STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145070	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Zahav of Berwyn	3601 South Harlem Avenue Berwyn, IL 60402

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to protect a resident from physical abuse during resident-to-resident altercation. This deficiency affects one (R1) of three residents reviewed for abuse. Findings include:R1 is a [AGE] year-old male, admitted in the facility on 03/21/22 with diagnoses of Type 2 Diabetes Mellitus without Complications; Unspecified Mood (Affective) Disorder; Opioid Use, Unspecified, Uncomplicated; Compression of Brain; Alcohol Abuse, Uncomplicated; Traumatic Subdural Hemorrhage without Loss of Consciousness, Subsequent Encounter; and Personal History of Traumatic Brain Injury. MDS (Minimum Data Set) dated 06/21/25 documented R1's BIMS (Brief Interview for Mental Status) score is 11 which means moderate impairment in cognition. Facility's incident report dated 08/08/25 recorded: On 08/04/25 around 3:15 PM, R1 stated his roommate (R2) became upset about his closet space and became physical with him (R1). R1 was separated immediately and de-escalated. He (R1) stated the incident was unprovoked and didn't have any history of altercations with R2. R2 stated he thought his roommate (R1), was taking his belongings and he was looking for them in his (R1) closet. He (R2) did not find any of his personal belongings in R1's closet. R1 sustained a small cut inside his mouth. On 09/10/25 at 10:10 AM, R1 was in bed, taking a nap. R1 is alert and oriented, verbal, and able to ambulate without assistance. R1 was asked for any incident with R2 or previous roommate, or to any other resident in the facility. R1 stated, No, not that I know of. I did not have any altercation with any residents here. I was not hit. He (R2) did not hit me. There was no skin alteration in R1's mouth, lip or face as observed. R1 stated he does not have any problems with his mouth. On 09/10/25 at 9:56AM, R2 was observed in his room, sitting in a wheelchair. R2 is alert, oriented. He (R2) was asked regarding incident with R1 on 08/04/25. R2 verbalized, I didn't hit him (R1). I don't remember. I'm okay with other residents here. I don't remember having an altercation with other residents.R2 is a [AGE] year-old, male, admitted in the facility on 10/14/22 with diagnoses of Parkinson's Disease without Dyskinesia, without Mention of Fluctuations; Cognitive Communication Deficit; Unspecified Dementia, Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance and Anxiety; Schizoaffective Disorder, Unspecified; and Brief Psychotic Disorder. MDS dated [DATE] recorded R2's BIMS score is 6, which means severe cognitive impairment. According to R2's care plan, he has history of aggressive/inappropriate behavior.On 09/10/25 at 10:52 AM, V6 Licensed Practical Nurse, LPN) was asked on what happened between R1 and R2 on 08/04/25 incident. V6 stated, I was at the nurses' station, I heard an argument. I went to see what was going on. When I entered the room, both (R1 and R2) were standing at the closet and were arguing. R2 swung his hand at R1. I tried to go between them. But R2 was able to hit R1 in the face. He (R1) had abrasion underneath the left eye with little bit of blood. I got him (R2) out of the room and called the CNA (Certified Nurse Assistant, CNA) to sit with him. I went back to room; I cleaned his (R1) abrasion. He didn't want to be touched and wanted to be left alone. I notified management, they came. R2 was sent out for psych evaluation. R1 refused to be sent out, physician was notified. I regularly work with them, and both have no prior behavior. They (R1 and R2) were arguing over a closet space and missing items. There was a confusion about which space belongs to who.On 09/10/25 at 11:08AM, V7 (CNA) was also asked regarding R1 and R2. V7 verbalized, On 08/04/25, I helped the nurse with 1:1 (one on one) monitoring of R2. When I went there, they were quiet. I did not witness anything. V5 (Social Services Director/Assistant Administrator) was interviewed on 09/10/25 at 11:32 AM regarding R1 and R2 incident on 08/04/25. V5 stated, I was notified of the incident immediately by V6. She informed me that residents (R1 and R2) had physical altercation. She found R1 on the floor in the room stating that his roommate (R2) had hit him in the face. Upon that point, she (V6) did a body assessment, moved R2 out of the room and placed him on 1:1. R1 did have some blood in the mouth, left inner portion. It was like a little blood. He (R1) had explained that R2 stated that he (R1) had his (R2) clothing and that was the reason why he (R2) was aggressive with him (R1). R2 has history of delusional processes, usually he believes he's at home. This is the first time he(R2) showed aggression towards a resident. He (R2) did hit him (R1) but there were no major injuries. R1 refused to go to the hospital. Physician was notified. R1 is alert, oriented, ambulatory. No violent or aggressive behaviors in the past. R2 is alert to self and place. He's been here for almost two years. He wanders in the facility, delusional behavior believing he is at home, or he wants to go home. R2 had no prior aggressive behaviors. They were separated, R2 was sent out for psych evaluation and admitted for about two weeks. R1 was placed on well-being check for three days and no concerns. Upon