STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145527	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brandel Health and Rehab	2155 Pfingsten Road Northbrook, IL 60062

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement policies and procedures to prohibit and prevent Abuse. This deficiency affects all five (R1, R3, R4, R5 and R6) residents reviewed for Abuse Prevention Program.Findings include: R1On 9/9/25 at 9:51AM, Observed R1 lying in bed with low air loss mattress. She has oxygen via nasal cannula. She is lethargic but arousable and weak. She needs total care with ADLs (Activity of Daily Living) and transfers. Both V6 RN (Registered Nurse) and V7RN said R1 has declined in mental status and ADLs. She is re-admitted yesterday from hospital with pneumonia. R1 is initially admitted on [DATE] and re-admitted on [DATE] with diagnosis listed I part but not limited to Atherosclerotic heart disease, Hypertension, Stage 3 Kidney disease, Stage 4 sacral pressure ulcer, Dysphagia, Cognitive and communication deficit, Gait and mobility abnormalities, Severe protein calorie malnutrition, Chronic embolism, and thrombosis of femoral vein. Comprehensive care plan indicated: She has history of Stage 4 sacral pressure ulcer and at risk for developing. She has ADLs and mobility deficit. She is at risk for falls related injury. She has history of depression with insomnia managed with medication. Trauma screening assessment was not upon initial admission. Trauma screening was only completed when R1 was re-admitted on [DATE]. R1 has reported mental abuse allegation on 6/3/25. No trauma assessment was done after the abuse allegation. No Abuse prevention care plan was developed.R3On 9/9/25 at 10:05AM, Observed R3 up on high back wheelchair in front of her room. V7 RN said, R3 has bilateral shin protector due for skin tear prevention. R3 need total assist with ADLs and uses mechanical lift for transfer. She is awake but confused. R3 is admitted on [DATE] with diagnosis listed in part but not limited to Cerebral infarction due to embolism, Hemiplegia affecting left non dominant side, Dysphagia, Type 2 Diabetes Mellitus, Atrial fibrillation, Hypertension, Gait and mobility abnormalities, Lack of coordination, Metabolic encephalopathy. Comprehensive care plan indicated: She is at risk for falls related injury. She has ADLs and mobility deficit. She has cognitive and communication impairment due to CVA. She is at risk for inadequate oral/fluid intake. She is on hospice care 8/13/25. She is on psychotropic medications for antipsychotic and anti-anxiety. R3 refused admission Trauma screening/assessment as indicated in assessment dated [DATE]. R3 is a vulnerable resident with cognitive impairment and behavioral issues. No Abuse prevention care plan was initiated upon admission. R3 has reported sexual abuse allegation on 8/25/25. No trauma assessment was done after the abuse allegation. No Abuse prevention care plan was developed.R4On 9/9/25 at 10:58AM, Observed R4 up in wheelchair in the activity/dining room. She has hard of hearing. She is alert and confused, responsive to simple questions. She needs assistance with ADLs and transfers. R4 is admitted on [DATE] with diagnosis listed in part but not limited to Age-related osteoporosis, Alzheimer's disease, Dementia, Type 2 Diabetes Mellitus, Depression, Lack of coordination, Gait and mobility abnormalities, Repeated falls. R4 refused trauma assessment upon admission as indicated in assessment. Comprehensive care plan indicated: She is at risk for falls related injury. She has depression managed by medication. She has ADLs and mobility deficit. She is at risk for inadequate oral/fluid intake. She has cognitive deficits due to Alzheimer's and Dementia. She refused Trauma assessment as indicated in assessment. She has physical abuse allegation report on 9/1/25. No trauma assessment was done after the abuse allegation. No Abuse prevention care plan was developed.R5On 9/10/25 at 10:17AM, Observed R5 up in recliner chair. She is alert and responsive with period of confusion. She needs maximum assistance with ADLs and transfers. R5 is admitted on [DATE] with diagnosis listed in part but not limited to Cerebral infarction, hemiplegia affecting right dominant side, Dementia with mood disturbance, Anxiety disorder, Depression, Gait and mobility abnormalities, Dysphagia. Comprehensive care plan indicated she is prone to skin tear or bruising related to fragile skin. She has history of depression and anxiety managed by medications. She has ADLs and mobility deficit. She has presented with rapid significant health declined. Family wishes comfort measures only. She is on hospice care on 2/11/25. No Trauma assessment done upon admission. R5 is a vulnerable resident with cognitive impairment and behavioral issues. No abuse prevention care plan was initiated upon admission. R5 has physical abuse allegation (employee to resident) report on 3/26/25. No trauma assessment was done after the abuse allegation. No Abuse prevention care plan was developed.R6 was admitted on [DATE] with diagnosis listed in part but not limited to Urinary Tract Infection, Congestive heart failure, Atrial fibrillation, Parkinson's disease with dyskinesia, Type 2 Diabetes mellitus, gait and mobility abnormalities, lack of coordination, Dementia, Cognitive deficit, Comprehensive