STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146028	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wealshire Ctr of Excellence	150 Jamestown Lane Lincolnshire, IL 60069

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** 34117 Based on observation, interview, and record review the facility failed to ensure a resident was free from physical abuse. This failure resulted in R1 being struck in the face by R2. R1 was sent to the local hospital and sustained a closed fracture of the left zygomatic arch (cheek bone). This applies to 1 of 3 residents (R1) reviewed for abuse in the sample of 3. The findings include: The facility's Initial Report dated 7/6/24 documents Activity staff reported to the nurse two residents (R1, R2) had an altercation. R1's face sheet shows she is a [AGE] year-old female with diagnoses including zygomatic fracture left side, osteoarthritis, type 2 diabetes, heart failure, cerebrovascular disease, major depressive disorder, unspecified dementia. On 7/10/24 at 9:43 AM, R1 was observed lying in bed, she had a dark purple bruise under her left eye and greenish discoloration to her left cheekbone. The left side of her face had some mild swelling. R1 was alert to herself, she could recall her date of birth and said she was at a home. This surveyor asked what happened to her left eye, she said somebody must have hit me, I don't know. R1 touched her left side of the face and said, it's tender. On 7/10/24 at 9:50 AM, V8 (Certified Nursing Assistant/CNA) said R1 is alert and forgetful. She gets along with others and has no behaviors. R2 has dementia and behaviors of aggression. He usually sits near the nurse's station and needs to be supervised because he attempts to get out of his wheelchair. On 7/10/24 at 9:56 AM, V9 (CNA) said she was working on 7/6/24 with the wound nurse. She heard R2 punched R1. R1 is alert and forgetful with no behaviors. R2 usually sits at the table near the nurse's station. R2 has to be supervised because he is a fall risk. He gets irritated at times and gets combative with staff. (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 - Actual harm Residents Affected - Few	On 7/10/24 at 11:43 AM, V7 (CNA) said she was working on 7/6/24. She said she told V11 (Agency CNA) she was going to answer a call light, and V11 said she would stay at the desk. V7 said she thinks it was agency staff because she had not seen her before. When she came back to the nurse's station V11 was not there. V6 (Activity Aide) was in the dining room, he reported R2 got up from his wheelchair and started hitting R1. She went to check on R1, R1's face was turning colors. R1 said he (R2) hit me, and she was pointing to the left side of her face. R2 said I'm in trouble now. R2 has behaviors, he's been combative with staff and he's very unpredictable. On 7/10/24 at 12:45 PM, V3 (Nurse Supervisor) said she was on duty on 7/6/24. She received a call from V4 (Manger on Duty) around 10:00 AM about an altercation on a unit. When she arrived at the unit, R1 was in the dining room. R1 had a huge hematoma to her left eye. R1 was sent out to the local hospital. On 7/10/24 at 1:00 PM, V5 (Licensed Practical Nurse/LPN) said she was working on 7/6/24. Sometime after 7:30 AM, she was told she had to pick four residents from a unit. V6 (Activity Aide) reported to me he was on the unit and witnessed R2 abuse R1. It happened. It was obvious R1 sustained a fracture to her face. On 7/10/24 at 1:10 PM, V4 (Manager on Duty) said around 10:00 AM, V6 reported an allegation of abuse with R1 and R2. V6 reported he was in the dining room because the CNA were providing care to other residents. R2 had struck R1 in the face. R2 did this unprovoked and out of the blue. Both residents were sent out to the local hospital. On 7/10/24 at 1:56 PM, V1 (Administrator) said it happened R2 stuck R1 in the face. V1 said he was still working on the final report. R1 sustained an injury to her face and R2 was admitted to behavioral health hospital. R1's Incident Note dated 7/6/24 documents received a call from the manager on duty there was an altercation between two residents. Upon entering the unit, (R1) was in the dining room in her wheelchair. The staff reported (R1) was hit. (R1) acquired a large hematoma under her left eye. R1's nurse's note dated 7/6/24 documents (R1) returned to the facility and per the hospital report (R1) has a closed fracture of the left zygomatic arch, swelling and discoloration to left side of face. R1's CT report dated 7/6/24 documents non-displaced fracture of the left zygomatic arch, overlying soft tissue swelling is noted. R2's face sheets shows he is a [AGE] year-old male with diagnoses including unspecified dementia, psychotic disorder with delusions due to physiological condition, anxiety, and Parkinson's. R2's Psychiatry Progress note dated 6/24/24 documents requiring redirection: often, not improved worse. Displays of inappropriate behavior: not improved, keeps standing up, agitated, restless, unable to redirected, poor safety awareness. Affect/Mood: anxious, irritable, poorly modulated, or labile. Patient report or observation of psychotic symptoms: delusions evident, (R2) not aware of psychotic symptoms, confabulated delusions are evident. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	R2's care plan dated 4/25/24 documents he has the potential to demonstrate physical behaviors related to dementia. Interventions include to assess and anticipate R2's needs, analyze key times, triggers, circumstances and what de-escalates behavior. The nurse's note dated 7/6/24 documents around 9:45 AM, staff were prompting residents to participate in activities. Another resident who was slowly wheeling herself (R1) towards the activity without any unusual occurrence. (R2) was observed standing up, approached (R1) and physically attacked her. The nurse's note dated 7/8/24 documents R2 was sent out to behavioral health hospital for aggressive behavior. The facilities undated Coordinating/Implementing Abuse, Neglect and Exploitation Policies and Procedures Policy states, polices are in that prohibit and prevent resident abuse .