STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510090	A. BUILDING: _____ B. WING _____	C 10/08/2024

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BROOKDALE VERNON HILLS	145 N MILWAUKEE AVE VERNON HILLS, IL 60061

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A 000	Initial Comment Investigation of Facility Related Incidents 7/16/24 IL175667, 9/9/24 IL177788, and 9/13/24 IL178018 - substantiated	A 000		
A2050	Section 295.2050 Incident and Accident Reporting This Regulation is not met as evidenced by: Type 3 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 by: Based on interview and record review, the	A2050		

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A2050	Continued From page 1	A2050		

establishment failed to ensure serious incidents/accidents were reported to the Department or did not report them within 24 hours after the occurrence. This applies to 3 of 3 residents (R1, R2, R3) reviewed for this requirement.

The findings include:

On 10/1/24-10/3/24, an investigation was conducted, related to Facility Reported Incidents received by the Department.

The establishment could not provide documentation to show the date/time the following serious incidents were reported to the Department:

-R1's progress notes, dated 7/8/24, written by E14 (Licensed Practical Nurse - LPN) showed R1 was sent to the hospital due to a fall and head injury. The note showed R1 was diagnosed with a closed fracture to the maxilla (upper jaw). This incident was one of the Facility Reported Incidents investigated, but the establishment had not documentation of the report.

-R3's Incident and Accident Report, date/time of incident 6/6/24 at 11:15 AM, showed no confirmation date/time that the report was sent to the Department. The report showed R3 was sent out for a fall that resulted in complaint of left hip pain and head pain.

-R3's Progress Note, dated 6/23/24, written by E15 (LPN), showed Z1 (R3's Power of Attorney - POA) refused to send R3 to the hospital for evaluation after R3 had a fall that resulted in left

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A2050	Continued From page 2 hip pain. -R3's Progress Note, dated 7/3/24, written by E16 (LPN), showed Z1 refused to send R3 to the hospital for evaluation after R3 had a fall that resulted in a skin tear to the top of the head and a cut on the left side of R3's head. -R3's Progress Note, dated 7/7/24, written by E17 (LPN), showed R3 was sent to the hospital for evaluation after R3 was found lying on the right hip on the floor, moaning in pain, with the wheelchair tipped over, a puddle of blood, and an abrasion to the right wrist. The establishment did not report the following incident to the Department within 24 hours after the occurrence: -R2's Incident Report, date of occurrence 8/29/24, was reported to the Department on 8/31/24 at 1:22 PM. The report showed R2 was sent to the hospital due to an unwitnessed fall that resulted in a left side pelvic fracture. The establishment policy titled Reportable Events (Last Revised: 4/2022) showed: Policy Overview ...The community/agency must adhere to all state specific, statutory, and regulatory reporting requirements and time frames. On 10/3/24, E10 (Associate Executive Director) confirmed the findings.	A2050		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr	A6010		

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A6010	Continued From page 3 This Regulation is not met as evidenced by: Type 2 Violation Section 295.6010 Abuse, Neglect, and Financial Exploitation Prevention and Reporting a) When the establishment has a reasonable belief that a resident has been the victim of abuse, neglect, or financial exploitation, the establishment shall: 1) Notify the Department within 24 hours after receiving the allegation, by contacting the Assisted Living Complaint Registry by telephone, fax, or other electronic means. The establishment shall document this report and maintain documentation on the premises for 12 months after the date of the report. 2) Investigate and develop a written report within 14 days after the initial report. The establishment shall send the written report to the Department within 24 hours after it is completed and shall maintain a copy of the written report on the premises for 12 months after the date of the report. b) A written report of the investigation conducted pursuant to subsection (a)(2) shall contain at least the following: 1) Dates, times, and description of the alleged abuse, neglect or financial exploitation; 2) Description of any injury to the resident;	A6010		

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A6010	Continued From page 4 3) Description of any change in the resident's physical, cognitive, functional, or emotional condition; 4) Any actions taken by the licensee; 5) A list of individuals and agencies interviewed or notified by the establishment; 6) Names of witnesses to the alleged abuse, neglect, or financial exploitation; and 7) If the abuse, neglect, or financial exploitation is substantial, a description of the action to be taken by the establishment to prevent the abuse, neglect or financial exploitation from occurring in the future ... This requirement was not met, as evidenced by: Based on interview and record review, the establishment failed to ensure an allegation of neglect of a resident was reported to the Department within 24 hours of receiving the allegation and provided an incomplete written report of the investigation to the Department. The establishment failed to provide documentation that an investigation was conducted related to a resident reported allegation of abuse and failed to provide a written report of the investigation to the Department. This applies to 1 of 3 residents (R3) reviewed for this requirement. The failure to investigate allegations of abuse/neglect creates a substantial probability of harm to a resident or residents, in that the establishment does not ensure the resident's right to be free of abuse/neglect.	A6010		

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A6010	Continued From page 5 The findings include: On 10/1/24-10/3/24, an investigation was conducted, related to a Facility Reported Incident of an allegation of neglect received by the Department. The establishment failed to ensure an allegation of neglect, related to R3, was sent to the Department within 24 hours of receiving the allegation. R3's Incident Report, emailed to the Department, showed, on 8/30/24, there was concern that staff neglected to provided incontinence care to R3 the night before, as evidenced by a soiled brief with dried fecal matter, and an investigation was started. The confirmation date/time to the Department showed 9/3/24 at 2:47 PM. The establishment failed to ensure a complete follow-up report was provided to the Department for R3's 8/30/24 neglect allegation. On 9/13/24 at 9:51 PM, the establishment sent the final report to the Department that did not include all the required information. The report did not indicate whether R3 sustained any injury due to the neglect; it did not indicate if there was any change in the physical, cognitive, functional or emotional condition; it did not list the individuals interviewed; and did not name the witness of the alleged neglect. The establishment failed to provide documentation to show they conducted an investigation for a resident reported allegation of	A6010		

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A6010	Continued From page 6 abuse or a written report of the investigation that was to be submitted to the Department within 14 days of reporting the initial allegation. R3's Incident and Accident report, date of occurrence 4/27/24, with Department confirmation date/time of 4/28/24 at 2:36 PM, showed R3 had a fall and sustained an injury, and while being treated, became increasingly agitated, and emergency services were called to transport R3 to the hospital for further evaluation. The report showed R3 told emergency services that R3 was attacked and requested to call the police. The report showed police conducted an investigation and the establishment initiated an investigation. On 10/3/24, E10 (Associated Executive Director) indicated the person that conducted the investigation is no longer employed and they cannot locate the documentation. The establishment policy titled Abuse, Neglect and Exploitation Policy (Last Revised: 5/2021) showed: Policy Overview: ...Instances or allegations of abuse, neglect or exploitation should be treated seriously and must be reported to the Executive Director or supervisor on duty for investigation and appropriate follow-up...Policy Detail: ...5) a) Internal Investigation. Upon receipt of an allegation of abuse, neglect or exploitation, the Executive Director, or their designee, should conduct a confidential internal investigation of the incident...5) e) Investigation Record. The Executive Director or designee should maintain a written record of the investigation...6) c) Report to the Department of Public Health, Assisted Living Complaint Registry...6) c) 1) b) A written report shall be developed within 14 days after the initial report. The establishment shall send the written report to the Department of Public Health within 24 hours after it is completed.	A6010		

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A6010	Continued From page 7 On 10/3/24, E10 confirmed the findings.	A6010		