

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 12/31/2025
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 - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</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 - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to prevent resident to resident verbal and physical abuse for one [R1] out of three residents reviewed for abuse. This resulted in R1 sustaining physical pain and mental anguish. Findings Include: R1's clinical record indicates the following in part: R1's medical diagnoses of post-traumatic stress disorder, chronic obstructive pulmonary disease, anxiety disorder, schizoaffective disorder, and overactive bladder. R2's clinical record indicates the following in part: Medical diagnoses: Schizoaffective disorder and major depressive disorder. R2's progress notes in part: V6 [Licensed Practical Nurse] note: 12/26/2025 3:46 AM Note Text: This writer heard loud yelling in R2's room around 1:45 AM. R2 noted to be verbally aggressive with her roommate [R1]. R2 pulling back her roommate privacy curtains, playing loud music on her phone and putting on bright lights. R2 noted to be highly agitated. This remains to be a threat to staff and other residents. resident sent for psych eval. R2's Petition for Involuntary Judicial admission: [DATE] at 2:18 AM R2 is verbally and physically agitated with other resident [R1] R2 remains a threat to staff and other residents. R2's Care plan in part: On 11/13/25, 11/26/25, 12/1/25, 12/2/25, and 12/26/25 R2 was sent to the hospital for psych evaluation due to behaviors. On 12/30/25 at 11:40 AM, R1 stated, On Christmas night, I was sleeping when my roommate [R2] hit me all in my back, everywhere on my body. Then R2 started throwing items at me, and some of the items hit me on my arm. R2 was cursing at me and yelling, she called me names I never been called before. I finally was able to get out of bed, and then I was yelling and screaming for help. I got out of bed and grabbed my walking cane to help me walk so I could get out of the room. R2 then tried to grab my cane out of my hands as she was pushing the cane towards my face trying to hit me with my own cane. I was holding on to my cane for my life. I knew if R2 got my cane she was going to bust my head open. I was so afraid, upset and in pain, my body was hurting. It took three staff members to pull R2 off me. My body was hurting all over very sore for a week. I do not know why she jumped on my like she did. I was crying every night, afraid to sleep. I felt so bad about myself and embarrassed, because I did not do anything to R2. On 12/31/25 at 12:00 PM V7 [Certified Nurse Assistant] stated, I worked on 12/25/25 night shift. I saw R1 and R2 arguing. I went into the room. I told them to stop arguing. That was it, I did not report the arguing. I don't know nothing else. I received abuse training a while ago, the abuse coordinator is the administrator. R1 and R2 was just nip picking each other, no cursing it was not verbal abuse. On 12/30/25 at 2:00 PM V5 [Agency-Certified Nurse Assistant] stated, I worked on 12/25/25 night shift rolling over to 12/26/25. I heard yelling from R1's room. I saw R2 hitting R1. I took V6 [Licensed Practical Nurse], V7 [Certified Nurse Assistant] and myself to pull R2 off R1. Once we separated R2 from R1, R2 kept charging at R1 and all of us then started throwing items at us. R2 broke loose from V6 and R2 started hitting R1 again. We separated them and removed R1 from the room. During the attack, R2 was throwing a jar of petroleum jelly, lotion, deodorant like personal items. The items were hitting all of us. R1 called the police and told them R2 attacked her, which was the truth. R2 was sent out to the hospital. Surveyor read V5 her written witness statement: [Read: To whom it may concern; I V5, heard arguing coming from resident room. I [V5] and other staff immediately went to see what happened. Residents [R1, R2] were having a verbal disagreement, staff separated residents to calm them down.] V5 stated, I never wrote or gave any one my statement. That statement is not the truth. No one asked me what happened or what I witness. On 12/30/25 at 3:30 PM, V2 [Director of Nursing] stated, On 12/26/25 early morning I received a phone call from V6 [Licensed Practical Nurse], told me R1 and R2 had a verbal argument and R2 was throwing items in the room. R2 refused to take medication to help calm her down, so R2 was petitioned out to the hospital. Later that day 12/26/25 I spoke to R1, and she did not tell me R2 hit her or any of the items that was thrown around hit her. I did not ask R1 if she was hit by R2 or any items hit R1. R2 was transferred back to the facility after the emergency room visit. R2 was moved to another room. On 12/30/25 at 4:00 PM, V1 [Administrator] stated, The incident occurred on 12/26/25. I was made aware R1 and R2 had an argument on 12/26/25. R2 was still agitated after the incident, offered medication to help calm down R2, but she refused the medication. R2 psychiatrist gave an order to send R2 to the hospital for psych evaluation. R2 was petition to the hospital. I was notified R1 phoned 911. I did not know what she told the police. I do not know why R1 phoned 911. I do not have a copy of the police report. I spoke with R1 on 12/26/25, R1 did not tell me she was struck by R2. I was not aware of the severity of the argument until 12/29/25 during morning meeting. I learn the argument was serious and I tried to report to IDPH. R2 returned back to the facility on</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to follow their Abuse Reporting Policy and report allegations of abuse within two hours of the incident for one [R1] out of three residents reviewed for abuse. Findings Include: Reviewed facility's IDPH Initial Report for incident 12/26/25 [R1 and R2]. Dated: 12/30/25 Time: 10:33 [NAME] 12/30/25 at 11:40 AM, R1 stated, On Christmas night, I was sleeping when my roommate [R2] hit me all in my back, everywhere on my body. Then R2 started throwing items at me, and some of the items hit me on my arm. R2 was cursing at me and yelling, she called me names I never been called before. I finally was able to get out of bed, and then I was yelling and screaming for help. I got out of bed and grabbed my walking cane to help me walk so I could get out of the room. R2 then tried to grab my cane out of my hands as she was pushing the cane towards my face trying to hit me with my own cane. I was holding on to my cane for my life. I knew if R2 got my cane she was going to bust my head open. I was so afraid, upset and in pain, my body was hurting. It took three staff members to pull R2 off me. My body was hurting all over very sore for a week. I do not know why she jumped on my like she did. I was crying every night, afraid to sleep. I felt so bad about myself and embarrassed, because I did not do anything to R2. On 12/31/25 at 12:00PM V7 [Certified Nurse Assistant] stated, I worked on 12/25/25 night shift. I saw R1 and R2 arguing. I went into the room. I told them to stop arguing. That was it, I did not report the arguing. I don't know nothing else. I received abuse training a while ago, the abuse coordinator is the administrator. R1 and R2 was just nip picking each other, no cursing it was not verbal abuse. On 12/30/25 at 2:00 PM V5 [Agency-Certified Nurse Assistant] stated, I worked on 12/25/25 night shift rolling over to 12/26/25. I heard yelling from R1's room. I saw R2 hitting R1. It took V6 [Licensed Practical Nurse], V7 [Certified Nurse Assistant] and myself to pull R2 off R1. Once we separated R2 from R1, R2 kept charging at R1 and all of us then started throwing items at us. R2 broke loose from V6 and R2 started hitting R1 again. We separated them and removed R1 from the room. During the attack, R2 was throwing a jar of petroleum jelly, lotion, deodorant like personal items. The items were hitting all of us. R1 called the police and told them R2 attacked her, which was the truth. R2 was sent out to the hospital. On 12/30/25 at 3:30 PM, V2 [Director of Nursing] stated, On 12/26/25 early morning I received a phone call from V6 [Licensed Practical Nurse], told me R1 and R2 had a verbal argument and R2 was throwing items in the room. R2 refused to take medication to help calm her down, so R2 was petitioned out to the hospital. Later that day 12/26/25 I spoke to R1, and she did not tell me R2 hit her or any of the items that was thrown around hit her. I did not ask R1 if she was hit by R2 or any items hit R1. R2 was transferred back to the facility after the emergency room visit. R2 was moved to another room. On 12/30/25 at 4:00 PM, V1 [Administrator] stated, The incident occurred on 12/26/25. I was made aware R1 and R2 had an argument on 12/26/25. R2 was still agitated after the incident, offered medication to help calm down R2, but she refused the medication. R2 psychiatrist gave an order to send R2 to the hospital for psych evaluation. R2 was petition to the hospital. I was notified R1 phoned 911. I did not know what she told the police. I do not know why R1 phoned 911. I do not have a copy of the police report. I spoke with R1 on 12/26/25, R1 did not tell me she was struck by R2. I was not aware of the severity of the argument until 12/29/25 during morning meeting. I learn the argument was serious and I tried to report to IDPH. R2 returned back to the facility on [DATE] and was moved into a different room. I sent in the IDPH reportable on 12/29/25, but I would not go through. No, I don't have an email or any documentation stating I make attempts to send in the IDPH reportable. I just tried to send in the IDPH reportable today and somehow it went through today. Any abuse allegations including verbal must be reported within two hours. Policy document in part: Abuse Policy [9/2025] All reports of resident abuse are reported to local, state, and federal agencies and thoroughly investigated by facility management. Findings of all investigation are documented and reported. Resident abuse is suspected, the suspicion must be reported immediately to the administrator and other officials. Immediately defined as within two hours of an allegation involving abuse</p>		