STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510335	A. BUILDING: _____ B. WING _____	C 04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL AT VERNON HILL, THE	350 SOUTH MILWAUKEE AVE VERNON HILLS, IL 60061

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A 000	Initial Comment Complaint Investigation Survey 2613477/IL200902 295.4010 a) b) 1-3) c) d) e) h) Facility Reported Incident Survey IL201191 295.4010 a) b) 1-3) c) d) e) h)	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 1 Violation-Repeat 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 residents' choices regarding the service plan. b) The service plan shall be developed by: 1) The resident, resident's representative or any individual requested by the resident. 2) The manager or manager's designer; and 3) A registered nurse, if the resident is receiving nursing services or medication administration or is unable to direct self-care. c) The service plan shall be signed and	A4010		

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A4010	Continued From page 1 dated by all individuals involved in its development. d) The service plan, shall be reviewed annually, or more often as the residents' 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) e) The service plan shall be reviewed and revised, if necessary, immediately after a significant change in the residents' physical, cognitive, or functional condition (see Section 295.4000). h) The service plan shall include all support services provided or arranged for by the establishment. These requirements are not met as evidenced by: Based on interview and record review, the establishment failed to ensure a resident (R5) who has cognitive decline and considered fall risk has fall interventions in place in her Service Plan and failed to ensure updates/changes were made to the fall interventions in a resident's (R1) Service Plan after each fall incident. The establishment also failed to show documentation the Service Plans are signed and dated during a care conference by the people involved in its development. This applies to 2 (R1, R5) residents reviewed for fall incidents in the establishment. These failures contributed to R5's fall incident in the establishment, hospitalization with fractures to	A4010		

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A4010	Continued From page 2	A4010		

the right hip and elbow, surgery with pin insertion, admission to a rehab facility, further decline in cognition and possible hospice admission. These failures also contributed to R1's fall incidents in the establishment, at various times, with injuries and hospital evaluation.

These failures also create a substantial probability of severe harm to the residents.

The findings include:

1. R5 was admitted to the establishment on March 16, 2026, with diagnoses of depression; dementia with behavioral issues; neurocognitive disorders; major depressive disorder, recurrent episode; and asthma.

On April 14, 2026, at 10:50 AM, E2 (Health and Wellness Director-HWD) said R5 is currently in a Rehab facility after her hospitalization due to a fall incident in the establishment.

On April 14, 2026, at 2:50 PM, E3 (LPN Charge Nurse) said R5 is anxious, independent in ambulation with the use of a walker. E3 added they always have a staff member in the dining room when the residents are there.

The establishment's Initial Incident and Accident Report sent to the Department dated March 24, 2026, and final report dated April 3, 2026, showed, it happened in the dining room at 5:00 PM. R5 was on her back on the floor next to her dining room chair. Her head was noted supported by staff member, with her right knee slightly bent and leg turned laterally outwards. Slip resistant shoes were on bilateral feet, and both legs appeared equal in length. Her left arm was lying

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A4010	Continued From page 3	A4010		

under her back, supporting her left hip. Her rolling walker was observed laying on its side on the floor next to the resident. R5's rolling walker was seen on its side on the floor next to her. R5 stated she was trying to pull out the chair and lost her balance. Complained of pain to right hip with pain at 6/10 and facial grimacing. Neuro checks conducted. ED, PCP, and POA were notified. Emergency service was called and R5 was transported and admitted to a local hospital at 5:30 PM with diagnosis of right femur fracture.

There was no documentation showing a staff member was on standby assist with the resident to help stabilize her while standing and pulling out her chair.

The establishment's Observation Notes for R5 dated March 26, 2026, showed she underwent hip surgery the previous day. The same Notes dated March 29, 2026, showed R5's nephew came to the facility earlier in the day to drop something off in the resident's room. Nephew spoke to ED notifying ED that resident's elbow is also fractured.

The Observation Notes for R5 dated April 10, 2026, showed R5 is currently at a short-term rehab facility and case manager noted that resident is having more significant cognitive decline. Family is considering transitioning R5 to hospice care but would like to see how she progresses more in rehab.

The same Observation Notes showed, at different instances, R5 was assessed as alert and oriented only to self, verbally responsive with severe forgetfulness and intermittent confusion, ambulated with a walker with standby assist.

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A4010	Continued From page 4 The establishment's Individual Service Plan for R5 dated March 11, 2026, did not have any initial fall interventions listed to help prevent fall incidents. The Mobility and Transfers category showed, "Staff to assist resident with ambulation as needed for safety...resident will choose and be able to transfer and move from chairs or bed as needed...Intervention: staff to provide assistance as needed for safety...staff to provide reminders or guidance for part of the task while resident initiates or completes independently." The Safety and Risk category showed, "Fall Risk-low risk with the only listed intervention as...staff to be aware of resident fall score (which is not mentioned/listed in the Service Plan)." The Service Plan was not signed and dated by the people involved in its development during a care conference. 2. R1 was admitted to the establishment on November 26, 2025, with diagnoses of Parkinson's; hyperlipidemia, unspecified; depression, unspecified; anxiety disorder, unspecified; essential hypertension; dysphagia, oropharyngeal phase, unspecified; asthma, uncomplicated. On April 14, 2026, at 2:50 PM, E3 (LPN Charge Nurse) described R1 as impulsive, ambulated with use of walker or wheelchair. After his fall incidents in the establishment, he was sent to the hospital with old fractures shown in his x-ray. He is currently on physical therapy. A review of the establishment's Incident and Accident Report from February 2026 to April 2026 showed R1 had 3 fall incidents in the establishment.	A4010		

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A4010	Continued From page 5 The establishment's Observation Notes for R1 showed he had numerous witnessed and unwitnessed fall incidents in the establishment. R1 is assessed as alert and oriented x2 with confusion, and very forgetful. The same Observation Notes showed, "On February 16, 2026, at 10:58 PM, R1 had a witnessed fall in his bathroom while sitting on the toilet. He lifted his leg up, lost his balance, and fell backward onto the floor, hitting his right shoulder and the back of his head. Resident stated he felt dizzy. Small abrasion on the left upper back was noted. The abrasion was cleansed with a wound cleanser and bacitracin ointment applied...On March 1, 2026, an unwitnessed fall incident was recorded. Sensor alarm went off in his room. Resident was sitting on the floor with his back by the wall of the closet and his walker in front of him. Resident was trying to get pants from the closet and lost his balance, landing on his buttocks. A small skin tear on the right side of his back was seen, cleansed with wound cleanser...covered with band aid...On March 11, 2026, an unwitnessed fall happened. Sensor alarm went off. Resident was sitting on the floor with walker in front of him. He stated he tripped and hit his back on the chair...abrasion on his right arm, cleansed with wound cleanser...covered with band aid...On March 19, 2026, the nurse was called to the common area. Resident was observed lying on his left side. Noted with swelling to the left side of his forehead. Resident said he got up to grab a Kleenex and fell. Complained of pain and discomfort to his left lower back area...Sent to the hospital for further evaluation...came back from the hospital same day with slight swelling and reddish discoloration to his left forehead...On March 24, 2026, an unwitnessed fall happened.	A4010		

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A4010	Continued From page 6 Resident's motion sensor went off in his room. Resident was on the floor in his room between his bed and his wheelchair...Resident said he was going to sit in his chair and missed. He slid between his bed and wheelchair. His left arm got caught in his wheelchair. Abrasion on left inner arm seen. Area cleansed and covered. Stated pain in left inner arm where abrasion is." R1's Individual Service Plan dated March 15, 2026, did not address R1's individual fall incidents in the establishment. There was no fall risk analysis made after each fall incident. There were no changes made to his fall risk interventions based on his fall root cause analysis. The support service of physical therapy as mentioned by E3 was not addressed in the Service Plan. The same Service Plan did not have a signature page to indicate it was agreed upon by all people involved in its development during a care conference. On April 14, 2026, at 3:30 PM, E2 (HWD) will make sure all Service Plans will be reviewed and individualized interventions are put in place regarding fall prevention. Changes will be reflected in the interventions after each fall incident.	A4010		