STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145878	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Patrick's Residence	1400 Brookdale Road Naperville, IL 60563

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 - 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 protect a resident from physical and mental abuse from staff. These failures caused R1 to sob and experience pain following the episode of witnessed abuse. This applies to 1 (R1) of 3 residents reviewed for abuse in a sample of 3. A reasonable person would experience fear and anxiety of the alleged perpetrator to provide care for a dependent resident with a history of suffering from abuse and has experienced significant trauma during their lifetime as stated in the care plan. The findings include: R1's Face sheet dated 4/10/26, shows R1's diagnoses included metabolic encephalopathy, dementia with psychotic disturbance, adult failure to thrive, major depression disorder, pain in left and right knee and low back pain, cervicalgia, muscle weakness, noncompliance with other medical treatment, psychosis not due to a substance, anxiety, hemiplegia, and legal blindness. The face sheet shows R1 was admitted to the facility on [DATE] and expired at the facility on 4/3/26.R1's MDS (Minimum Data Set), dated 1/9/26, shows R1's cognition was severely compromised. Psychology note dated 3/23/26, shows Resident was cooperative. Resident is making stable progress on goals listed above. Ongoing psychotherapy could help improve symptom management. The resident's cognitive functioning seems sufficient at this time. The note shows R1 had the capacity to participate meaningfully and benefit from psychotherapy. R1's care plan initiated 4/22/24, shows R1 had a history of financial abuse/exploitation alleged toward her son and was considered a vulnerable adult due to poor and compromised health/mental health status, cognitive issues, physical decline, and need for 24-hour care. The care plan shows R1 experienced a significant trauma during her lifetime, and she is a trauma survivor. The care plan also shows R1 exhibited manipulative behavior and makes accusations against staff and other residents related to her diagnosis of dementia with psychotic disturbance and anxiety. The interventions include having two staff present during care in R1's room and during showers as of 11/25/24. On 4/2/26 at 1:54 PM, V5 (Certified Nursing Assistant/CNA Student) stated on 3/25/26 at approximately 5:40 PM she and V14 (CNA Student) delivered a dinner tray to R1's room and witnessed R1 lying on her back in her bed, the right side of the bed was against the wall, and the right side of R1 body positioned close to the wall. V8 (CNA) was standing on the left side of R1's bed, hit R1 several times with an open hand on R1's left shoulder and forcefully pushed R1's shoulder downward in the mattress holding her shoulder down for several seconds. V8 also forcefully shoved R1's left knee down on the bed. V5 stated V8 also put her left hand on R1's left knee and her right hand on R1's left shoulder and forcefully push R1 against the wall. V5 stated R1 was already close and almost touching the wall when the CNA began pushing R1 further into the wall. V5 stated R1 was screaming asking for help the entire time and asking V8 to stop because V8 was hurting her. V5 stated V8 did not notice the students were in the room. V5 and V14 reported what they saw to V4 (CNA Instructor) and then to V9 (Wound Nurse/Manager on Duty) and V10 (Quality Assurance). On 4/2/26 at 3:53 PM, V7 (CNA Student) stated she met V8 (CNA) and V14 outside R1's room to feed R1 and V8 told the students she did not care if R1 ate because R1 was going to die. V7 stated they entered the room together and R1 was asleep. V8 touched R1's chest using force with the palm of her hand and shook her palm on R1's chest (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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(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 - Actual harm Residents Affected - Few	without saying anything prior. V7 stated R1 woke up and V8 told the students to give the dinner to R1. V7 stated when V8 left R1's room, R1 cried and stated V8 was a liar, that V8 pushed R1's knee, and V8 pushed and hit R1 in the chest. R1 told the students she was still in pain. V7 stated V14 (CNA Student) and V5 (CNA Student) told her they saw V8 pushing R1 when they delivered R1's tray. V7 stated R1 told the students not to act like V8, that the students were good girls, and that V8 was a liar. V7 stated V8 reentered the room and removed R1's tray saying R1 did not want to eat any more. V7 stated they were still assisting R1 to drink her milk and R1 did not say she was finished with her tray. V7 stated the students reported the information to V9 (Wound Nurse/Manager on Duty) and V10 (Quality Assurance). On 4/6/26 at 10:30 AM, V1 (Administrator) stated V9 and V10 completed the abuse investigation and the abuse investigation file provided on 4/6/26 (which did not include the written witness statements from V5, V7, and V14) was the full and complete investigation.On 4/6/26 at 11:54 AM, V9 (Wound Nurse/Manager on Duty) stated V5, V7 and V14 (CNA Students) were interviewed and all wrote statements and provided them to the facility at the time they alleged abuse by V8 (CNA) on R1. V9 stated V5 reported V8 pushed R1 into the wall while R1 said stop hurting me while having her gown changed. V9 stated the students demonstrated the incident by pushing V10's shoulder and holding her shoulder as well as V5 demonstrating V8 holding R1's knee. V9 stated she was unable to locate the students' written statements. On 4/6/26 at 2:45 PM, V8 (CNA) stated she was replacing R1's gown that R1 removed after a prior bed bath V8 gave her earlier. V8 stated R1 did not want the gown replaced and kept moving her arms but V8 continued to put the gown on. V8 stated she did not push on R1's knee and only touched her arms while R1 continued to say, No, it hurts, it hurts. V8 denied having to roll R1 in the bed and denied the students delivered R1's dinner tray when V8 was in the room. V8 stated she walked R1's dinner tray from the dining room to R1's room with the student CNAs.On 4/6/26 at 3:09 PM, V14 (CNA Student) stated she and V5 were passing dinner trays from a meal cart located in the hallway when they delivered R1's tray to her room. V14 stated, We walked in the room to put the tray down and we saw V8 (CNA) pushing the resident from her left side using a lot of unnecessary force - it looked like she was hurting her. V14 stated R1 was lying on her back and V8 was leaning over R1 and putting her weight on R1. V14 stated R1 had a gown completely on. V8 was pressing on R1's left shoulder, and V14 could see V8 leaning over R1 and putting most of her weight down on R1 into the bed. V14 stated she was clear that the CNA was not trying to prevent R1 from hitting her because R1's hand was not coming up toward V8 or trying to hit V8. V14 stated R1 told V8 to stop and that V8 was hurting R1 but V8 continued. V14 stated V8 did not see the students drop off the dinner tray. V14 stated when they left R1's room she and V5 were surprised, questioned themselves and were unsure what to do. V14 stated the students walked to the dining room and she and V7 (CNA Student) were then assigned to feed R1 her meal. V14 stated when they returned to R1, R1 was sobbing and stated V8 was really hurting her. V14 stated R1 was trying to show her and grabbed V14's shoulder and told her not to be like V8. V14 stated V8 then returned to the room, asked the students if R1 drank anything and the students replied no. V14 stated V8 responded that didn't matter because she was on hospice anyway and told the students stop giving R1 her milk and go back to the dining room. V14 stated she reported the abuse to her supervisor. V14 stated V9 (Wound Nurse/Manager on Duty) and V10 (Quality Assurance) asked the students to provide handwritten statements and physically demonstrate the abuse they witnessed on V10. On 4/7/26 at 7:21 AM, V5 (CNA Student) stated she was interviewed, asked to provide a written statement, and asked to physically demonstrate what she witnessed by V9 and V10. V5 stated she tried to use the same force she witnessed V8 use on R1 when she demonstrated on V10. On 4/7/26 at 10:51 AM, V12 (Director of Nursing) stated she was told the CNA students reported V8 pushed R1 during care. V12 stated she did not interview R1 and received a verbal account of what R1 stated from V9 and V10. V12 stated she interviewed V8 who stated she tapped R1 and R1 was hitting V8 while V8 was putting a gown on R1. V12 stated she was not confident regarding the allegations the students were making. V12 stated she received the written statements which conflicted but could not locate their written statements again. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	V12 stated they concluded the abuse was unsubstantiated. On 4/7/26 at 12:42 PM, V10 (Quality Assurance) stated V5, V7, and V14 (CNA Students) all provided written statements regarding the abuse they witnessed. V10 stated she went to R1's room when the abuse was reported and R1 was in her room, was very confused and moving around, and stated she wanted to sleep. V10 stated when she asked R1 if she felt safe at the facility, R1 replied she wanted to go to sleep. V10 stated the students told her they saw V8 push R1 against the wall and push her leg because R1 kept moving her body. V10 stated the students reported R1 was moving in the bed and said don't hurt me but V8 kept holding R1. V10 stated she asked the students to physically demonstrate what they witnessed - including V7 who did not witness the abuse. V10 stated the students' physical accounts of the abuse differed. V10 stated she was unable to locate the students' written statements.Initial abuse report, dated 3/25/26 and provided 4/6/26, shows while being assisted with a meal, R1 reported to nursing students that a CNA hit her. Final abuse report, dated 3/27/26 and provided 4/6/26, shows the allegation of abuse was unsubstantiated. The report shows R1 misrepresented staff simple cues and had medication changes which caused delusional thoughts and visual hallucinations. The report shows R1 was described as restless, combative, manipulative, and preferred not to be touched. The report shows V8 (CNA) reported she was providing simple cues and touched the resident's leg and shoulders when she repositioned R1 during a gown change. The report shows R1 was moving her arms during care and told the CNA not to hit her, and V8 reassured R1 she was providing care. The final report fails to show any references to the CNA student eye-witness accounts during interviews or in written statements. On 4/8/26 at 12:11 PM, camera footage from 3/25/26 was reviewed with V1 (Administrator), V2 (Assistant Administrator) and V12 (Director of Nursing). The video showed at 5:07 PM V5 and V14 were working with a CNA taking a food tray cart into R1's hall. At 5:14 PM, V8 exited R1's hall and at 5:15 PM, the students exited R1's hall and then entered the dining room. At 5:21 PM, V14 and V7 left the dining room and entered R1's hall with V8 with no meal tray. V8 leaves and returns to R1's hall/room twice without a meal tray and later exits the room with a meal tray.Facility Prevention, Identification, Investigation and Reporting of Abuse, Neglect, Mistreatment or Exploitation of a Resident or Misappropriation of Resident Property, effective 8/18/22, shows the facility will provide an environment for residents that is safe and free from abuse, neglect, exploitation, mistreatment and misappropriation. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Physical abuse includes, but is not limited to, hitting, slapping, punching and kicking. Mental abuse includes, but is not limited to, humiliation, harassment, threats of punishment, deprivation or abuse.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to notify the local law enforcement agency regarding allegations of resident abuse per the facility policy. This applies to 2 (R1 and R2) of 3 residents reviewed for abuse allegations in the sample of 3.The findings include: 1.Initial abuse report dated March 25, 2026, and final report dated March 27, 2026, shows an allegation of physical abuse was reported to the facility regarding R1. On 4/6/26 at 3:09 PM, V14 (Certified Nursing Assistant/CNA Student) stated she and V5 (CNA Student) witnessed V8 (CNA) pushing R1 on her left side while lying in bed and using a lot of unnecessary force - it looked like she was hurting her. V14 stated R1 was telling V8 to stop, and she was being hurt and V8 was pressing very hard on R1's shoulder while leaning over her and putting her weight into R1. V14 stated she and V7 (CNA Student) were then sent into R1's room to feed R1. V14 stated R1 began sobbing and stated V8 hurt her. V14 stated R1 attempted to show V14 and V7 her knee where it hurt and R1 grabbed V14's shoulder and told V14 and V7 not to be like V8. The record showed an abuse allegation was submitted to the state surveying agency. However, review of the abuse investigation showed no evidence of the facility notifying the local law enforcement agency. 2.Initial and final abuse reports both dated December 9, 2025, and final report dated show an abuse allegation was submitted to the state surveying agency regarding R2. R2 alleged that someone pulled her arm during care, someone was rough during oral care and people were laughing at her. A skin assessment was completed, and bruising was observed on front and back of both arms. Review of the abuse investigation showed no evidence of the facility notifying the local law enforcement agency. On April 9, 2026, at 2:13 PM, V12 (Director of Nursing) stated the police should be notified of any allegations of abuse. The facility's August 18, 2022 Prevention, Identification, Investigation and Reporting of Abuse, Neglect, Mistreatment or Exploitation of a Resident or Misappropriation of Resident Property showed 3. Reporting/ Response: the facility will report all alleged violations and all substantiated incidents to the state agency and to all other agencies as required. The policy continued .The Administrator.shall also report to the local police if such allegation meets the requirements.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to conduct a thorough and impartial investigation of resident abuse by a staff member. The facility also failed to maintain documentation from the witnesses of the abuse. R1 experienced pain and was crying following the incident. The alleged perpetrator was allowed to return to work another two shifts with R1. A reasonable person would experience fear and anxiety having the alleged perpetrator provide care for a dependent resident with a history suffering from abuse. This applies to 1 of 3 residents (R1) reviewed for abuse in a sample of 3.The findings include: The facility failed to conduct a thorough and impartial abuse investigation. This failure resulted in an Immediate Jeopardy. The Immediate Jeopardy began on [DATE] at 5:40 PM when CNA (Certified Nursing Assistant) students reported to V9 (Wound Nurse/Nurse Supervisor) that they witnessed V8 (CNA) abuse R1. V9 then conducted witness interviews in a coercive manner, failed to substantiate the abuse allegation, and allowed V8 to return to work another two shifts with R1. V1 (Administrator), V2 (Assistant Administrator), and V15 (Corporate Nurse Consultant) were notified of the Immediate Jeopardy on [DATE] at 2:30 PM and the template was provided.V1 provided an Immediacy Removal Plan at 5:58 PM on [DATE], which was rejected and returned to V1 on [DATE] at 9:30 AM. The facility's second Immediacy Removal Plan was provided by V1 at 10:43 AM on [DATE] which was rejected and returned to V1 at 11:05 AM. The facility's third Immediacy Removal Plan was provided by V1 at 11:21 AM on [DATE] which was rejected and returned to V1 at 11:35 AM. The facility's fourth Immediacy Removal Plan was provided by V1 at 11:49 AM on [DATE] and it was accepted at that time. The surveyor confirmed by observation, interview and record review that the Immediate Jeopardy was removed on [DATE], but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training.R1's Face sheet dated [DATE], shows R1's diagnoses included metabolic encephalopathy, dementia with psychotic disturbance, adult failure to thrive, major depression disorder, pain in left and right knee and low back pain, cervicalgia, muscle weakness, noncompliance with other medical treatment, psychosis not due to a substance, anxiety, hemiplegia, and legal blindness. The face sheet shows R1 was admitted to the facility on [DATE] and expired at the facility on [DATE]. R1's MDS (Minimum Data Set), dated [DATE], shows R1's cognition was severely compromised. Psychology note dated [DATE], shows Resident was cooperative. Resident is making stable progress on goals listed above. Ongoing psychotherapy could help improve symptom management. The resident's cognitive functioning seems sufficient at this time. The note shows R1 had the capacity to participate meaningfully and benefit from psychotherapy. R1's care plan initiated [DATE], shows R1 had a history of financial abuse/exploitation alleged toward her son and was considered a vulnerable adult due to poor and compromised health/mental health status, cognitive issues, physical decline, and need for 24-hour care. The care plan shows R1 experienced a significant trauma during her lifetime, and she is a trauma survivor. The care plan also shows R1 exhibited manipulative behavior and makes accusations against staff and other residents related to her diagnosis of dementia with psychotic disturbance and anxiety. The interventions include having two staff present during care in R1's room and during showers as of [DATE]. On [DATE] at 3:50 PM, V5 (Student CNA) stated she witnessed V8 (CNA) hitting R1's left shoulder hard with an open hand and pushing her shoulder down forcefully into the mattress, holding R1 down. V5 stated V8 also shoved R1's knee down forcefully into the mattress and pushed the right side of R1's body toward the wall with force. V5 stated R1 was dressed in a gown and was screaming, saying she was being hurt and asking for help and asking V8 to stop. V5 stated V9 (Wound Nurse/Nurse Manager on Duty) asked her to provide a written statement describing what she witnessed, and she gave it to V9. On [DATE] at 3:53 PM, V7 (Student CNA) stated she fed R1 dinner with V14 on [DATE]. V7 stated R1 said V8 pushed her chest and knee and hit her, and then R1 called V8 a liar. V7 stated she and the other students (V5 and V14) reported the allegations to V9 (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(Wound Nurse/Nurse Manager on Duty) and V10 (Quality Assurance) and then provided handwritten statements. V7 stated V9 and V10 asked if the students were sure about their report because V8 had a child and V8 was a mother and they were attempting to make the students feel guilty. On [DATE] at 3:09 PM, V14 (CNA Student) stated she and V5 (CNA Student) witnessed V8 (CNA) pushing R1 on her left side while R1 was lying in bed and using a lot of unnecessary force - it looked like she was hurting her. V14 stated R1 was telling V8 to stop and she was being hurt. V14 stated V8 was pressing very hard on R1's shoulder while leaning over her and putting her weight onto R1. V14 stated she and V7 (CNA Student) were then sent into R1's room to feed R1. V14 stated R1 began sobbing and stated V8 hurt her. V14 stated R1 attempted to show V14 and V5 her knee where it hurt and R1 grabbed V14's shoulder and told V14 and V7 not to be like V8. V14 stated V14, V5, and V7 notified V4 (CNA Student Instructor), V9 (Wound Nurse/Nurse Manager on Duty) and V10 (Quality Assurance). V14 stated V9 seemed really mad for us saying anything. V14 stated V9 talked over the students when they tried to talk - including V9 stating R1 is combative, R1 often behaves the way they reported, and that the students needed to think about what they were reporting because [V8] was a single mother. V14 stated, Honestly that made me feel really uncomfortable and I wanted to leave, and I was just doubting myself for saying something. V14 stated V7 tried to talk to V9 and V10 but had a very hard time speaking English, and V9 and V10 would not listen to V7. V14 stated during the discussion, V9 tried to tell her that V8 was giving R1 a bed bath but she wasn't. V14 stated all three students provided written statements to V9 as requested by the facility. V14 stated the students were also asked to demonstrate on V10 (Quality Assurance) what V8 did to R1. V14 stated she told V10 she would not use the same force she saw V8 use because she would hurt V10, but she demonstrated how V8 leaned onto R1. V14 stated V7 was then asked to demonstrate what she saw, but V7 was not present during the abuse. V14 stated that after the demonstrations, V9 commented that all the students demonstrated different versions of the allegation. On [DATE] at 10:22 AM, V5 (CNA Student) stated while reporting the allegation on [DATE], V9 (Wound Nurse/Nurse Manager on Duty) told the students multiple times that V8 was a single mother, had no husband, and could lose her job if she were accused of abuse. V5 stated V9 made the students feel like they were lying about the allegation, and they started to regret their decision to report the abuse. V5 stated she gave V9 her written witness statement on [DATE], and she physically demonstrated V8's actions on V10 (Quality Assurance). V5 stated V10 then asked for V7 (CNA Student) to come in and physically demonstrate V8's abuse, even though V7 was not present when it occurred. On [DATE] at 10:30 AM, V1 (Administrator) stated V9 (Wound Nurse/Nurse Manager on Duty) and V10 (Quality Assurance) completed R1's abuse investigation and the investigation documents provided on [DATE] were all the documents included in R1's completed investigation. V9's typed document dated [DATE] showed the students provided written statements and then were asked to demonstrate the abuse they witnessed. On [DATE] at 10:33 AM, V4 (CNA Student Instructor) stated she was shocked by V9's behavior toward the students and V9's line of questioning when the students reported the abuse allegations. V4 stated V9 (Wound Nurse/Nurse Manager on Duty) interrupted the students as they tried to explain what they saw. V4 stated V9 abruptly said V8 would lose her certificate and not be able to work again. V4 stated V9 told them that V8 was a single mother, and she would not be able to feed her child as a single parent if she was accused of abuse. V4 stated, I have never seen so much heated debate about what was going to happen to the CNA and how she would lose her job. V4 stated V9 and V10 then took V5, V7 and V14 away from V4 and told the students to physically demonstrate on V10 what they saw V8 do to R1. V4 stated the students were also asked to write statements describing what they saw, and those written statements were provided to V9. On [DATE] at 10:41 AM, V13 (Licensed Practical Nurse) stated she was present when V9 (Wound Nurse/Nurse Manager on Duty) asked the students to describe what they witnessed. V13 stated V9 told the students that V8 (CNA) had a daughter and could lose her job if accused of abuse. V13 stated the students were asked to write statements to describe what they saw. The facility's Final Abuse Investigation Report, submitted to (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the state surveying agency on [DATE], showed the facility determined the allegation of abuse regarding R1 and V8 was not substantiated. Under the Brief Description of Incident, it showed The nursing students reported to the nursing instructor who reported to the nurse manager that [R1] reported to them during meal assistance, that the CNA hit her. The Final Report does not include any reference to or consideration of the witness statements made by V14 and V5 (CNA Students) that describe what they saw V8 do with R1.The facility's Daily Staffing schedules and Time Detail showed V8 was again assigned to R1 on [DATE] and [DATE].Review of the final abuse investigation included no handwritten statements provided by V5, V7 or V14 (CNA Students), and the only handwritten statements included were those written by V8 (alleged perpetrator) and V4 (CNA Student Instructor). A [DATE] typed document signed by V10 (Quality Assurance) and not by the students they refer to, was included in the investigation. V10's document showed a different and less aggressive version of the statements the students reported, and not the actual written statements. A second typed but undated document written by V9 (Wound Nurse/Nurse Manager on Duty) and not by the students they refer to, also showed a less aggressive interpretation of their statements and re-enactments.On [DATE] at 12:42 PM, V10 (Quality Assurance) stated she did not know where the written statements from the students were. On [DATE] at 11:54 AM, V9 (Wound Nurse/Nurse Manager on Duty) stated she gave the written statements from the students to V12 (Director of Nursing). On [DATE] at 10:51 AM, V12 stated she gave the statements back to V9 and was unable to locate them. V12 also stated she never interviewed R1 because she trusted V9 and V10 to do it. V12 stated she never received any statements with R1's interview.Facility policy, Prevention, Identification, Investigation and Reporting of Abuse, Neglect, Mistreatment or Exploitation of a Resident or Misappropriation of Resident property, effective [DATE], shows, Residents, families, visitor, and Nursing Home Staff will receive education on reporting concerns, incidents and grievances without the fear of retribution. member facilities strictly prohibit any retaliation, discrimination, harassment or any other adverse action taken against an employee who reports or participates in the investigation audit in good faith. Nursing Home Staff who are asked to provide a statement for the purpose of the investigation will comply by providing a written statement or dictating the statement to the Nursing Supervisor/Designee and acknowledging the statement made by their signature. Upon receiving a report of an allegation or suspicion of abuse, neglect, mistreatment, misappropriation, or exploitation, the Supervisor shall immediately ensure that the resident is protected from any further violation from occurring and contact the Administrator or Director of Nursing. When the investigation is complete, the Director of Nursing/Designee will present all relative documentation to the Administrator. The Administrator will: . b. Review that investigation is complete including: 1) All statements from staff, residents and any other person deemed necessary to complete the investigation. Ensure Director of Nursing/designee provides CMA (Central Management Services) with a complete written investigation with conclusion. Either the witness will write his/her statement and sign and date it, or the investigator may obtain the witness statement, read it back to the witness and have him/her sign and date it.The Immediate Jeopardy began on [DATE]. The immediacy was removed on [DATE] when the facility took the following actions to remove the immediacy:V8 (CNA) was suspended on [DATE] at 6:41pm and returned to work on [DATE] and then terminated on [DATE] at 5:30pm.Investigating nurse (V9) was suspended on [DATE] at 10:20am and terminated [DATE].On [DATE], V15 (Corporate Nurse Consultant) reviewed all abuse allegations dated [DATE] to [DATE] to identify any improper investigations.On [DATE], residents with a BIMS (Brief Interview for Mental Status) score of 10 or above were interviewed for care concerns, witnessing or experiencing abuse or any abuse that was reported, and they felt was not handled correctly.On [DATE], skin assessments were performed on residents with a BIMS score of 9 or lower to identify any signs or symptoms of abuse or neglect.On [DATE], staff were interviewed for any knowledge of any abuse not reported or any abuse that was reported that they felt was not handled properly or with coercion.Education provided to all staff regarding Abuse and reporting by [DATE] by Director of Mission Integration. Staff not educated will (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145878	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Patrick's Residence	1400 Brookdale Road Naperville, IL 60563

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	be taken off the schedule until the abuse education is completed.Abuse policy reviewed and/or updated on [DATE].On [DATE], the Investigation Checklist was updated to include senior level review by Corporate Nurse, validation of interviews confirming their statements by the Abuse Coordinator or designee, Director of Mission Integration, Director of Nursing or Infection Preventionist/Nurse Educator.On [DATE], education was provided to the Administrator, Director of Nursing, Director of Mission Integration and Nurse Educator/IP Nurse Manager on conducting an objective and impartial investigation and investigation checklist.On [DATE], the Corporate Nurse Consultant provided education to the Administrator and nurse managers on preventing abuse, neglect and misappropriation, abuse policy, abuse reporting procedure, and abuse investigation protocol.Ad-hoc Quality Assurance and Root Cause Analysis was completed with the Interdisciplinary Team and Medical Director on [DATE].Twenty interviewable residents will be interviewed three times a week for four weeks, then twenty residents twice weekly for four weeks, and then twenty residents weekly for four weeks.On any residents with BIMS scores of 9 and below, twenty skin check audits will be conducted three times a week for four weeks, then twenty residents twice weekly for four weeks, and then twenty residents weekly for four weeks.Twenty staff members will be given a post test on abuse and coercion to validate understanding and report any incidents of abuse three times a week for four weeks, then twenty staff twice weekly for four weeks, and twenty staff weekly for four weeks.All state reportable events will be reviewed by the Corporate Nurse Consultant to ensure investigations are thorough, accurate, and uncoerced. This will be done weekly for twelve weeks.