

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  14E169	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/13/2025
NAME OF PROVIDER OR SUPPLIER  Winston Manor Cnv & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  2155 West Pierce Chicago, IL 60622	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45000</p> <p>Based on interview and record review, the facility failed to prevent and protect a resident from staff to resident abuse. This failure affects one (R2) resident out of four residents reviewed for abuse.</p> <p>Findings include:</p> <p>R2 is no longer in the facility and was reviewed as a closed record.</p> <p>R2's Face sheet documents that R2 has diagnoses not limited to: schizophrenia, insomnia, and attention deficit hyperactivity disorder.</p> <p>R2's MDS/Minimum Data Set, dated dated dated [DATE], documents that R2 is alert and oriented with a BIMS/Brief Interview for Mental Status of ,d+[DATE], indicating that R2 is cognitively intact. R2 requires supervision and set up assist with ADL/Activities of Daily Living care. R2 is continent of bowel and bladder and ambulates via walking.</p> <p>On [DATE], at 12:34 PM, R1 states 2 days ago on [DATE], he witnessed V3 (Social Services Director/SSD) pull R2 out of a chair causing R2 to fall on the floor. R1 states he was standing outside of V3's office door on the first floor of the facility and witnessed the entire incident. R1 states R2 was located inside of V3's office sitting in a chair with the wheels at the bottom. R1 states R2 was trying to talk to V3 and V3 was pushing R2 away. R1 states R2 told V3 to stop touching R2 as R2 continued to sit in the chair. R1 states V3 then got up from a sitting position and went over to R2. V3 took the chair and removed it from underneath R2. R1 states R2 then fell out of the chair, got back up, picked the chair up and broke it by slamming the chair down. R1 states R2 then went to the front door and kicked it about 10 times and ran out the front door. R1 states R2 was caught by staff, arrested, and sent to the hospital. R1 states he did not inform anyone of the incident between R2 and V3. R1 states this is because V12 (Activity Aide) was also present and witnessed the incident between R2 and V3.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE], at 1:12 PM, V3 (Social Services Director) states on [DATE], housekeeping came to V3 and informed her that paper wrapped around cannabis was found in R2's room. V3 states she went to R2's room and found a torch lighter that belonged to V3 inside of R2's room. V3 states R2 was not located inside of his room at that time so she informed staff to tell R2 to come to V3's office to speak with her. V3 states R2 came to her office and was sitting in a chair that had no back support on it. V3 states she was asking R2 questions about the cannabis that was found in his room. V3 states R2 was not responding to her questions. V3 states R2 kept saying he don't give a f**k and only wanted to go to a funeral the next day. V3 states R2 then stood up and became verbally aggressive so V3 asked R2 to leave her office. V3 states R2 sat back down and was trying to roll around in the chair while sitting in it. V3 states she told R2 not to do that. R2 stood up and took the chair and slammed it on the wall, causing the chair to break. V3 states R2 then went to the front door and started kicking the front door and the staff followed him. V3 states she retreated back into her office because she was scared and remained in her office during the entire ordeal. V3 states she never pushed R2 out of the chair and never pulled the chair from underneath R2. V3 states she has never been physically or verbally abusive to the residents. V3 states she was informed that police arrived at the facility and R2 was sent to the hospital for psychiatric evaluation. V3 states due to R2's behavior, R2 is not allowed to return to the facility. V3 states R2 has been calling and asking for V3 to plead with V1 (Administrator) for R2 to come back to the facility.</p> <p>On [DATE], at 1:53 PM, V12 (Activity Aide) states on [DATE], she was standing outside of V3's office because the smoking break was about to start. V12 states she saw R2 sitting in a chair located inside of V3's office. V12 states R2 was having a bad day due to someone close to him dying and R2 wanted to talk to V3. V12 states V3 asked R2 to come back later but R2 wasn't taking no for an answer. V12 states R2 continued to glide around in the chair inside of V3's office. V12 states V3 then got up and tried to shove R2 out of her office. V12 states V3 also snatched the chair from underneath R2 while he was sitting in it and R2 fell to the floor. V12 states R2 snatched the chair back from V3 and threw it to the floor and the chair broke in half. V12 states R2 did not injure himself but R2 was very upset about V3 touching him. V12 states she considers this act a form of abuse and if V3 would not have touched R2 or snatched the chair from under him, then the situation would not have escalated. V12 states the police were called. V12 remained with R2 monitoring him until the police brought R2 back to the facility. V12 states she was trained on abuse last month and reported the incident between V3 and R2 to V2 (Director of Nursing/DON). V12 states on the same day of the incident ([DATE]), she informed V2 that V3 pulled the chair from underneath R2. V12 states there was so much commotion going on that day, and no one was really hearing what was going on. V12 states the facility still sent R2 out to the hospital. V12 states R2 is not usually aggressive and should not have been sent out to the hospital. R2 was only triggered by V3's actions. V12 states V3 acts unprofessionally with the residents by joking around with them too much. The nature of V3's relationships with the residents are too friendly.</p> <p>On [DATE], at 2:15 PM, V2 (DON) states the incident between R2 and V3 was not reported to her, and this is the first time she is hearing about the incident. V2 states she was never informed that V3 pulled a chair from underneath R2. V2 states V12 (Activity Aide) only informed her R2's cousin died. V2 stated if a staff member pulls a chair from underneath a resident and causes them to fall, this is considered abuse.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE], at 2:28 PM, V1 (Administrator) states he was made aware of R2's behaviors on [DATE]. V1 states he was made aware that R2 had an outburst, slammed a swivel chair on the floor and broke it. V1 states he was also made aware that R2 kicked the front door several times and was very aggressive with staff. V1 states due to R2's behavior, the interdisciplinary team (IDT) made the decision not to accept R2 back into the facility. V1 states the corporate team informed the admissions department that the facility is not accepting R2 back into the facility. V1 states he is the abuse coordinator, and he was not made aware of any allegations of physical abuse involving V3 (SSD) against R2. V1 states he is learning of allegations from surveyor and will now report to the State Agency and start an investigation. V1 states V3 (SSD) will be suspended pending the investigation. V1 states if V3 pulled a chair from underneath R2 and caused R2 to fall, then this is considered abuse.</p> <p>R2s' care plan dated [DATE] documents in part, R2 will remain safe, will be treated with respect, dignity and reside in the facility free of mistreatment (i.e., abuse/neglect).</p> <p>Ombudsman Residents' Rights for People in Long-Term Care Facilities dated ,d+[DATE] documents in part, You must not be abused, neglected, or exploited by anyone - financially, physically, verbally, mentally, or sexually.</p> <p>Facility policy dated ,d+[DATE] titled Abuse Prevention Program Facility Policy and Procedure documents in part, Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish .Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.</p> <p>Facility policy dated [DATE] titled Abuse Prevention Program documents in part, As part of the resident abuse prevention, the administration will implement the following protocols: 1. Protect our residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual.</p>		