STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E169	A. Building B. Wing	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winston Manor Cnv & Nursing	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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 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 interviews and record review, the facility failed to report that one newly admitted resident (R7) eloped from the facility; and failed to report that two residents (R5 and R6) left the facility unauthorized and did not return to the facility. This failure has affected three of fifteen residents in the sample and has the potential to affect all 123 residents that reside in the facility.R5 is a [AGE] year-old male with diagnoses of Schizophrenia, schizoaffective disorder, essential hypertension, tachycardia, and chronic obstructive pulmonary disease.R6 is a [AGE] year-old male with diagnoses of schizoaffective disorder, suicidal ideations, acute embolism, and thrombosis of unspecified deep veins of bilateral lower extremity, Gastro-esophageal reflux disease.R7 is a [AGE] year-old male with diagnoses of bipolar disorder, major depressive disorder, generalized anxiety, tachycardia, insomnia, and suicidal ideations.During investigation on 8/12/2025 at 11:15 AM, V1 (Administrator) stated the following, R5 left the facility alone on yesterday (8/11/2025) at 1:30 pm and has not returned to the facility. R7 eloped during a smoke break on yesterday (8/11/2025). R6 left the facility out on pass on 8/9/2025 and has not returned yet. I (V1) have been in contact with the police department and there is no new information regarding their whereabouts.On 8/12/25 at 12:21pm, V2 Director of Nursing (DON) stated that a Physician order is needed for any resident to leave the facility and that if a resident does not return by 4:00 pm, administration should be notified immediately for further instructions to be carried out. On 8/12/25 at 2:00 pm, V4 (LPN/ Licensed Practice Nurse) stated the following, when R6 went out on pass on 8/9/25 I gave him a pass at 1:30 pm. My shift ended at 3:30 PM. When I was leaving that day (8/9/25), I informed V5 (LPN) that R6 had not returned yet since V5 was R6's night nurse. When I came in the next day (8/10/25), I also notified management once I realized that R6 still had not returned to the facility.On 8/13/25 at 12:23pm, V1 stated that he had been in contact with the police department and that there was no information regarding the whereabouts of R5 and R6. At that time V1 also stated that he was not aware that he had to report missing residents to the State Agency.Employee statement written by V6 (Smoking Monitor) on 8/11/25 documents, V27 (Smoking monitor) had lit R7's cigarette and sat down. I (V6) was bringing the wheelchair (residents) up (the ramp back into the facility) and as I was focusing on that, R7 started to get up and began walking away from the smoking area. V27 was following him and asked where he (R7) was going. The moment R7 passed the curb of the sidewalk. I (V6) had went up the ramp and yelled out to the receptionist to announce a code 99 over the intercom. A code 99 stands for a resident who is fleeing or running away from the facility. R7's Medical Chart excludes an elopement assessment, elopement care plan, smoking assessment/ agreement or smoking care plan.R5's Nurse's Note dated 8/11/25 at 10:19 pm documents, R5 left on pass and failed to return.R5 Physician Order sheet documents the following active order as of 7/22/25, may not go out on pass. Facility Front Door List dated 8/12/25 documents R5's pass privileges as 'with supervision'.Facility's Resident Sign-out Sheet dated 811/25 documents, R5 signed out of the facility at 1:30 pm.Missing Persons Police Report dated 8/12/25 documents R6 missing as of 8/11/2025 at 1:30 pm.R6s' Nurse's Note dated 8/10/2025 at 12:27 pm and authored by V4 (LPN) documents, writer called 911 of missing person since yesterday. R6 did not return to the facility by 4:00 pm. R6s' Nurse's Note dated 8/10/2025 at 10:34 pm documents, R6 has not returned back to the facility. Facility's Resident Sign-out Sheet dated 8/9/2025 documents excludes R6's signature.R6's Nursing Progress notes excludes any documentation on 8/9/25 of R6 signing out of the facility. Facility Census report dated 8/11/25 excludes R5, R6 and R7 as active residents.Facility reportable binder excludes reported incidents regarding R5, R6 or R7. Facility's undated policy titled Accidents and Incidents-Investigating and Reporting documents in part: All accidents or incidents involving residents, employees,visitors,vendors,etc.,occurring on our premises shall be investigated and reported to the administrator; Policy Interpretation and Implementation:2.(a)The date and time the accident or incident took place;(b) The nature of the injury/illness;(g) The time the injured person's physician was notified, as well as the time the physician responded and his or her instructions;(h)The date/time the injured person's family was notified and by whom;(n)The signature and title of the person completing the report;(4)The nurse supervisor/charge nurse and/or the department director or supervisor shall complete a Incident report and submit the original to the director of nursing services within 24 hours of the incident or accident.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a person-centered behavior care plan to address the resident's mental and psychosocial needs in an effort to attain or maintain the resident's highest practicable mental and psychosocial well-being. This failure affected 1 (R8) resident reviewed for care planning in the total sample of 15 residents. Findings include:R8's admission Record documented that R8's initial admission was on 07/09/2025; and R8's diagnoses: (include but not limited to) schizoaffective disorder, depression, and mild intellectual disabilities. R8's (08/15/2025) care plan documented, in part SOCIALLY INAPPROPRIATE/ MALADAPTIVE BEHAVIORS. displays socially inappropriate and maladaptive behavior. A history of dysfunctional behavior, mental illness diagnoses, anger, agitated depression, Restless/agitated behavior (rocking, picking, banging, etc.). Of note, inappropriate/maladaptive behavior care plan was initiated on 08/15/2025, the day this surveyor requested for R8's behavior care plan. R8's (Date Initiated: 08/15/2025) care plan documented, in part VERBALLY PHYSICALLY ABUSIVE BEHAVIOR. demonstrates behavioral distress attempting to push, shove, scratch, hit, slap, kick, grab or otherwise harm another person, Being challenged by mental illness, Ineffective coping mechanisms., Physically abusive behavior when agitated, Poor verbal skills and inability to express self in more appropriate language., Use of profanity, demeaning statements, verbal threats and yelling at others., Verbally abusive behavior when agitated. On 08/15/2025 at 11:38am, V13 (Escort) stated he (R8) gets angry really quickly; that she saw him (R8) got upset really fast. V13 stated she witnessed him (R8) asking for food and the staff told him No, he raised his voice and mumbled ‘Why?' Repeatedly. On 08/16/2025 at 11:28am, V16 (Psychiatric Rehabilitation Services Assistant) stated she (V16) had seen him (R8) upset when they were doing paperwork and he (R8) wanted her (V16) to write something and when she (V16) asked him to wait, he kicked the Social Service office's door. The incident of kicking happened on 07/28/25. That behavior should have been care planned on the day the behavior was observed to ensure who sees the behavior of kicking knows what to do. On 08/16/2025 at 1:14pm, V3 (Psychiatric Rehabilitation Services Coordinator) stated when this surveyor requested for (R8) behavior care plan, she (V3) realized she messed up because she did not put any behavior care plan for him (R8). That any moment a behavior is exhibited by the resident, that behavior should be care planned so when the behavior is repeated, an intervention can be implemented to deescalate the behavior. V3 stated he (R8) is quick to anger, and it felt like he (R8) is having tantrums. His (R8) being quick to anger is not care planned. And it should have been 100% care planned. The (undated) Comprehensive Person-Centered Care Plans documented, in part A comprehensive, person-centered care plan that includes measurable objectives and timetables to [NAME] the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 8. The comprehensive, person-centered care plan will: b. describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. G. incorporate identified problem areas. 13. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. 14. The interdisciplinary team must review and update the care plan: a. when there has been a significant change in the resident's condition.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon interviews and record review the facility failed to: conduct head counts (every two hours); failed to provide supervision for one resident (R7) in the sample; failed to follow Doctor's pass order for one resident (R5); and failed to implement the elopement and pass policies for three residents in a sample of 15 (R5, R6 and R7). These failures resulted in an immediate jeopardy and has the potential to affect 123 residents that reside in the facility.An immediate jeopardy began on 8/9/25 at 9:00 am, when R6 left the facility unauthorized and continued with subsequent failures that led to R5 and R7 also being away unauthorized.On 8/14/25 at 3: 47.pm, V1 (Administrator) and V20 (Regional Consultant) were notified of the Immediate Jeopardy and the IJ template was presented.On 8/19/25 an acceptable removal plan was accepted after revisions to other removal plans that were submitted on 8/18/2025.The immediacy was removed on 8/19/25, however deficiency remains at a level two because more time is needed to evaluate the implementation and effectiveness of staff training. Findings include:R7 is a [AGE] year-old with diagnoses including but not limited to: Suicidal Ideations, Major Depressive disorder, Bipolar disorder and Generalized Anxiety disorder. R7's admission Record documents an admission date of 8/11/25.On 8/12/2025 at 11:15 am, V1 (Administrator) stated the following, R5 left the facility alone on yesterday (8/11/2025) at 1:30 pm and has not returned to the facility. R7 eloped during a smoke break on yesterday (8/11/2025). R6 left out on pass on 8/9/2025 and has not returned yet. I have been in contact with the police department and there is no new information regarding their whereabouts.On 8/13/25 at 3:37 pm, V6 (Smoking Monitor) stated the following, On Tuesday (8/11/25) during the 2:00 pm smoke break, a new resident (R7) was outside smoking and began walking off. Another smoking monitor was following him (R7) and he crossed the street. I came in the building and announced a code 99 (elopement code) because he (R7) was away from the smoking area. At that time, staff members ran out to try and get him but couldn't find him. I have not seen him since.On 8/13/25 at 4:30 pm, V12 (Social Service Director) stated the following, R7 had just been admitted to the facility. Usually, a smoking and elopement assessment is done within 24 hours of admission. In certain cases, I will allow the resident to smoke with supervision prior to the assessments (smoking and elopement). Residents who are elopement risks and new admits are scheduled a specific time to smoke (apart from the other smokers) to have special supervision. I had allowed R7 to smoke with the regular smokers and smoking monitor because he was agitated and stated that he had not smoked in days.On 8/18/25 at 4:55 pm, V26 (Medical Doctor) stated the following, When a patient is admitted to the facility, the patient should have an evaluation prior to being allowed to go out and smoke or to go out on pass. If no evaluation is done, there is a great risk taken when a resident is allowed out of the facility because we don't know that patient. If a patient elopes, especially a psych patient, we don't know what can happen because they are mentally unstable.Employee statement written by V6 (Smoking Monitor) on 8/11/25 documents, V27 (Smoking monitor) had lit R7's cigarette and sat down. I (V6) was bringing the wheelchair (residents) up (the ramp back into the facility) and as I was focusing on that, R7 started to get up and walking away from the smoking area. V27was following him and asking where he (R7) was going. The moment R7 passed the curb of the sidewalk. I had went up the ramp and yelled out to the receptionist to announce a code 99 over the intercom. A code 99 stands for a resident who is fleeing or running away. On 8/20/25 at 11:30 am, V1 (Administrator) stated that R7 had not returned to the facility.R7's Medical Chart excludes an elopement assessment, elopement care plan, smoking assessment/ agreement or smoking care plan.Facility Census report dated 8/11/25 excludes R7 as an active resident.R6 is [AGE] year-old with diagnoses including but not limited to: Suicidal Ideations, major depressive disorder, bipolar disorder and schizoaffective disorder.During investigation on 8/12/25 at 2:00 pm, V4 (LPN/ Licensed Practice Nurse) stated the following, when R6 went out on pass on 8/9/25 I gave him a pass. R6 came to the nursing station and said that he was leaving the facility and coming back at 4:00 pm. Once he takes the pass to the front desk, he is supposed to sign out and back in by 4:00 pm. My shift ended at 3:30 PM. When I was leaving that day (on 8/9/25), I (V4) informed V5 (LPN) that R6 had not returned yet since V5 was R6's night nurse. When I came in the next day (on 8/10/25), I also notified management once I realized that R6 still had not returned to the facility. I am not sure if management was notified prior to my notification.On 8/12/25 at 12:48 pm, V2 (Director of Nursing/ DON) stated the following, We (facility staff) are responsible for the residents, and it is important to recognize early if a resident is missing so that the resident can be searched for and reported to the police. Most residents