

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 08/29/2025
NAME OF PROVIDER OR SUPPLIER Winston Manor Cnv & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 2155 West Pierce Chicago, IL 60622	
<p>For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.</p>			
(X4) ID PREFIX TAG	<p>SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)</p>		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide a homelike environment for two (R3 and R4) out of three residents reviewed for homelike environment in a total sample of 4 residents. The findings include: On 08/26/2025 at 11:21 AM, surveyor observed a hole on the ceiling and paint chip in R3's room. There was a musty smell, and a blue blanket placed on the floor. R3 stated, the water leaks when it rains, and a bin must be placed to help collect the water. R3 stated he has told V4 (Maintenance Director) to fix it, but nothing has been done. On 08/26/2025 at 12:07 PM, V4 was first made aware of the water leak in R3's room approximately 1 1/2 months ago. V4 told V5 (Regional Maintenance Director) about the leaking from the walls in R3's room. He let him know that there was a hole in the wall in room [ROOM NUMBER]. V4 stated he has not seen any vendors come to the facility to address these issues. V4 stated no residents should be in the room under these conditions and will require a room change. On 08/26/2025 at 12:10 PM, surveyor observed there was a large hole on the wall, with a rusty metal object exposed, paint chipping surrounding the hole and throughout the ceiling. R4 stated the hole was much bigger and someone came to fix it but never came back to finish the job. On 08/26/2025 at 12:12 PM, V4 stated the painter had to scrape off the paint, clean the walls, and repaint the affected area in R4 room. V4 stated the painter was let go on August 12, 2025, and no one has come to finish the job. V5 is made aware that there is still a hole in the wall. V4 stated there should not be any residents living under these conditions and should be removed. On 08/26/2025 at 12:21 PM, V5 stated he is aware of the water leak in R3 and R4 room. V5 stated he tried to go up in the roof to patch it one week ago with no success. V5 stated he put in a work order for room [ROOM NUMBER] and 236 last week. Someone will be coming in 2 days to make necessary repairs. V5 confirmed it is not safe for residents to stay in the room, until the affected area is repaired. Policy titled Homelike Environment with review date of February 2021 documents Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. Staff provides person- centered care that emphasizes the residents' comfort, independence and personal needs and preference. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike settings. These characteristics include: clean, sanitary and orderly environment.</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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