STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146149	A. Building B. Wing	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westwood Vlge Nrsg and Rhb Ctr	2444 West Touhy Avenue Chicago, IL 60645

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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent and protect residents from verbal abuse for two (R1 and R2) out of four residents reviewed for resident-to-resident abuse. The findings include:R1's face sheet showed R1's admission date was on 1/6/25 with diagnoses not limited to Asthma, Bipolar disorder, Hypertensive heart disease without heart failure, Delusional disorders, Other psychoactive substance use, Other chronic pain, Anxiety disorder, Insomnia. MDS (Minimum Data Set) dated 7/9/25 showed R1's cognition was intact.R2's face sheet showed R2's admission date was on 5/30/25 with diagnoses not limited to Hemiplegia, unspecified affecting left dominant side, Bipolar disorder, Chronic obstructive pulmonary disease, Type 2 diabetes mellitus, Myelodysplastic syndrome, Pathological fracture left ankle, Spinal stenosis cervical region, Hypertensive heart disease without heart failure, Chronic kidney disease, Generalized anxiety disorder, Schizoaffective disorder, Personal history of transient ischemic attack (TIA), and cerebral infarction, Nicotine dependence. MDS dated [DATE] showed R2's cognition was moderately impaired.On 8/24/25 At 10:05AM observed R1 ambulating with a walker with steady gait, alert, oriented x 3, and verbally responsive. R1 said about a couple of weekends ago, R2 threatened/harassed her. She said R2 was going to attack me or hit me. R2 was shouting at me. R1 further stated that R2 cursed her and stated, B****, get out of my way. F*** you. I will beat you're a** out. On 8/24/25 at 10:24am R2 observed sitting up in a wheelchair by his bedside, alert and oriented x 3, verbally responsive. He said about a couple of weekends ago, R1 called him N***R. R2 said R1 is mad at him whenever she saw him. He said R1 cursed him and called out names whenever he is coming. R2 stated R1 yelled/screamed at him saying F*** you, F*** off. R2 said he cursed back at R1 and stated leave me alone, CRAZY or I will knock on your a** out, F*** you. R2 said he yelled/screamed/cursed R1 too. On 8/24/25 At 10:53AM V3 (Licensed Practical Nurse/LPN) said had worked with R1. Surveyor reviewed R1's EHR (electronic health record) with V3 and he stated he wrote progress notes for R1 on 8/10/25. V3 said there was incident between R1 and R2 on 8/10/25. He said R1 was verbally aggressive with R2, there was a lot of back and forth between R1 and R2 but did not hear specific words that they (R1 and R2) were saying to each other. V3 said both R1 and R2 were raising voices/yelling at each other. V3 said he could hear upset voices from R1 and R2 but was not able to hear specific words. He said staff separated R1 and R2. V3 said it was reported to him that that R1 was harassing R2 with yelling profanities or using swear words probably F*** words. V3 said R1 and R2 were using not appropriate language - more of aggressive words but can't say specific words or appropriate language that were used by R1 and R2. R1's Progress Note dated 8/10/25 by V3 (LPN) showed in part: R1 has been verbally aggressive with various staff/peers. Staff received complaints from peers/staff that R1 was agitating other clients unprovoked by yelling profanities at them.R1's Care plan dated 1/6/25 showed in part: R1 is at risk for abuse due to residing at a long-term care facility. Resident will be free of abuse/neglect daily.On 8/24/25 At 11:07AM V9 (Certified Nursing Assistant/CNA) stated she had worked with R2 but not with R1. Stated she knew R1. V9 said there was an encounter between R1 and R2 about couple of weekends ago, both R1 and R2 were yelling/screaming/cursing at each other. V9 stated R1 said to R2 shut the f*** then R2 cursed back to R1 stating, get the f*** out of my way. V9 said both R1 and R2 were exchanging F words to each other. She said both residents were separated. V9 said it was verbal abuse between R1 and R2 because they were yelling/screaming and cursing at each other. Stated she thought the administrator was aware of it because there were nurses who heard or witness the verbal abuse at that time. On 8/24/25 At 12:08PM V12 (CNA) stated had seen R1 and R2 yelling and screaming at each other and staff need to break up and control the situation. V12 said it happened about a couple of weekends ago when R1 and R2 passed or saw each other. V12 said R2 cursed at R1, stated F*** you. I am tired of this shit. I want the f*** out of here. I am tired of that b****. V12 said R1 did cursed back to R2 and stated F*** you, F*** off. V12 said it was a verbal abuse between R1 and R2 and he thought the Administrator knew about it. On 8/24/25 At 1:25PM V13 (LPN) stated she had been working with R2. She said R2 is alert and oriented x 3, Easily agitated, cursing, yelling and screaming to staff. Surveyor reviewed R2's EHR with V13 and stated that R2 had a verbal altercation with R1 on 8/10/25. V13 said R1 and R2 were going back and forth. She said R1 and R2's voices were raised or were yelling at each other. V13 said R2 yelled at R1, R2 stated leave me the F*** alone. V13 said R1 was threatening R2 to call the police on him and R1 will put R2 in jail. V13 said R1 called R2 N***R. She said R1 does not like R2. V13 said she heard R1 cursing but could not identify or remember