STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wentworth Rehab & Hcc	201 West 69th Street Chicago, IL 60621

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. 29536 Based on record review and interview the facility failed to follow their abuse policy for one resident (R1), out of three residents reviewed abuse. This failure resulted in R1 falling to the floor during a behavior episode when a staff member who was not appropriately trained on Crisis Prevention Interventions (CPI) attempted to assist with the behavior. Finding Include: R1's care plan reads: R1 has difficulties managing her anger/frustration as evidenced by verbal and physical aggression. During periods of increased agitation, move resident to a quiet location, and intervene as appropriate. 10/26/2024 08:40 R1 Behavior Note Text reads: Writer witness resident grab food rack from staff and shove and throw (it) down, at her, and other residents in facility. Writer responded asking resident to calm down, attempting to redirect. Resident then refused and said, you can't touch me, and you will be next if you don't shut up talking to me. Resident then walked east and around towards room shouting, stop talking to me. 10/26/2024 14:14 R1 Nurses Note Text reads: resident was exhibiting aggressive behavior toward staff. DR (doctor). was called and over order to petition resident out to hospital. On 1/30/25 at 5:00 PM V4 (Certified Nurse Aide) stated she has worked at the facility for seven years. V4 stated she has worked around V1 (housekeeper) for seven years. V4 stated V1 was a nice hard-working guy from what she had seen of him. V4 stated she has never seen V1 abuse anyone or curse at the residents. V3 stated she was in the dining room passing breakfast trays when R1 came in cursing and talking to herself. V4 stated she gave R1 her tray when R1 suddenly jumped up and threw her plate of food on the floor. V3 stated then R1 snatched the cord out the socket of the television. V4 stated she called the social worker (V5) who came and talked to R1 to try to get R1 to calm down. V4 stated V1 then walked into the dining room to clean the floor so no one would slip and fall. V4 stated she was on the other side of the dining room and did not hear his conversation with R1. V3 stated V1 cleaned up the floor and then he left the dining room. V4 stated V5 escorted R1 out of the dining room. V4 stated she helped another resident leave the dining then saw R1 go down the hall to her room when she suddenly grabbed a broom and swung it at V5. V4 stated during the incident she broke V5 glasses. V4 stated during the commotion did not see what happened but that suddenly R1 and V1 were on the floor. (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: 145429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/04/2025
NAME OF PROVIDER OR SUPPLIER Wentworth Rehab & Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE 201 West 69th Street Chicago, IL 60621	

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/30/25 at 5:20pm V5 (Social Worker) stated he was called to the dining because R1 was being irate and throwing food on the floor. V5 stated when he walked into the dining room, he saw R1 knocking things off the table. V5 stated he attempted to redirect and deescalate the situation. V5 stated someone had already called V1 in to clean the food off the floor. V5 stated as R1 was leaving the dining room she knocked over the food tray cart and then they called the code for security. V5 stated R1 went on the other side hallway like she was going towards her room when she picked up the broom stick and was swinging it like a baseball bat. V5 stated while talking to R1 she did hit him, and his glasses broke. V5 stated she continued swinging and she lost her balance while V1 was trying to grab it (the broom) from her and R1 slid onto her buttocks. V5 stated while R1 was sitting on the floor they eventually got the broom stick from her. V5 stated the paramedics and police arrived at the facility and R1 was taken out of the facility in handcuffs. V5 stated R1 has a history of aggression towards staff and was a considerably large woman for her size and could be intimidating to some. On 1/30/25 at 5:50pm V3 (Assistant Administrator) stated received a phone call about an incident between staff (V1) and a resident. V3 stated was told by staff that R1 was in the dining room acting out and that she threw breakfast on the floor. V3 stated told by staff they tried to deescalate the situation to get R1 to calm down. V3 stated was told staff called for housekeeper (V1) to the dining room to clean the food off the floor. V3 stated the staff told her that V1 did not curse or hit R1 while he was cleaning the floor then left the dining room. V3 stated the social worker (V5) noticed that R1 was still agitated and directed R1 to go to her room to calm down. V3 stated was told when R1 left the dining room shortly thereafter. V3 stated he was told by staff that on her way to her room R1 grabbed a broom off V1's housekeeping cart. V3 stated interviewed V1, and he told her he thought R1 was going to hit them, so he grabbed the broom and they tripped and slid onto the floor. V3 stated staff placed R1 on 1:1 supervision until the paramedics and police arrived to take R1 to the hospital. V3 stated after they were told what had transpired V1 was sent home. V3 stated V1 was suspended while an investigation could be done. V3 stated he was never trained on how to confront an aggressive resident and it was not his place or part of his duties to try to subdue R1. V3 stated even though resident sustained no injuries he (V1) was terminated because he had no training on CPI (Crisis Prevention Intervention) and because he touched her and should have not. V2 (Human Resource Manager) she on 1/30/25 at 6:15 PM stated came to work the following Monday 10/28/24. V1 stated told that an incident occurred Saturday (10/26/24) morning after breakfast between R1 and V1. V2 stated that R1 was irate and took a broom or mop off the housekeeper cart. V2 stated was informed that V1 approached R1 and while trying to get the broom from R1 they slid onto the floor. V1 stated told by staff that they called one of the supervisors and V1 directed to leave the facility until he talks with administration. V1 stated while V1 was suspended facility did an investigation and administration concluded even though R1 had no injuries, because V1 physically touched R1 and was not supposed to, he was to be terminated. R1's incident report dated 11/1/24 reads the housekeeper states that he responded physically to R1. Housekeeper stated out of concern for resident and staff safety R1 was subdued. Facility conclude that the housekeeper acted out of his scope of duty by assisting to subdue R1. Corrective measures were taken with housekeeper. V1 disciplinary memorandum dated 11/5/24 denotes Employee to be discharged for getting into a physical altercation with resident on 10/26/24. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility's abuse policy reads the facility is committed to protecting our residents from abuse by anyone including but limited to facility staff. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment. This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion.