| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146013 | A. Building<br>B. Wing | 04/30/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Berkeley Nursing & Rehab Center | 6909 West North Avenue<br>Oak Park, IL 60302 |

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 interview and record review, the facility failed to ensure residents are free from verbal abuse for one of three residents (R1) reviewed for abuse. Findings include:R1 is an [AGE] year-old male who was readmitted in the facility on 05/02/2024 with diagnoses of not limited to rhabdomylosis, dementia and schizoaffective disorder. R1's Brief Interview for Mental Status (BIMS) done on 04/02/2026 indicated R1 has BIMS score of 15 which indicated R1 is cognitively intact.On 04/30/2026 at 9:54AM during interview, R1 stated that V3 (Former Certified Nursing Assistant/CNA) was always mad at R1. R1 stated that whatever R1 says, V3 turns it against R1.On 04/30/2026 at 11:24AM during phone interview with V3, V3 stated that R1 had been calling her with racial slurs every time R1 sees her. V3 stated that she already talked to V5 (Registered Nurse/RN), V8 (RN) and V9 (Licensed Practical Nurse/LPN) about it, and she was always told to ignore R1. V3 stated that on the day of the incident, she was passing by R1 carrying a breakfast tray and heard R1 call her stupid but V3 ignored R1. V3 stated that she then heard R1 talk to another resident asking the resident when that resident would get a wig like V3's. V3 stated that R1 walked past her, so V3 told R1 to leave V3 alone without raising V3's voice, because R1 was just right in front of her. V3 stated that she felt like R1 just didn't want black people.On 04/30/2026 at 12:05PM during phone interview with V8, V8 stated that V3 never complained to her about R1 calling V3 with racial slurs.On 04/30/2026 at 12:09PM during phone interview with V9, V9 stated that V3 never came to her to complain about R1 making racial comments towards V3 or anyone. V9 stated that she is African American herself but never heard R1 make racial comments towards her.On 04/30/2026 at 12:32PM during phone interview with V5 (Registered Nurse), V5 stated that V3 came up to V5 telling V5 to tell R1 to stop talking about V3 in Spanish. V5 stated that R1 came up to her as well, then V3 started pointing at R1 and became really verbally aggressive towards R1 telling R1 that if R1 won't stop talking about V3, V3 would slap the shit out of (R1). V5 stated that she asked R1 to go behind V5 because she was scared that V3 would hit R1. V5 stated that she tried to deescalate, and reminding V3 that R1 is a resident in the facility and the facility is R1's home. V5 stated that she tried to calm V3 down but V3 was not hearing any of what she was saying. V5 stated that V3 looked like she had a nervous breakdown that day. V5 stated that R1 was a kind man and never heard R1 say any racial slurs or curse anyone. V5 stated that this is the first time V3 came up to her to tell her that R1 was talking about V3.On 04/30/2026 at 1:55PM during interview with V1 (Administrator), V1 stated that if any resident was making negative comments towards staff, the staff is expected to walk away, ignore or speak towards the residents in a calm, polite way. V1 stated that he expects staff to understand that the residents can present with behavioral symptoms, especially residents with dementia and mental illness, and still continue to provide compassionate care towards them. V1 stated that he never heard R1 make racial slurs or curse anyone, and R1 is an easily redirectable resident. V1 stated that he expects staff to treat and speak to all residents with respect and dignity.Review of R1's Care Plan revised 03/26/2026 indicated R1's comprehensive assessment reveals a history (hx) of suspected abuse, neglect, exploitation, past trauma and/or other factors that may increase my susceptibility to abuse/neglect. It also indicated goals including R1 will<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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| | 146013 | A. Building<br>B. Wing | 04/30/2026 |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | be treated w/ (with) respect, dignity and reside in the facility free of mistreatment (i.e., abuse/neglect). It also indicated interventions including assuring R1 that he is in a safe & secure environment w/ caring professionals.Review of IDPH (Illinois Department of Public Health) Incident Report Form involving R1 and V3 with incident date of 03/14/2026 indicated the following:Conclusion: (V3) became upset, believing that (R1) was speaking derogatorily about her to other residents in Spanish. (V3) reported this to the Charge Nurse in a loud and angry tone in the presence of (R1). Two nurses tried to calm (V3) down but (V3) continued yelling and cursing and was verbally abusive to (R1).Review of V5's Statement on incident date of 03/14/2026 indicated (V3) came up to (V5) yelling and screaming that (R1) was talking about (V3) in Spanish. It also indicated that (R1) came to (V5) and stated that (R1) never said anything to (V3). It indicated that (V3) raised her left arm to (R1) and stated you say one more thing about me in Spanish, (V3) going to f**king slap the sh*t out of (R1), you motherf**ker. It also indicated that (V3) told (V5) that (V3) is going to slap (R1).Review of facility's policy entitled Abuse, Neglect, Exploitation: Prevention - Investigation - Reporting revised 05/16/2016 indicated the following:Policy: It is the policy of this facility to prevent resident abuse, neglect, mistreatment, and misappropriation of resident property. The following Procedures shall be implemented when an employee or agent becomes aware of the abuse or neglect of a resident or of an allegation of suspected abuse or neglect of a resident or by a 3rd party. |