STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145796	A. Building B. Wing	03/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Balmoral Home	2055 West Balmoral Avenue Chicago, IL 60625

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that residents were free of abuse/physical assault. This failure affected three residents (R3, R4, and R5) of five residents reviewed for resident-to-resident abuse in the facility.Findings include: R1's medical diagnoses include but are not limited to right heart failure, schizoaffective disorder, essential hypertension, type 2 diabetes. R1's Minimum Data Set (MDS) dated [DATE] has a Brief Interview for Mental Status (BIMS) score of 14, indicating R1's cognition is intact. R1's progress note dated 02/27/26 at 1:40pm documents in part, SSD (Social Service Director) made aware resident physically attacked peer unprovoked. R1's progress note dated 02/27/27 at 3:20pm documents in part, Resident was observed with physical/aggressive behavior to co resident by hitting and pushing him out of his wheelchair. R4's medical diagnoses include but are not limited to quadriplegia, schizophrenia, and traumatic brain injury. R4's MDS dated [DATE] has a BIMS score of 11, indicating R4's cognition is moderately impaired. R4's progress note dated 02/27/26 documents in part, SSD (Social Service Director) med with resident and conducted wellness check due to being involved in altercation with peer unprovoked. Both residents were immediately separated. R4's progress note dated 03/07/26 documents in part, Resident was involved in a disagreement with another resident that became physical. Staff intervened and physician was notified. Resident was placed on increased monitoring. Social services reviewed anger management and appropriate skills techniques with resident. R5's medical diagnoses include but are not limited to schizoaffective disorder, depression, insomnia, chronic obstructive pulmonary disease. R5's MDS dated [DATE] has a BIMS score of 15, indicating R5's cognition is intact. R5's progress note dated 03/07/26 documents in part, This nurse was called from down the hall, from in front of room [ROOM NUMBER], to come to room [ROOM NUMBER] d/t (due to) the two (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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	roommates fighting. Other resident stated that he was hit on the right side of his face twice by R4 without provocation. On 03/20/26 at 11:50am R5 stated that on the date of the incident, he was sitting in the hallway and R4 approached R5 and R4 hit R5 in the face two times. R5 stated that he did not hit R4 back but R5 stated that he did push R4 away from him. R5 stated that he was not injured during the incident. On 03/20/26 at 11:57am V8 (Licensed Practical Nurse/LPN) stated that R4 tries to hit people all the time. V8 stated that normally the staff could intervene and prevent R4 from hitting other residents. V8 stated that on the date of the incident between R4 and R5, she was sitting at the nurse's station and was unable to intervene before R4 and R5 hit each other. V8 stated that she rushed to R4 and R5 and separated them after they both hit each other. On 03/20/26 at 1:06pm V10 (Social Service Director) stated that R1 had a history of verbal aggression towards staff and other residents but had never been physically aggressive. V10 stated that she was not present for the incident between R1 and R4. V10 stated that she was informed of the incident between R1 and R4 and was told that R1 was the aggressor. V10 stated that the facility has a no tolerance for the behaviors of R1 and that R1 was involuntarily discharged from the facility. R1's care plan dated 10/06/25 documents in part, History of aggressive/inappropriate behavior. The resident has a history of aggressive/maladaptive behavior but has demonstrated stability during the admission screening process and is therefore considered appropriate for admission. The history includes conflicts/altercations with others, verbal or physical aggression towards staff. loud and intimidating towards his roommate. Pt (patient) will daily refrain from any verbally/physically aggressive towards others. R4's care plan dated 01/28/26 documents in part, Risk for violence related to dx (diagnosis) of schizophrenia as evidenced by behavioral changes, agitation, or difficulty with redirection. resident will maintain safe behavior through the review date. Resident will do no harm to self or others through the review date. Monitor resident behavior closely. Facility's final internal report for R1 and R4 dated 03/07/26 documents in part, Based on the internal report, residents and staff statements, the above allegations appear to be substantiated. Facility's final internal report for R4 and R5, dated 03/12/26 documents in part, On 02/27/26 R1 was allegedly physically aggressive towards R4. Based on the internal report, residents and staff statements the above allegations appear to be substantiated. As a result, R1 was transferred to the hospital and received and immediate IVD (Involuntary Discharge) due to the safety of individuals in this facility being endangered. Findings include: On 3/6/26 a facility reported incident was sent to Illinois Department of Public Health (IDPH) which included R2 and R3 were involved in an altercation on 3/6/26. On 3/13/26 the final incident investigation states that the altercation between R2 and R3 was substantiated. R2 was sent out to the hospital for evaluation and received an Involuntary Discharge (IVD) due to the safety of individuals in this facility being endangered. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's admission record diagnoses include but are not limited to schizophrenia, heart failure, insomnia, and pulmonary hypertension. R2's Minimum Data Set (MDS), dated [DATE], documents in part, Section C. Brief Interview for Mental Status (BIMS) Score:11 which indicates that R2 has moderate impairment. R2's Section E. Behavior: E0100. Potential Indicators of Psychosis documents in part, A. Hallucinations (perceptual experiences in the absence of real external sensory stimuli) B. Delusions (misconceptions or briefs that are firmly held, contrary to reality). R2's 3/5/26 progress notes documents in part, Patient (R2) hit roommate, Nurse Practitioner (NP) notified, instructed to send patient to hospital. R2's 3/6/26 Social Service Director (SSD) progress notes documents in part, made aware Resident physically attacked peer unprovoked. Staff immediately intervened physicians notified, CPD contacted, police report made, resident room moved and placed on one-to-one monitoring with staff until departure for Psych evaluation at hospital per physician order. Physicians notified IDT Interdisciplinary team recommend IVD due to the safety of individuals in this facility being endangered, R2's screening assessment for indicators of Aggressive and/or harmful behavior dated 12/11/25, documents in part, A. Risk Assessment: 4. History or recent episode of aggressive/agitated behavior (aggression toward others including destruction of property, fire setting or other violent acts) and or non-compliance with medications, treatment regimen, resisting care. It is coded a 1 which indicates moderate problem. 6. History of abuse/neglect either as a recipient or perpetrator including abusive and/or inappropriate sexual behavior. It is coded a 1 which indicates moderate problem. R2's screening assessment for indicators of Aggressive and/or harmful behavior dated 3/5/26, document in part, History or recent episode of aggressive/agitated behavior (aggression toward others including destruction of property, fire setting or other violent acts) and or non-compliance with medications, treatment regimen, resisting care. It is coded a 2 which indicates significant problem. 6. History of abuse/neglect either as a recipient or perpetrator including abusive and/or inappropriate sexual behavior. It is coded a 2 which indicates significant problem. R2's (3/5/26) care plan documented in part, Focus: Resident struck roommate. Nurse Practitioner (NP) for psych notified and instructed transfer to hospital for an evaluation. Interventions: Resident remains on 1:1 monitoring with staff; currently awaiting EMS arrival for transport. Residents relocated to ensure safety of all parties. All facility safety protocols initiated R3's admission record diagnoses include but are not limited to Alzheimer's, atrial fibrillation, Diabetes, hypertension, and osteoarthritis. R3's Minimum Data Set (MDS), dated [DATE], documents, in part, Section C. Brief Interview for Mental Status (BIMS) Score:8 which indicates that R3 has moderate impairment. On 3/20/26 at 11:50 am, R3 stated that he was hit in the arm and face when he was in bed. R3 did an action with his fist that someone hit him in the arm and face. R3's progress noted dated 3/5/26 documented in part, Resident (R3) was hit by roommate R2. Redness was noted to the left side of face, and the Medical Doctor (MD) was notified. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's 3/6/26 care plan documents in part, Focus: Alleged occurrence with peers. Goal: the resident will be treated with respect, dignity, and reside in the facility free of mistreatment (abuse/neglect) on an ongoing basis. Interventions: Provided with support-frequent check-ins. On 3/20/26 at 12:05 pm, V6 Certified Nursing Assistant (CNA) stated, I (V6) had heard about R2 hitting R3 but was not here. R2 does have aggressive behavior at times toward other residents. He (R2) would get in their face and would verbally threaten them. When he could not be redirected, the nurse would send him out to the hospital. On 3/20/26 at 12:10 pm, V7 CNA stated, I would take care of R2 in the facility. He would have aggressive behavior even before he hit his roommate. He would get in his face and would be screaming and cursing him. We would tell the nurse and sometimes he would have to be sent out to the hospital. We would try to redirect him, but he would be aggressive toward women staff with the men he would not be aggressive toward them. On 3/20/26 at1:22 pm, V10 Social Service Director (SSD) stated, I was told that R2 hit R3 while R3 was lying in bed. I was not in the building; I was told the next day. A meeting was held, and we decided not to let R2 come back to the facility because of being a danger to other residents. There was a safety concern for the other residents. R2 was redirectable when he would scream and yell, but he was not physically abusive. Staff would be fearful and timid of him because of the way he looks. Residents should not endure that behavior of aggression, screaming and threatening. He was sent out to the hospital after he hit his roommate. On 3/20/25 at 1:57 pm, V1 Administrator stated, I am the abuse coordinator. that the regulatory requirement for abuse is to separate them immediately. V1 stated that the administrator, doctor, family, should be notified and report to IDPH (Illinois Department of Public Health). Aggressive behavior is IVD and is a danger to others they will not come back. Abuse is not tolerated. I was not here the day R2 hit R3. I was notified right aware. And IDPH was notified. It was substantiated because of the redness on his (R3) face. All parties were notified, family, police and doctor. Screaming and yelling is a form of abuse. Abuse in-services are conducted with staff and were done a couple of months ago. On 3/20/26 at 3:20 pm, V4 Assistant Director of Nursing (ADON) stated, I (V4) was here when the incident between R2 and R3 happened. It happened after dinner. The nurse on the floor of the CNA both notified me. I went to the resident's room. R2 was not in the room, he was at the nurse's station. I asked him what happened, and he looked at me and did the action with his fist that he had hit someone. The staff moved R2 to another room, and I had the CNA do 1:1 monitoring. R2 was sent out to the hospital that day. I reported the incident to the administrator, who is the abuse coordinator. The nurse on duty called the police. On 3/21/26 at 1:20 pm, V11 Registered Nurse stated, I (V11) was notified by the CNA that R2 had hit R3. When I went into the room R3 had redness to his face and a scratch on his nose. R3 pointed to R2 that he had hit him. The two were separated. I called the doctor and the doctor said to send R2 out for an evaluation. R2 was agitated but at that time he was redirectable because he was put in another room. Facility's Resident Rights Policy Statement dated 9/1/24 documents in part, 1. Federal and state laws guarantee certain basis rights to all residents of this facility. These rights include the resident's right to: be free from abuse, neglect, misappropriation of property and exploitation. (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 policy titled Abuse Prevention Program Facility Procedures dated 11/16/18, documents in part, IV. Establishing a Resident Sensitive Environment: This facility desires to prevent abuse, neglect, exploitation, mistreatment and misappropriation of resident property by establishing a resident sensitive and resident secure environment.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to supervise and prevent a resident who repeatedly stated she did not want to be in the facility from eloping from the facility. This failure affects one (R6) out of three residents reviewed for supervision in a total sample of three residents. Findings include: R6's MDS/Minimum Data Set, dated [DATE] documents that R6 has a BIMS/Brief Interview for Mental Status of 15/15, indicating that R6 is cognitively intact without any memory problems. R6's MDS documents that R6 ambulates via walking without any impairment and without assistive devices. R6 requires supervision with ADL/Activities of Daily Living care and mobility. R6 is continent of bowel and bladder. R6's progress notes are as follows: 02/24/2026 at 3:54PM written by V4 (ADON/RN) Received [AGE] year-old resident from hospital with admitting diagnosis of schizophrenia. R6 is AxOX3. Ambulatory without any assistive device. Orders verified with both MD. R6 on general diet, thin liquids. Upon assessment, no skin breakdown noted. Per R6, she really don't have any medications even before. 02/24/2026 at 7:00PM written by V13 (Social Worker) Writer met with R6 to establish relationship upon admission. R6 was not receptive to conversation. R6 repeatedly stated that she does not want to be here. R6 refused mental status exam. R6 was able to repeat correct date. Writer attempted to ask further questions about background and how she got here, which the R6 did not cooperate with. R6 will be monitored for issues adjusting to facility. Writer will continue to attempt to gather social services admissions information. 03/06/2026 at 2:51AM written by V14 (LPN) 11:30 pm During rounds R6 was lying quietly in bed. 1:40 am Back stairwell alarm sounded. Myself and the CNA ran to door and R6 was at the bottom of the stairs. V15/CNA took elevator to the 1st floor and noted R6 going thru the back door. He exited the front door but unable to locate R6. 1:55 am called 911 and gave a description of R6. Writer left facility and drove around trying to locate R6. I was unsuccessful. 2:02 am Called V3/DON also left a text message. 2:15 am Officer arrived. Face sheet and picture given. 2:27 am called administrator V1 informed of elopement 2:39 am Officer called and stated R6 was located, and she requested to go to the hospital. R6 also stated I might have frostbite. The officer stated we took her to hospital. 03/06/2026 at 3:30AM written by V14 2:35 am Nurse called from hospital. Stated R6 might return back to nursing home. 3:25 am Officer called stated who will pick her up? Informed officer hospital should send R6 back by ambulance/medicar. 03/06/2026 at 5:07AM written by V14 5:05 am Social worker called from hospital and stated R6 refuses to return. Spoke with RN informed writer the MD will see her. and notify us of the outcome. 03/06/2026 at 1:21PM written by V4 (ADON/RN) Follow up made with hospital, R6 discharged from there. Unable to tell where R6 was gone.R6's elopement assessment dated [DATE] at 5:06PM, documents a No answer to the question Does the resident verbalize a strong desire to leave? R6' care plan documents in part, Limited/Poor Discharge Potential: R6 requires assistance from staff with her care and benefits from their nursing home placement at this time. R6 is unable to care for herself in a less structured setting. R6 voices no interest in community re-entry at this time, see social service notes for additional details. Initial Facility Reported Incident dated 03/06/2026 documents that R6 eloped from the facility on 03/06/2026. Final Facility Reported Incident dated 03/12/2026 documents that the facility learned that R6 was taken to the hospital and was discharged from the hospital after refusing to return to the facility. On 03/21/2026 at 1:17PM, V15 (Certified Nursing Assistant/CNA) states he was working at the facility on 03/05/2026 during the 11:00PM-7:00AM shift. V15 states he was assigned to the third floor and to care for R6. V15 states he had a good rapport with R6 and R6 was cool and friendly. V15 states around 1:00AM to 2:00AM, he heard an alarm sound coming from one of the staircase doors on the third floor. V15 states each floor has staircase doors that require a code and if the code is not put in, then the doors will alarm when opened. V15 states none of the staff saw anyone exit through the staircase doors and only heard the alarm. V15 states other staff began (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	checking residents' rooms and V15 went towards the alarm sound at the staircase door. V15 states once at the third-floor staircase door, he entered the code to stop the alarm and did not see anyone in the staircase. V15 states he then heard another alarm coming from the first floor. V15 states the alarm sound coming from the first floor has a different sound than the third floor, which is how V15 knew that someone had gone through the first-floor staircase door unauthorized. V15 states he went to the first floor and saw R6 standing next to one of the outside exit doors. V15 states R6 stayed at the exit door for about 2 minutes then pushed through the exit door. V15 states he then followed R6 outside and was located about 5-6 feet away from R6. V15 states R6 was calm and staying put and he was making sure R6 was safe. V15 states R6 then began to walk towards the main road. V15 states he did not have on a coat or hat and did not have his phone with him as a means for communication. V15 states he then went back into the facility to retrieve his items and a hat and coat because it was too cold outside. V15 states it took him less than two minutes to go back out to R6 but once he went back outside, R6 was not standing where she once was located. V15 states he then ran around the building to check all the exits doors to try and locate R6 but could not find her. V15 states the police arrived shortly after and he gave a description of R6 in order for the police to try and search for her. V15 states he and other staff members continued to try and search for R6 but still was unable to locate R6. V15 states he is not sure if R6 was hiding but R6 was gone, and staff could not find her either. V15 states there are no security guards who work in the facility. On 03/21/2026 at 2:30PM, V10 (Social Services Director/SSD) states she oversees a total of four social workers in the facility. V10 states there are two social workers who are new social workers. V10 states usually anyone from social services is responsible for completing the elopement risk assessments for the residents. V10 states she expects the elopement risk assessments to be completed within 3-7 days. V10 states this allows staff a chance to get to know the resident more and observe their behaviors. V10 states residents are identified to be at risk for elopement if they have a history of elopement, if they display behaviors such as exit seeking, staying near exit doors, if they verbalize things related to psychosis, and if they say things related to wanting to leave the facility. V10 states if a resident states they do not want to be in the facility, then this information would be brought up to the team to address it. V10 states they would ask questions, contact the doctor, and start a discharge plan for the resident. V10 states R6 never verbalized to her that she wanted to leave the facility. V10 states she was working on getting community access for R6 and things were going good. V10 states then she find out that R6 eloped on her birthday. V10 states to her knowledge, R6 did not tell anyone in the facility that she wanted to leave the facility. At 2:39PM surveyor makes V10 aware of the progress note written by V13/Social Worker on 02/24/2026 at 7:00PM and R6's desire to not be in the facility. V10 states V13 never made her aware that R6 did not want to be in the facility. V10 states she has to look more into this and follow up and what happened. V10 states that V13 is a new social worker in the facility and this is V13's first position as a social worker. V10 states if R6 informed V13 that she did not want to be in the facility then V13 should have informed V10. V10 states she would have immediately informed R6's doctor to discuss other discharge planning options for R6. V10 states if R6 made V13 aware that she did not want to be in the facility, then R6's elopement assessment should reflect that. V10 states if V13 would have informed her that R6 stated that she did not want to be in the facility, then things could have went a different way and R6's elopement would have been prevented. V10 states she could have initiated a safe discharge for R6. Facility policy undated, titled Wandering and Elopement documents in part, The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety.