director of Nursing), and E16 (Regional Director of Nursing), survey concerns were communicated. At 12:04 PM, E2 said for a resident who has frequent falls such as R1, further interventions such as private caregiver are case by case. Have at times reached out to family and suggested a private caregiver which would be at the family's expense. At 12:05 PM, E16 (Regional Director of Nursing) said the determination for placement at a skilled facility is case by case and if a physician signs off for that to occur. E16 added that a skilled facility is a higher out of pocket cost and some families may not be able to afford the higher cost. At 12:21 PM, E2 said "in my opinion, a UTI contributed to R1's fall. Safety checks were changed back to hourly on 03/16/2026 due to the antibiotic being effective and R1 had no further fall incidents. E1 added that if R1 sits on the floor, they would not consider this a fall due to the resident choosing to sit on	A2000		

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A2000	Continued From page 6 the floor to complete her ADL's. Review of R1's service plan upon survey exit did not show that her safety checks were changed back to hourly on 03/16/2026. Safety checks remained documented at every thirty minutes. Resident Fall policy last revised 05/2023 reads in part: it is the intent of the community to maintain safety after a resident has fallen. Follow the guidelines provided if a resident has been witnessed to have fallen or observed on the ground, presumably fallen. Service Plan policy last revised 05/2023 reads in part: to identify and assure the continuity of care and services as provided by the resident, the community, and outside services. The service plan will be the basis for coordination of services and tailored to everyone's specific needs. Individualized service plans will be developed for each resident based on health and functional, cognitive and lifestyle evaluations.	A2000		
A2040	Section 295.2040 Disaster Preparedness This Regulation is not met as evidenced by: TYPE 1 VIOLATION Section 295.2040 Disaster Preparedness 295.2040a)b)1)c)d)e)h) a) For the purpose of this Section, "disaster" means an occurrence, as a result of a natural force or mechanical failure such as water, wind or fire, or a lack of essential resources such as electrical power, that poses a threat to the safety	A2040		

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A2040	Continued From page 7 and welfare of residents, personnel, and others present in the establishment. b) Each establishment shall: 1) Have a written plan for protection of all persons in the event of disasters, for keeping persons in place, for evacuating persons to areas of refuge, and for evacuating persons from the building when necessary. The plan shall address the physical and cognitive needs of residents and include special staff response, including the procedures needed to ensure the safety of any resident. The plan shall be amended or revised whenever any resident with unusual needs is admitted. The plan shall also: c) At least six drills shall be conducted per year on a bimonthly basis. At least two of the drills shall be conducted during the night when residents are sleeping. All drills shall be held under varied conditions to: d) The establishment shall conduct a tornado drill on each shift during February of each year for employees. e) Drills shall include residents, establishment personnel, and other persons in the establishment. h) A written evaluation of each drill shall be submitted to the establishment manager and shall be maintained for one year from the date of the drill. The evaluation shall include the date and time of the drill, names of employees participating in the drill, and identification of any residents who received assistance for evacuation. This regulation is NOT MET as evidenced by: Based on interview and record review, the establishment failed to ensure residents who participated in disasters drills on the overnight shift were identified either on drill participation log or resident roster.	A2040		

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A2040	Continued From page 8 This failure has the substantial probability to affect all residents in the establishment. This failure creates a substantial probability of severe harm or death to a resident or residents. The findings include: On 03/24/2026 at 01:45 PM, review of fire/tornado drill logs provided by E20 (Director of Facilities) showed the following: On 02/26/26 at 5:00 AM, tornado drill conducted on third shift and documented under "residents who participated" to "see note page 2". Log documented under observations/comments on drill on page 2, "3rd shift tornado drill in-service for staff only due to residents being asleep. Residents that were awake were evacuated to the areas of refuge". Undated resident roster was attached but did not indicate which residents were awake, who participated or who received assistance for evacuation. On 02/17/2026 at 05:10AM, fire drill conducted on third shift and documented under "number of residents evacuated" to "see note page 3". Log documented under observations/comments on drill on page 3, "3rd shift fire drill in-service for staff only due to residents being asleep. Residents that were awake were evacuated to the safe zone". Undated resident roster was attached but did not indicate which residents were awake, who participated or who received assistance for evacuation. On 11/25/25 at 5:20 AM, fire drill conducted on third shift and documented under "number of	A2040		

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A2040	Continued From page 9	A2040		

residents evacuated" to "see note page 3". Log documented under observations/comments on drill on page 3, "3rd shift fire drill in-service for staff only due to residents being asleep. Residents that were awake were evacuated to the safe zones". Undated resident roster was attached but did not indicate which residents were awake, who participated or who received assistance for evacuation.

On 08/28/25 at 5:45 AM, fire drill conducted on third shift and documented under "number of residents evacuated" to "see note page 3". Log documented under observations/comments on drill on page 3, "3rd shift fire drill in-service for staff only due to residents being asleep. Residents that were awake were evacuated to safe zones". Undated resident roster was attached but did not indicate which residents were awake, who participated or who received assistance for evacuation.

On 03/26/2026 at 9:21 AM, E17 (Licensed Practical Nurse) said drills are overseen and coordinated by E20 (Director of Facilities). E17 added that staff evacuate residents to the hallways and away from windows during tornado drills. At 09:24 AM, said if a resident is sleeping, staff have to wake them up for safety due to most beds are next to the windows. During an overnight drill, the nurse will assign caregivers to go to a specific floor and the nurses and caregivers keep track of residents that participated, usually with a resident roster.

On 03/26/2026 at 09:48 AM, E19 (Licensed Practical Nurse) said regarding fire/tornado drills, "we count them and indicate on the resident roster who participated in the drill or evacuation".

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A2040	Continued From page 10 On 03/30/2026 at 12:02 PM, E1 (Executive Director) said residents who participate in a disaster drill should be identified in order to have a record of their participation in the drill(s).	A2040		
A2060	Section 295.2060 Quality Improvement Program This Regulation is not met as evidenced by: TYPE 2 VIOLATION Section 295.2060 Quality Improvement Program 295.2060a)b)1)2) a) The establishment shall establish an effective quality improvement program that encompasses oversight and monitoring, resident satisfaction, and ongoing quality improvement and implementation of any plan that addresses improved quality services. The quality improvement process implemented by the establishment must benchmark performance, be customer centered, be data driven, and focus on resident satisfaction. (Section 30(a) of the Act) For the purpose of this Section, "benchmark" means creating points of reference from which measurements can be made. b) A system shall be in place to facilitate the detection of issues and problems, to expedite the implementation of action, and to resolve problems. 1) Data analysis shall be used to identify and implement changes that will improve performance or reduce the risk of additional events. 2) The establishment shall maintain documentation that shows that data analysis has occurred and that actions, as appropriate, have been implemented to address identified issues	A2060		

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A2060	Continued From page 11 and to resolve problems, as well as any follow-up actions taken by the establishment. 295.3000: Personnel Requirements, Qualifications and Training r/t no CPR coverage on 2/4-2/7 and did not keep staff records x12 months after last date of employment This regulation is NOT MET as evidenced by: Based on interview and record review, the establishment failed to have an effective quality assurance committee or program in place to detect and resolve any issues or problems. This failure has the substantial probability to affect all residents in the establishment. This failure creates a substantial probability of harm to a resident or resident. The findings include: On 03/24/2026, requested quality improvement plan from E1 (Executive Director) during entrance conference. No plan was provided by the community. On 03/25/2026 at 03:50 PM, E1 said there is no current quality assurance program, but management meet as needed when resident issues arise. E1 indicated she would provide policy and documentation of meetings. No policy or documentation were provided by the community. On 03/26/2026 at 9:16 AM, E1 provided "Quality Excellence Process" with effective date of	A2060		

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A2060	Continued From page 12 03/2023 that documented the processes for strategic/success planning; monthly QAPI meetings; Quality Assurance (QA); Performance Improvement (PI); and to evaluate previous improvement plans up to 3 months following implementation, ensure that what you have implemented is continuing to work, maintain all documentation of your QAPI meetings and PIP's. No meeting minutes were provided by the community. On 03/30/2026 at 12:09 PM, E1 indicated there is no "QAPI" but the establishment does meet monthly to discuss resident issues, trends, etc. and the minutes are documented. At 02:03 PM and after survey exit, E1 provided a document titled "2026 Focus Areas for Performance Improvement" that included focus areas for staff, residents, and property with meeting dates on 01/15/2026, 02/19/2026, and 03/19/2026. Upon further review, document did not include data analysis to address or detect issues and problems, how to expedite the implementation of action to resolve problems, or of any follow-up actions taken.	A2060		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: TYPE 1 VIOLATION Section 295.3000 Personnel Requirements, Qualifications and Training 295.3000a)b)e)1)2)B)C)3)f)1)g)n) a) The establishment shall have staff	A3000		

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A3000	Continued From page 13 sufficient in number with qualifications, adequate skills, education and experience to meet the 24 hour scheduled and unscheduled needs of residents and who participate in ongoing training to serve the resident population. (Section 35(a)(3) of the Act) b) The establishment shall have on duty at all times at least one direct care staff person who has obtained cardiopulmonary resuscitation (CPR) training specific to adults, which includes a demonstration of the individual's ability to perform CPR, and who has current certification in CPR. e) A file shall be maintained for each employee containing the following: 1) The employee's name, date of birth, home address, Social Security number and telephone number; 2) Documentation of: B) Employee orientation; and C) Ongoing training; 3) An employee's starting date of employment and ending date, if applicable. f) In addition to the information required in subsection (e) of this Section, the file for each direct care employee shall contain documentation of: 1) Current certification in CPR, if applicable; g) All records required by this Section shall be maintained throughout the individual's employment or service and for at least 12 months after the individual's last date of employment or service, unless required for a longer period of time by State or federal law. n) Prior to employing any individual in a position that requires a State professional license, the establishment shall contact the Illinois Department of Professional Regulation to verify that the individual's license is active. A copy of the verification shall be placed in the individual's personnel file.	A3000		

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A3000	Continued From page 14 This regulation is NOT MET as evidenced by: Based on interview and record review, the establishment failed to ensure at least one direct care staff had an active nursing license and had cardiopulmonary resuscitation (CPR) training; and failed to maintain a staff members records for at least 12 months after last date of employment. This failure has the substantial probability to affect all residents in the establishment. This failure creates a substantial probability of severe harm or death to a resident or residents. The findings include: On 03/24/2026, review of undated staff roster provided by E1 (Executive Director) showed that all current licensed nurses were CPR certified. On 03/25/2026 at 12:45 PM, E1 indicated that all licensed nurses are CPR certified, and the establishment schedules a licensed nurse twenty-hour hours a day. On 03/26/2026, reviewed nursing schedules for February and March 2026 that were provided by E1 (Executive Director) on 03/24/2026. During review, noted on the February schedule that E14 (Licensed Practical Nurse) was the only nurse listed for third shift from the 4th through the 7th. Review of current staff roster did not show that E14 was a current employee. Requested from E1, E14's employment dates, CPR certification and nursing license or review.	A3000		

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A3000	Continued From page 15 On 03/26/2026 at 04:31 PM, E1 said that E14 is a former employee and "we would not have her CPR certification; we shred upon termination of employment. Hire date was 12/22/2023. Term date was 02/08/2026". E1 provided E14's professional nursing license at this time that showed a license expiration date of "01/31/2025". During exit conference on 03/30/2026 from 12:00 - 12:26 PM, surveyor informed E1 of the regulation that requires establishment to maintain a staff members records for at least 12 months after last date of employment and therefore surveyor could not verify whether a CPR certified staff member was on duty for the above dates in question. E1 was not aware of this regulation regarding employee files.	A3000		
A3020	Section 295.3020 Employee Orientation and Ongoing Training This Regulation is not met as evidenced by: TYPE 2 VIOLATION Section 295.3020 Employee Orientation and Ongoing Training 295.3020a)1)2)3)4)5)6)d)1) a) Each new employee shall complete orientation within 10 days after the starting date of employment that includes: 1) The establishment's philosophy and goals; 2) Promotion of resident dignity, independence, self-determination, privacy, choice, and resident rights;	A3020		

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A3020	Continued From page 16 3) Confidentiality of resident records and resident information; 4) Hygiene and infection control; 5) Abuse and neglect prevention and reporting requirements; and 6) Disaster procedures. d) All training shall be documented with: 1) Date; This regulation is NOT MET as evidenced by: Based on interview and record review, the establishment failed to ensure an employee completed the required orientation trainings within the timeframe per regulations. This failure has the substantial probability to affect all residents in the establishment. This failure creates a substantial probability of harm to a resident or resident. The findings include: On 03/24/2026, E1 (Executive Director) provided a current and undated staff roster. At 12:05 PM, nine staff members were selected from roster for the staff requirements review that included E9 (Dining Room Server). At 12:38 PM, requested staff documents from E1. On 03/25/2026, reviewed staff documents provided by E15 (Assistant Executive Director). Review of E9's employee file showed she completed the required 10 day post start of employment trainings for establishment's philosophy and goals, confidentiality of resident records and resident information, hygiene and infection control, abuse and neglect prevention and reporting requirements, and disaster	A3020		

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A3020	Continued From page 17 procedures. No completed training certificate was noted for resident rights. Requested this document from establishment. On 03/25/2026 at approximately 02:30 PM, E15 indicated she would provide the document then said E9 was "Polish and part-time", and it wasn't a priority for here to complete all the trainings in a timely manner. On 03/26/2026 at 8:01 AM, E15 (Assistant Executive Director) provided E9's resident rights training document. Review of document showed E9 completed the required 10 day orientation training for resident rights on 03/24/2026. Staff roster showed E9's date of hire was 03/10/2026 and indicated the resident rights training was completed outside of the 10 day orientation period.	A3020		
A3030	Section 295.3030 Initial Health Eval for Dir Care and FS empl This Regulation is not met as evidenced by: TYPE 2 VIOLATION Section 295.3030 Initial Health Evaluation for Direct Care and Food Service Employees 295.3030a)b) a) Each direct care and food service employee shall have an initial health evaluation, which shall be used to ensure that employees are not placed in positions that would pose undue risk of infection to themselves, other employees, residents, or visitors. b) The initial health evaluation shall be	A3030		

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A3030	Continued From page 18 conducted not more than 30 days prior to and no later than 30 days after the employee's initial employment in the establishment. This regulation is NOT MET as evidenced by: Based on interview and record review, the establishment failed to ensure an employee completed an initial health evaluation not more than 30 days prior to the employee's initial employment date. This failure has the substantial probability to affect all residents in the establishment. This failure creates a substantial probability of harm to a resident or resident. The findings include: On 03/24/2026, E1 (Executive Director) provided a current and undated staff roster. At 12:05 PM, nine staff members were selected from roster for the staff requirements review that included E9 (Dining Room Server). At 12:38 PM, requested staff documents from E1. On 03/25/2026, reviewed staff documents provided by E15 (Assistant Executive Director). Review of E9's employee file showed she completed her pre-employment physical examination on 01/23/2026. Staff roster showed E9's date of hire was 03/10/2026 that indicated the physical was completed more than 30 days prior to the start of employment date. On 03/26/2026 at 8:01 AM, E15 (Assistant Executive Director) said E9 "never went back to clinic, can I send her now, so she is current as	A3030		

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A3030	Continued From page 19 she just started with us". On 03/30/2026 at 12:03 PM, E1 (Executive Director) said initial staff physicals should be completed within 30 days of hire.	A3030		
A3040	Section 295.3040 Health Care Worker Background Check This Regulation is not met as evidenced by: TYPE 2 VIOLATION Section 295.3040 Health Care Worker Background Check An establishment shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code. (Source: Amended at 36 Ill. Reg. 13632, effective August 16, 2012) This regulation is NOT MET as evidenced by: Based on interview and record review, the establishment failed to provide a date for a staff member's healthcare worker background check to ensure the search was conducted prior to date of hire. This failure has the substantial probability to affect all residents in the establishment. This failure creates a substantial probability of harm to a resident or resident. The findings include: On 03/24/2026, E1 (Executive Director) provided	A3040		

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A3040	Continued From page 20 a current and undated staff roster. At 12:05 PM, nine staff members were selected from roster for the staff requirements review that included E9 (Dining Room Server). At 12:38 PM, requested staff documents from E1. On 03/25/2026, reviewed staff documents provided by E15 (Assistant Executive Director). Review of E9's employee file showed a healthcare worker background check was completed but no date was indicated on the provided documents. Review of E9's background authorization forms showed E9 signed forms on the "15th" of "2026"; month was illegible. Requested further documentation to show E9's search date from E15 (Assistant Executive Director) on 03/25/2026. No documentation was provided. On 03/30/2026 at 12:26 PM, E1 said she would provide the date of E9 background check search. At 02:03 PM, E1 provided a document of an email request made by E15 (Assistant Executive Director) on 03/25/2026 at 03:59 PM for the date of search. No date was indicated or provided by the establishment.	A3040		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: TYPE 1 VIOLATION Section 295.6000 Resident Rights 295.6000a)1)5) a) No resident shall be deprived of any	A6000		

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A6000	Continued From page 21	A6000		

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:
1) The right to live in an environment that promotes and supports each resident's dignity, individuality, independence, self-determination, privacy, and choice and to be treated with consideration and respect;
5) The right to receive the services specified in the service plan, to review and renegotiate the service plan at any time; and to be informed of the cost of the changes;

This regulation is NOT MET as evidenced by:

Based on interview and record review, the establishment failed to provide a safe environment to avoid an accident or injury for a cognitively impaired resident by failing to provide adequate supervision. This failure affects one of seven residents (R1) reviewed for this requirement.

This failure has the substantial probability to affect all residents in the establishment.

This failure creates a substantial probability of severe harm or death to a resident or residents.

The findings include:

R1's Mini Mental State Exam dated 06/19/2025 (virtual assessment) documented score of 24 which indicates normal to uncertain mild impairment.

R1's face sheet documented a move-in date of

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A6000	Continued From page 22 06/23/2025 with a past medical history not limited to glaucoma, hypertension, ataxic gait, urinary tract infection and incontinence, osteoporosis, restless legs syndrome, sleep apnea, and dementia. Incident report dated 02/19/2026 documented staff member went to R1's room to check on her and noticed a bruise to her left side forehead that measured "4 cm [centimeters] x 3.5 cm greenish in color, above the bruise two small abrasions, 0.3 cm x 0.2 cm and minimal swelling around abrasion". Resident stated, "I fell and didn't call anyone" then stated "I hit [my head] with my foundation". Resident stated a little pain in the area, acetaminophen was administered. Staff encouraged resident to call for help right away when a fall occurs. Resident verbalized understanding. (Injuries included a bruise on the left side of forehead, two small abrasions, and hematoma to the right forehead) Incident report dated 03/12/2026 documented at approximately 6:00 AM, resident came out from her room with her walker asking for an ice pack to the caregiver for her left eye area. Caregiver called nurse on duty who observed resident with moderate swelling near left eye area. Noted purple discoloration and minimal dried blood. Resident stated she fell on the floor face down when walking to the bathroom to get her walker that was inside the bathroom. Resident managed to get herself up from fall. Resident complained of pain to the area. Power of attorney came to the unit to take R1 to the emergency room. (Injuries included hematoma next to and under resident left eye) Review of R1's incident log from admission to current showed the following:	A6000		

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A6000	Continued From page 23 fall on 07/04/2025 at 2:45 AM where she sustained abrasion to left & right knee; fall on 07/04/2025 at 4:30 PM; observed on floor on 07/25/2025 with unspecified injury to left leg; fall on 08/12/2025 at 12:15 AM; fall on 08/31/2025 at 9:30 PM; fall on 10/15/2025 at 12:15 AM where she sustained a skin tear to right knee; fall on 10/21/2025 at 11:45 AM with no documented injuries and at 3:30 PM where she sustained a skin tear to right arm; observed on floor on 10/27/2025 at 7:15 PM; fall on 11/18/2025 at 9:00 AM; fall on 01/13/2026 at 5:30 PM; fall on 02/19/2026 at 9:45 AM; observed on floor on 02/2025/26 at 7:30 AM; fall on 03/11/26 at 6:00 AM where she sustained a hematoma to eyebrow; fall on 03/14/2026 at 3:15 AM where sustained injury to left eye. R1's service plan dated 03/16/2026 reads in part: level of assistance for mobility/ambulation: independent, uses walker independently, resident reminded to lock brakes before standing; does not require assistance with using the community response system; requires regularly scheduled safety checks per memory care protocol-every one hour daily; has a history of falls; transferring: independent, resident does not require assistance with transferring; occasional poor judgment. Resident at time may refuse staff assistance with activities of daily living (ADLs); resident has current or history of frequent or difficulty in remembering and using information, requires directions and reminding from others; short and long term memory impairment; observe/monitor for safety checks overnight every thirty minutes. R1's interventions and fall incidents included but not limited to:	A6000		

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staff to assist in keeping a clutter free apartment; encourage resident to wear proper footwear; remind resident to ask for assistance as needed; staff to round on resident per memory care protocol; encourage resident to scoot over to the middle of the bed when laying down.

9/1/25 slid off bed (not indicated on incident log) on to bottom, no injuries. 9/1/25 call to family to bring new blanket as comforter is too slippery.

10/15/25 noted on floor small skin tear to R lower knee. 10/15/25 staff to remind/assist to wear non-skid socks to prevent falls in room at nighttime.

10/21/25 fall while walking and multitasking moving the tissue to side of her walker, lost balance with fall. 10/21/25 staff to remind, put tissues or other objects in pockets, to keep both hands on the walker, new order for therapy received. 10/21/25 3:30 PM, request sent to power of attorney asking if they can purchase a walker tote to go over resident's walker to replace carrying a purse (received 10/22), also reinforced the importance with resident of keeping both hands on walker when she walks.

10/24/25 discoloration to right flank faded, may be from recent fall, undetected at the time of fall (not indicated on incident log). 10/24/25 staff to continue to monitor for safety and remind resident she can pull bathroom cord for assistance.

10/27/25 status post fall, physician in to see resident, new order for physical therapy. Staff to remind resident to get up slowly for transfers.

11/18/25 staff to provide cues while in room

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A6000	Continued From page 25 providing care, encourage to wait for assistance. 01/13/26 fall after dinner, foot caught on chair, lost balance, no injuries. 1/13/26 intervention for staff to encourage resident to use proper body mechanics and to get up slowly for independent transfers with rolling walker. 02/19/26 resident had a self-reported fall with bruising noted to right forehead. Resident states she fell and hit her head with her foundation. 02/19/2026 staff to offer assistance to resident with applying makeup. 02/26/26 unwitnessed fall (UWF) near her bathroom while attempting to clean her floor with no shoes on at time of fall. 2/26/26 staff to encourage proper footwear or non-skid sock when out of bed. 03/11/26 self-reported UWF fall while attempted to ambulate herself to the washroom. 3/11/26 resident to continue antibiotics for urinary tract infection (UTI). Staff to offer to toilet every two hours during the day and twice at nighttime. 03/14/26 3:15 AM fall in bathroom complained of dizziness no new injury. 03/14/26 new order for blood pressure monitoring x 48 hours and safety checks changed to every 30 minutes. Review of R1's safety check logs showed documented checks as follows: safety checks from 12/16/2025 8:33 PM - 1/10/2026 12:08 PM every two hours; 01/10/2026 12:08 PM - 03/14/2026 4:17 AM every two hours; 03/14/2026 4:17 AM - 03/16/2026 2:15 PM every thirty minutes; 03/16/2026 2:15 PM - current every one hour.	A6000		

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A6000	Continued From page 26 Page four of R1's March 2026 log showed she was found on the bathroom floor on 03/15/2026 at 02:11 AM that was not indicated on R1s's incident log. On 03/25/2026 at 03:06 PM, E2 (Director of Nursing) said "we don't do fall assessments". Incident reports are done post fall and interventions are updated with each fall within twenty-four hours of business. On 03/25/2026 at 03:08 PM, E21 (Assistant Director of Nursing) said R1 has mild to moderate cognition. E2 added that R1 ambulates independently with a wheeled walker and her safety checks were increased to thirty minutes due to increased falls. On 03/26/2026 from 09:08 - 09:28 AM, E17 (Licensed Practical Nurse) said verbatim regarding R1: he was the overnight nurse on the night of R1's 03/11/2026 incident. Around 6:00 AM, the caregiver called him to come to R1's room in memory care. When he came to the unit, he saw R1 in the living room area. She had come out of her room looking for someone to give her an ice pack for her left eye. R1 said she fell, just now. Saw the left side of her eye, close to eyebrow was swollen and had a bump to the area. It was already dark purple with some area of redness. I did a full body assessment and saw no other injuries or skin issues. No open areas not even to the eye area. Don't recall the specific time R1 was last seen by staff. I was the only nurse working in the building that night. For memory care, there were 3 caregivers working and 2 for the assisted living side. That's how its typically scheduled. R1 is alert to self but was not confused on day of incident. R1 said she got up from her bed and went to the bathroom to get her	A6000		

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	ASL510331	A. BUILDING: _____ B. WING _____	03/30/2026

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

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A6000	Continued From page 27 walker that she previously left in bathroom. Said she fell on the way to the bathroom, so she was walking without her walker. She said she fell "facedown". I called her son to say I was sending her to the emergency room for further evaluation due to hitting her head. He said he would come and take her instead of calling the ambulance. He came in about fifteen minutes later. I heard she came back the same day. Don't believe there was any findings. She had no new orders or change to any of her medications. E17 added that R1 is a high fall risk especially when in her room. She always tries to walk without her walker. Is dark in her room at night and she still tries to walk. Safety checks were done hourly before this incident. After incident was changed to every thirty minutes. She fell again after this incident. Nursing staff do the safety checks, majority are done by caregivers. Think it is documented. E17 also added that R1 does not have a call pendant because she doesn't know how to use it. She forgets how to use it due to her dementia. On 03/26/2026 from 09:30 - 9:39 AM, E18 (Caregiver) said verbatim regarding R1's 03/11/2026 fall incident: it was about 4-5:00 AM during the overnight shift. I was changing the residents with another caregiver. R1 came out of her room. I saw her left eye was swollen and was reddish-purple in color. There was no bleeding. She said something hit her face. I called the nurse then we sat in the dining room area. She did not me tell she fell, but she told the nurse when he assessed her. When the nurse came, she said it was hurting a little bit. Said she is alert, she communicates and remembers lots of things. E18 added that R1 used to be every hour safety checks but after this incident, she became every thirty minutes checks. Not sure if she is a fall risk. Last time I saw her was at about 3:00 AM.	A6000		

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A6000	Continued From page 28 On 03/26/2026 from 09:40 - 09:50 AM E19 (Licensed Practical Nurse) said verbatim regarding R1's 02/19/2026 incident: I started work around 7:00 AM. Got report from the night nurse, don't recall who the nurse was. Did not get anything in report about R1 during the night. Started doing my morning meds. Around 8-8:30 AM, caregivers started bringing breakfast trays. I went into R1's room to see if she was up. I saw she had a bruise that was green to purple in color to the left side of her face near the eyebrow. R1 told me she had fallen last night and did not call for help; she got up by herself. Said she hurt herself with mascara. I assessed her, did her vitals, then notified the E2 (DON) and E21 (ADON). Called her physician and her son. E19 then said R1 is alert but forgets to use her walker at times. I would say she is a fall risk. Has had previous falls. Her safety checks are either every one hour or thirty minutes, not sure. Caregivers did not tell me the last time they saw her. During exit conference on 03/30/2026 from 12:00 PM - 12:26 PM with E1 (Executive Director), E2 (Director of Nursing), and E16 (Regional Director of Nursing), survey concerns were communicated. At 12:04 PM, E2 said for a resident who has frequent falls such as R1, further interventions such as private caregiver are case by case. Have at times reached out to family and suggested a private caregiver which would be at the family's expense. At 12:05 PM, E16 (Regional Director of Nursing) said the determination for placement at a skilled facility is case by case and if a physician signs off for that to occur. E16 added that a skilled facility is a higher out of pocket cost and some families may not be able to afford the higher cost. At 12:21 PM, E2 said "in my opinion, a UTI contributed to R1's	A6000		

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A6000	Continued From page 29 fall. Safety checks were changed back to hourly on 03/16/2026 due to the antibiotic being effective and R1 had no further fall incidents. E1 added that if R1 sits on the floor, they would not consider this a fall due to the resident choosing to sit on the floor to complete her ADL's. Review of R1's service plan upon survey exit did not show that her safety checks were changed back to hourly on 03/16/2026. Safety checks remained documented at every thirty minutes. Resident Fall policy last revised 05/2023 reads in part: it is the intent of the community to maintain safety after a resident has fallen. Follow the guidelines provided if a resident has been witnessed to have fallen or observed on the ground, presumably fallen. Service Plan policy last revised 05/2023 reads in part: to identify and assure the continuity of care and services as provided by the resident, the community, and outside services. The service plan will be the basis for coordination of services and tailored to everyone's specific needs. Individualized service plans will be developed for each resident based on health and functional, cognitive and lifestyle evaluations.	A6000		
A8000	Section 295.8000 Food Service This Regulation is not met as evidenced by: TYPE 2 VIOLATION Section 295.8000 Food Service 295.8000 a)1)	A8000		

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A8000	Continued From page 30 a) If food service is provided by the establishment or by contract with a food service provider, the following requirements shall be met: 1) Food services shall meet the Food Service Sanitation Code (77 Ill. Adm. Code 750) and any applicable local requirements. Section 750.230 Food Handlers-Training 750.230a)1)2)c)1) a) All Food Handlers 1) All food handlers, other than someone holding a certified food protection manager certificate, shall receive or obtain training in basic food handling principles, as outlined in Section 750.210, within 30 days after employment. 2) The regulation of food handler training is considered to be an exclusive function of the State, and local regulation is prohibited. (Section 3.05 of the Food Handling Regulation Enforcement Act) c) Food Handlers Employed By a Food Service Establishment That Is Not a Restaurant 1) All food handlers employed by a food service establishment that is not a restaurant, other than someone holding a food service sanitation manager certificate, shall receive or obtain training in basic food handling principles, as outlined in Section 750.210. (Sections 3.05(a) and (e) of the Food Handling Regulation and Enforcement Act) This regulation is NOT MET as evidenced by: Based on interview and record review, the establishment failed to ensure all food handlers received or obtained training in basic food handling principles within 30 days after start of employment.	A8000		

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A8000	Continued From page 31 This failure has the substantial probability to affect all residents in the establishment. This failure creates a substantial probability of harm to a resident or resident. The findings include: On 03/24/2026 at 01:29 PM, reviewed dietary trainings/certificates provided by E3 (Dining Director) with current dietary staff per roster and noted food handlers training certificate for ten dietary staff were not provided. At 02:19 PM, requested the missing documents for review from E1 (Executive Director). E1 indicated she would provide the requested documents. On 03/25/2026 at 10:30 AM, reviewed the additional dietary trainings/certificates provided by E1 that were not noted previous day. During this review, it was noted that three staff members completed the "serv safe" training on 03/24/2026 (day of survey entrance). The findings showed: E11 (Dining Room Server) completed the "serv safe" food handler course and exam on 03/24/2026. Undated employee roster provided by E1 (Executive Director) on 03/24/2026 showed E11's hire date was 11/25/2025. E12 (Dining Room Server) completed the "serv safe" food handler course and exam on 03/24/2026. Undated employee roster provided by E1 (Executive Director) on 03/24/2026 showed E12's hire date was 02/16/2026. E13 (Dining Room Server) completed the "serv safe" food handler course and exam on 03/24/2026. Undated employee roster provided by E1 (Executive Director) on 03/245/2026	A8000		

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A8000	Continued From page 32 showed E13's hire date was 11/11/2025. On 03/30/2026 at 12:01 PM, E1 (Executive Director) said all dietary staff should have their food handlers training completed within 30 (thirty) days of being on the floor.	A8000		