STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510123	A. BUILDING: _____ B. WING _____	C 04/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGES OF NEW LENOX, COTTAGE #3	1027 S CEDAR RD NEW LENOX, IL 60451

(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 IL200701 - Unsubstantiated* changed to #201509 on 4.27.26 Facility Reported Incident IL201462 295.6000a)13)	A 000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 2 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 observation, interview and record review, the facility failed to prevent the theft of a resident's (R2) cell phone by an employee (E3, Caregiver). This failure creates the substantial probability of harm to a resident or residents. Findings include: R2 was admitted to the facility with a diagnosis of Alzheimer's and Dementia with severe cognitive impairment. R2 is currently recieving hopice care.	A6000		

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The facility's Investigation and State Reportable on R2's missing cell phone documents the following:

"Initial report below regarding an incident currently under investigation: On 04/20/26, in Cottage 3 (R2)'s room, (R2's POA/Power of Attorney) contacted the RCC (Resident Care Coordinator) and Nursing Supervisor via text at 1:40 PM requesting a call at 2:00 PM. During the 2:00 PM call, (R2's POA) reported that she had received an email notification at 11:23 AM indicating that a verification code for the resident's (Email Account) was sent to his phone number, and that someone successfully used that code to access the account. She expressed concern that this could only have occurred if someone had possession of the resident's phone, as the two-factor authentication code was sent directly to his phone. At approximately 2:10 PM, the nurse on duty went to Cottage 3 (R2's Room) to locate the resident's phone but was unable to find it. The POA was notified that the phone was not located in the room. The POA stated that the phone was last active at 1:39 PM, with its location showing Cottage 3, and that it has not been turned on since that time. A full room search was conducted, including all bedrooms and common areas within the cottage; however, the phone was not found. On 04/21/26 at 11:54 AM, the POA contacted the ED (Executive Director) to report that upon further review of camera footage from 04/20/26, she observed that the camera had been moved and a teddy bear placed in front of it by employee (E3). The employee in question was sent home immediately pending investigation, and local police were contacted. A report was filed under case number(Case # and Local Police Officer). The POA was informed of the police

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report, as well as the Hospice MD. At approximately 12:30 PM, the nurse on duty completed a head-to-toe assessment of the resident, with no skin issues or concerns noted at that time."

The resident's family provided video footage depicting (E3) engaging in conduct that appears to obstruct the authorized monitoring device on multiple occasions while present in (R2)'s room. The family also reported a missing cellular phone during the same general timeframe and has filed a report with local law enforcement. Upon notification, The (Facility) immediately initiated an internal investigation in accordance with applicable state regulations and facility policy. The investigation included a review of the video footage and an interview with (E3) who was unable to provide a satisfactory explanation for the observed conduct. The community has not substantiated any allegation of theft and has made no determination regarding the reported missing property. This matter has been referred to law enforcement and remains under their jurisdiction. (E3) was placed on administrative leave pending the outcome of the investigation. Following completion of the community's internal review, (E3)'s employment was terminated for conduct inconsistent with facility policies, applicable regulations, and resident rights, including interference with an authorized electronic monitoring device."

A text message between E1, Executive Director and E8, Caregiver, dated "Today at 2:05 pm" documents "I (E8) worked on Sunday night (4/19) through Monday morning (4/20) and I recall seeing the phone on the kitchen counter."

R2's POA statement to E1 documents:

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"I first noticed the camera being moved slightly on 4/17/26. On that day, I observed a caregiver (E3) move his camera about an inch or so by hand at 7:54am. She did the same thing again at 7:58am (moved it slightly in the same direction, away from my dad's (R2) bed and towards the door). Also, the whole time she was in the room during this time, she was walking around, glancing at the camera very often and also put the fall mat against the piece of furniture that the camera is on too (as if to try and make it seem like the fall mat bumped into it - I have this action on video as well if you need to see). On 4/20/26, the same caregiver enters the room at 7:07am with a mask on (did not have one on 4/17), opens the blinds then immediately moves the camera again in the same direction (to the point where I can barely see my dad's bed now) then leaves the room. At 7:48am, I observed her standing over by his counter where I believe his phone was charging and looking at something for a suspicious length of time (also have footage of this as well). At 7:50am, she uses her hand to pull a teddy bear in front of the camera, but you can see her head in the very top left corner of the video and she walks over to the counter where I believe the phone was at that time. About 1.5 minutes later, she comes back and throws the bear out of the way and adjusts the camera slightly to move it back where it was earlier that morning."

On 4/24/26 at 8:45 am, E1 stated "We got a call from (R2's POA) that she received a verification code notification for (R2)'s email account that was sent to his phone number, and that someone used that code to access his email. She said someone has (R2)'s cell phone because the only way to get the verification code was through the two-factor authentication code sent directly to his phone. We immediately went to (R2)'s room and

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searched everywhere for it. We couldn't find it. I called the POA and she said the phone was last active at 1:39 PM, with its location showing Cottage 3, and that it hasn't been turned on since. We did another search of (R2)'s room and common areas, but we couldn't find the phone. (R2's POA) called me the next day and told me they have (E3) on camera moving the camera and obstructing it with a teddy bear. I contacted (E8) and she told me she remembers seeing (R2)'s cell phone charging on the counter before she left that day. (E3) was assigned to (R2) that day and followed (E8). The phone came up missing during (E3)'s shift. We called (E3) and she refused to give or write a statement." E1 went on to explain that E3 was terminated after the investigation and R2's cell phone was never recovered.

On 4/24/26 at 9:31 am, E1 was asked if she could show this surveyor where R2's phone was charging. E1 walked this surveyor to R2's Room. Upon entering, R2 was observed in his room with hospice. E1 was asked where the cell phone was sitting to charge. E1pointed to the left side of a small built-in counter that sits opposite side of the room from the camera and stated "(E8) said it was plugged in right here to charge before she left. It was the same day (E3) worked, and the phone went missing." The camera was observed sitting on top of a bookcase on the opposite side of the room from the counter next to a window pointing toward R2's bed and counter.

On 4/25/26, the video footage dated 4/20/26 at 7:07am, and 7:48-7:51am was reviewed. (E3) could be seen entering R2's room at 7:07am, opening the blinds, turning the camera right towards the wall, away from the window and out of the view of the resident's bed and exiting. At

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A6000	Continued From page 5 7:48 am, (E3) is observed picking up a pair of R2's pants from a chair in R2's room, setting the pants on the counter by the cell phone, while still holding the pants and her back to the camera and looking at something on the counter, then picking the pants back up and walking toward the window out of view of the camera. Then at 7:50 am, E3 while still out of view of the camera, walks over and slides a teddy bear in front of the camera. You can see the top of E3's head then head back in the direction of the counter that contains the cell phone and then walks back toward the window and moves the camera again more towards the wall. At 7:51 am, E3 is then seen moving the teddy bear from out of the camera's view and moving the camera back to the left, without the resident in view and appears to be exiting the room.	A6000		