| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145974 | A. Building<br>B. Wing | 05/02/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Norwood Crossing | 6016 North Nina Avenue<br>Chicago, IL 60631 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and records reviewed the facility failed to ensure one resident (R1) remained free from verbal and physical sexual abuse from a resident (R2) who had a history of inappropriate sexual behavior with another resident (R3) prior. This failure affected three of three residents reviewed for abuse on the sample list of five. Findings include: On 1/14/26 the facility reported an incident involving R1 and R2 on 1/14/26. R1 reported to staff he was in bed when R2 approached him, made inappropriate verbal comments and placed his (R2's) hand over R1's upper leg. R1 said he told R2 he did not want to engage in this type of interaction.R1 is [AGE] year old male with diagnosis, including but not limited to Difficulty Walking, Muscle Atrophy, Weakness, Need for Assistance with Personal Care, Blindness, Symptoms and Signs Involving Cognitive Functions and Awareness, and Major Depressive Disorder.R2 was [AGE] year old male with diagnosis (prior to incident), including but not limited to Peripheral Autonomic Neuropathy, Hypertension, Anemia, Major Depressive Disorder. R2 passed away in the facility on 2/20/26 following a stroke experienced on 1/20/26.On 5/1/29 R1 stated R2, my room mate, made verbal comments to me, about sex. He touched my leg with his hand and was running it up my leg. R1 said I didn't want R2 to do that, we were not in a relationship like that. R1 said R2 was trying to touch me with his hand, but I put my hand down to block him from touching me. The staff came in to help me; they moved me right away. R1 said I didn't want to go back to that room. R1 said it was not ok, what R2 tried.On 5/1/26 at 1:41PM V6 ,Social Service Coordinator, said I was told to see R1 because there was an incident with him and R2. V6 said I don't remember if I spoke to R2. V6 said R1 said he was good. V6 said R1said he did not want to go back to the room. V6 said R1 was alert and oriented, with confusion when he gets ill. V6 said R1 was at baseline when I spoke with him. V6 said R2's baseline at the time was confused at times but he could carry on a conversation, and he was usually in a wheelchair. V6 said at the time R2 was new to me. V6 said this was when I first heard about the incident, I think I had been off for a couple of days when it happened. V6 said I was not aware of an episode between R2 and R3. V6 said depending on the investigation the incident between R1 and R2 could be abuse. V6 said if abuse occurs or is reported we report to the administrator and we start an investigation.On 5/1/26 at 12:21PM V2, Registered Nurse, said there were multiple incidents with R2. V2 said I was told the first incident was with a nursing student. V2 said I didn't see that, I was told R2 touched a male student and the student reported it. V2 said I witnessed at dinner time, we were in the cafeteria and we were passing meal trays. R2 rolled up to R3, on R3's weak side. V2 said R3 had a stroke and has weakness. V2 said R2 was touching R3 inappropriately. V2 said R3 raised his good hand up in the air and was yelling hey, hey to get staffs' attention. V2 said we turned and immediately took R2 away and told him what he was doing was not allowed and he has to stop. A few minutes later R2 tried to do it again to R3, but we stopped him. V2 said the 3rd time R2 did something it was with his room mate, R1. V2 said when I came to work, I noticed R1 was in a new room and they told me because R2 was touching R1 at night. An additional interview with V2 on 5/2/26 at 10:19AM was conducted. V2 said I saw R2 had his hand on R3's upper thigh and moving his hand into R3's groin. V2 said R3 was waving his hand and calling<br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | out. V2 said when I spoke to R2 about he said it's fine. V2 said I moved R2 away from R3 and then about 5- 10 minutes later, R2 was going back to R3, so then we moved R2 back toward his room and R3 stayed in the dining room. V2 said the CNAs said this was not the first time R3 did something like that. V2 said the CNAs said that a nursing student reported to his instructor that R3 was inappropriate with him by either saying things to him or touching him. V2 said they said the instructor reported to someone here, but I don't know who. V2 said R3 was in a wheelchair at the time, but he could move around easily in it.On 5/1/26 at 12:32pm V4, RN, said we were monitoring R2's behavior. V4 said I did not see him actually do anything, but we had a task to monitor him daily. V4 said I was told R2 had touched someone inappropriately. The surveyor asked V4 about the progress note she had written. V4 said I saw R2 was sitting outside R3's room. R3 was in his bed. V4 said R2 was inching closer to R3's room. V4 said I told R2 to stop and redirected him, but then later on the same shift he was doing it again. V4 said I redirected him again. V4 said we kept watching R2. V4 said I told the CNAs to watch him and keep him away from R3. V4 said the managers were notified. V4 said I am not aware of his behavior prior to him coming to the unit, he was in the assisted living portion. V4 said R2 was not placed on 1:1, we will assign 1:1 if we need it.On 5/1/26 V3, RN, said when abuse occurs or is reported an investigation is done.On 5/2/26 at 11:47AM V6 said we do trauma Informed Consent assessment on admission, readmission, and quarterly. The assessments are not specifically related to abuse allegation made. Prior to this assessment, we did not have another assessment in place of it. The purpose of the assessment is to see if the resident has anything that triggers behaviors. V6 said they tell us their symptoms and if they ask for counseling we will assist. V6 we will develop specific interventions to address individual needs. V6 said after speaking with R1, he did not request anything special after the incident with R2.On 5/2/26 at 9:39AM V5, Administrator, I said spoke with the previous administrator and she said she had no knowledge of an incident of R2 touching a nursing student inappropriately. At 11:25AM The surveyor reviewed R2's progress note written on 12/5/25. V5 said that sounds like it should have been investigated. V5 said I would have sent R2 out to be evaluated, that is not normal. V5 said the purpose of an investigation is to determine the root cause of this inappropriate behavior. V5 said I can't say if we could have prevented the incident with R2 and R3 had the investigation for 12/5/25 been done. V5 said R2 and R3's incident report is not a substantiated case of abuse. V5 said I am not aware what a Trauma Informed Consent is. At 12:24PM V5 said R3 does not have a Trauma Informed Consent in his record. V5 presented an undated Abuse Policy titled Illinois Council of Long Term Care: Abuse Preventions Program. V5 said I am confident this abuse policy covers all areas we follow.R1's progress notes dated 1/14/16 read writer (V9, RN) told by CNA that resident (R1) informed her that roommate (R2) was engaging in inappropriate behavior toward him. Writer RN spoke directly with resident, who reported that roommate was rubbing his leg, attempting to touch his genital area, and made repeated sexual, vulgar, inappropriate verbal statements, including requests for resident to expose his genitals, and comments regarding sexual function.R1's Trauma Informed Consent dated 1/16/26 notes question 7. Has anyone ever made or pressured you nto some type of unwanted sexual contact? Yes Roommate verbal sexually inappropriate comments and touched [h]is leg.R1's care plan includes impaired vision to left and right eye. R1 is a trauma survivor-Unwanted inappropriate verbal sexual conversation by roommate. Date Initiated: 01/16/2026.R2's care plan date initiated 12/8/25 includes Resident with a behavioral concern. Resident inappropriately touching other male residents. Interventions inlcude: distract the resident when noting to approach other males or from entering other male rooms.R2's care plan date initiated 1/16/26 includes The resident is/has potential to demonstrate physical/verbal sexual behaviors Resident approached roommate related to Dementia. Poor Impulse Control telling roommate I want to see your c*** [additional questions]. I'll show you mine you show me yours, touching roommates leg while roommate told him to stop.R2's progress notes dated 12/5/25 written by V2 states writer notified residents attempted to touch another male inappropriately while both in the common area. Staff observed resident reaching towards other male resident leg and groin area. Staff (continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | noticed due to resident's distress and intervened. R2 proceeded to attempt multiple times after that. Writer notified administrator, POA, physician, and supervisor.R3 is [AGE] year old male diagnosis include, but are not limited to Hemiplegia following Cerebral Infarction affecting his Dominant side and Aphasia following Cerebral Infarction.On 5/1/26 at 1:08PM R3 observed in the dining room, in a wheelchair, has assistive devices for support of right leg and upper right body. Interviewed R3 in his room. R3 answers yeah, smiles, gives audible laughter for most responses can give thumbs up, shakes head left to right to say no. Noted facial expressions change depending on question. R3 says yes and visibly smiles when discussing staff care, changing him, bathing him, bringing medications, and assisting when needed. Visible change in facial expression when asked about R2 touching him in the dining room. He said yeah when asked if he remembers. Asked him if the person is still here R3 said die. When asked what happened R3 indicated the man (pointed outwards) touched towards his groin (pointing and gesturing towards groin area). R3 was asked if he consented to the touch he shook head left to right and made unpleasant face. Indicated it only happened 1 time (put hand up and held up 1 finger) and nodded yes when asked if staff took the person away from him. On 5/1/26 at 1:41PM V6 said I don't know about an incident between R2 and R3.A review of R3's Progress notes for 12/5/25-12/6/25 has no record of the incident documented by V2 in R2's record related to R2 touching R3 on 12/5/26.On 5/2/26 at 12:42PM V5 said R3 does not have a Trauma Informed Consent Assessment in his chart. [None in the record when the surveyor reviewed.]R3's cognitive assessment dated [DATE] identifies short and long term memory problems. Functional abilities identified R3 requires a minimum of 1 person assistance with all activities, except eating. R3's communication care plan identifies he has expressive aphasia related to a stroke. R3 has impaired thought process. R3's care plan does not identify he is at risk or has potential for abuse.The facility's undated abuse policy, in part states the facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment neglect or abuse of our residents. Sexual abuse includes but is not limited to sexual harassment sexual coercion or sexual assault. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and records reviewed the facility failed to report an allegation of abuse to the state agency. This failure affects two of three residents (R2/R3) reviewed for abuse in the sample of five. Findings include: R2's progress notes dated 12/5/25 written by V2 states writer notified residents attempted to touch another male inappropriately while both in the common area. Staff observed resident reaching towards other male resident leg and groin area. Staff noticed due to resident's distress and intervened. R2 proceeded to attempt multiple times after that. Writer notified administrator, POA, physician, and supervisor.On 5/1/26 at 1:08PM R3 observed in the dining room, in a wheelchair, has assistive devices for support of right leg and upper right body. Interviewed R3 in his room. R3 answers yeah, smiles, gives audible laughter for most responses can give thumbs up, shakes head left to right to say no. Noted facial expressions change depending on question. R3 says yes and visibly smiles when discussing staff care, changing him, bathing him, bringing medications, and assisting when needed. Visible change in facial expression when asked about R2 touching him in the dining room. He said yeah when asked if he remembers. Asked him if the person is still here R3 said die. When asked what happened R3 indicated the man (pointed outwards) touched towards his groin (pointing and gesturing towards groin area). R3 was asked if he consented to the touch he shook head left to right and made unpleasant face. Indicated it only happened 1 time (put hand up and held up 1 finger) and nodded yes when asked if staff took the person away from him. On 5/1/26 at 12:21PM V2, Registered Nurse, said there were multiple incidents with R2. V2 said I was told the first incident was with a nursing student. V2 said I didn't see that, I was told R2 touched a male student and the student reported it. V2 said I witnessed at dinner time, we were in the cafeteria and we were passing meal trays. R2 rolled up to R3, on R3's weak side. V2 said R2 was touching R3 inappropriately. V2 said R3 raised his good hand up in the air and was yelling hey, hey to get staffs' attention. V2 said we turned and immediately took R2 away and told him what he was doing was not allowed and he has to stop. A few minutes later R2 tried to do it again to R3, but we stopped him. V2 said the 3rd time R2 did something it was with his room mate, R1. An additional interview with V2 on 5/2/26 at 10:19AM was conducted. V2 said I saw R2 had his hand on R3's upper thigh and moving his hand into R3's groin. V2 said R3 was waving his hand and calling out. V2 said I moved R2 away from R3 and then about 5- 10 minutes later, R2 was going back to R3, so then we moved R2 back toward his room and R3 stayed in the dining room. V2 said the CNAs said this was not the first time R3 did something like that. V2 said the CNAs said that a nursing student reported to his instructor that R3 was inappropriate with him by either saying things to him or touching him. V2 said they said the instructor reported to someone here, but I don't know who.On 5/1/26 at 12:32pm V4, RN, said we were monitoring R2's behavior. V4 said I did not see him actually do anything, but we had a task to monitor him daily. V4 said I was told R2 had touched someone inappropriately. The surveyor asked V4 about the progress note she had written. V4 said I saw R2 was sitting outside R3's room. R3 was in his bed. V4 said R2 was inching closer to R3's room. V4 said I told R2 to stop and redirected him, but then later on the same shift he was doing it again. V4 said I redirected him again. V4 said we kept watching R2. V4 said I told the CNAs to watch him and keep him away from R3. V4 said the managers were notified.On 5/2/26 at 9:39AM V5, Administrator, I said spoke with the previous administrator and she said she had no knowledge of an incident of R2 touching a nursing student inappropriately. At 11:25AM The surveyor reviewed R2's progress note written on 12/5/25. V5 said that sounds like it should have been investigated. V5 said I would have sent R2 out to be evaluated, that is not normal. V5 said the purpose of an investigation is to determine the root cause of this inappropriate behavior. V5 said I can't say if we could have prevented the incident with R2 and R3 had the investigation for 12/5/25 been done.On 5/1/26 at 1:41PM V6 said I don't know about an incident between R2 and<br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R3.R2 was [AGE] year old male with diagnosis (prior to incident), including but not limited to Peripheral Autonomic Neuropathy, Hypertension, Anemia, Major Depressive Disorder. R2 passed away in the facility on 2/20/26 following a stroke experienced on 1/20/26.R3 is [AGE] year old male diagnosis include, but are not limited to Hemiplegia following Cerebral Infarction affecting his Dominant side and Aphasia following Cerebral Infarction.A review of R3's Progress notes for 12/5/25-12/6/25 has no record of the incident documented by V2 in R2's record related to R2 touching R3 on 12/5/26.On 5/1/26 and 5/2/26 the surveyor asked V5 if they have a reportable or investigation for R3 and R2 on 12/5/26. No documentation was provided.The facility's undated abuse policy, in part states all incidents will be documented whether or not abuse occurred was alleged or suspected. Any incident or allegation involving abuse, neglect, or misappropriation will result in an abuse investigation. Final abuse investigation report: the investigator will report the conclusions of the investigation in writing to the administrator or designee within 5 working days of the reported incident the investigation. Report shall contain the following: name, age, diagnosis, and mental status of the resident allegedly abused or neglected. The original allegation day, time, location, and specific allegation. Facts determined during the process of the investigation. Conclusion of the investigation: Attach a summary of all interviews conducted with the names, address, phone numbers and willing to testify of all witnesses. External reporting of potential abuse initial reporting of allegations if mistreatment has occurred the residents representative and Department of Public health shall be informed as soon as possible within 24 hours. The written report should contain the following information: name, age, diagnosis, and mental status of the resident allegedly abused or neglected type of abuse reported date, time, location, and circumstances of the alleged incident steps, the facility has taken to protect the resident. Within 5 working days after the report of the occurrence a complete written report of the conclusion of the investigation will be sent to the Department of Public health. |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and records reviewed the facility failed to investigate an allegation of abuse for one resident (R3). This failure affects two of three residents (R2/R3) reviewed for abuse on the sample list of five. Findings include: R2's progress notes dated 12/5/25 written by V2 states writer notified residents attempted to touch another male inappropriately while both in the common area. Staff observed resident reaching towards other male resident leg and groin area. Staff noticed due to resident's distress and intervened. R2 proceeded to attempt multiple times after that. Writer notified administrator, POA, physician, and supervisor.On 5/1/26 at 1:08PM R3 observed in the dining room, in a wheelchair, has assistive devices for support of right leg and upper right body. Interviewed R3 in his room. R3 answers yeah, smiles, gives audible laughter for most responses can give thumbs up, shakes head left to right to say no. Noted facial expressions change depending on question. R3 says yes and visibly smiles when discussing staff care, changing him, bathing him, bringing medications, and assisting when needed. Visible change in facial expression when asked about R2 touching him in the dining room. He said yeah when asked if he remembers. Asked him if the person is still here R3 said die. When asked what happened R3 indicated the man (pointed outwards) touched towards his groin (pointing and gesturing towards groin area). R3 was asked if he consented to the touch he shook head left to right and made unpleasant face. Indicated it only happened 1 time (put hand up and held up 1 finger) and nodded yes when asked if staff took the person away from him. On 5/1/26 at 12:21PM V2, Registered Nurse, said there were multiple incidents with R2. V2 said I was told the first incident was with a nursing student. V2 said I didn't see that, I was told R2 touched a male student and the student reported it. V2 said I witnessed at dinner time, we were in the cafeteria and we were passing meal trays. R2 rolled up to R3, on R3's weak side. V2 said R2 was touching R3 inappropriately. V2 said the CNAs said this was not the first time R3 did something like that. V2 said the CNAs said that a nursing student reported to his instructor that R3 was inappropriate with him by either saying things to him or touching him. On 5/1/26 at 12:32pm V4, RN, said we were monitoring R2's behavior. V4 said I did not see him actually do anything, but we had a task to monitor him daily. V4 said I was told R2 had touched someone inappropriately. The surveyor asked V4 about the progress note she had written. On 5/2/26 at 9:39AM V5, Administrator, I said spoke with the previous administrator and she said she had no knowledge of an incident of R2 touching a nursing student inappropriately. At 11:25AM The surveyor reviewed R2's progress note written on 12/5/25. V5 said that sounds like it should have been investigated. V5 said I would have sent R2 out to be evaluated, that is not normal. V5 said the purpose of an investigation is to determine the root cause of this inapprorpairate behavior. V5 said I can't say if we could have prevented the incident with R2 and R3 had the investigaiton for 12/5/25 been done.On 5/1/26 at 1:41PM V6 said I don't know about an incident between R2 and R3.R2 was [AGE] year old male with diagnosis (prior to incident), inlcuding but not limited to Peripheral Autonomic Neuropathy, Hypertenison, Anemia, Major Dperessive Disorder. R2 passed away in the faciilty on 2/20/26 following a stroke experienced on 1/20/26.R3 is [AGE] year old male diagnosis include, but are not limited to Hemiplegia following Cerebral Infarction affecting his Dominant side and Aphasia following Cerebral Infarction.A review of R3's Progress notes for 12/5/25-12/6/25 has no record of the incident documented by V2 in R2's record related to R2 touching R3 on 12/5/26.On 5/1/26 and 5/2/26 the surveyor asked V5 if they have a reportable or investigation for R3 and R2 on 12/5/26. No documentation was provided.The facility's undated abuse policy, in part states all incidents will be documented whether or not abuse occurred was alleged or suspected. Any incident or allegation involving abuse, neglect, or misappropriation will result in an abuse investigation. Final abuse investigation report: the investigator will report the conclusions of the investigation in writing to the administrator or designee within 5 working days of the reported incident the investigation. Report shall contain the following: name, age, diagnosis, and mental status<br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | of the resident allegedly abused or neglected. The original allegation day, time, location, and specific allegation. Facts determined during the process of the investigation. Conclusion of the investigation: Attach a summary of all interviews conducted with the names, address, phone numbers and willing to testify of all witnesses. External reporting of potential abuse initial reporting of allegations if mistreatment has occurred the residents representative and Department of Public health shall be informed as soon as possible within 24 hours. The written report should contain the following information: name, age, diagnosis, and mental status of the resident allegedly abused or neglected type of abuse reported date, time, location, and circumstances of the alleged incident steps, the facility has taken to protect the resident. Within 5 working days after the report of the occurrence a complete written report of the conclusion of the investigation will be sent to the Department of Public health. |