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	02/19/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure that two residents (R3 and R14) were free from verbal abuse. This failure has affected two of four residents reviewed for abuse. Findings include:R3 is [AGE] year old with diagnosis including but not limited to: schizophrenia, generalized anxiety disorder, neuralgia and neuritis.R3 has a BIMS (Brief Interview of Mental Status) score of 14, which indicates cognitively intact.R14 is [AGE] year old with diagnosis including but not limited to: major depressive disorder, schizoaffective disorder, essential hypertension and hidradenitis suppurativa.R14 has a BIMS (Brief Interview of Mental Status) score of 15, which indicates cognitively intact.R4 is [AGE] year old with diagnosis including schizoaffective disorder and essential hypertension. On 2/10/26 at 10:58 am, V1 (Administrator) stated the following, R4 was sent out to the hospital today for aggressive behaviors towards other residents. It was just reported to me that on yesterday (2/9/26), R4 was said to have made sexually inappropriate comments to female residents. On 2/10/26 at 11:46 am, V13 (Agency Registered Nurse) stated the following, On 2/8/26 around 3:15pm R4 was on the third floor pacing the unit. He was unable to redirect and went down to the second floor. I was notified by the second floor staff that R4 was on the unit/ second floor harassing female residents. R4 returned to the third floor and was becoming loud and aggressive. I called V4 ADON (Assistant Director of Nursing) and was told to send R4 out for evaluation. I was not as rest because I don't know how he (R4) began following me around because he knew that I called 911. R4 was eventually sent to the hospital, but returned within a couple of hours. R4 was eventually sent to the hospital, but returned within a couple of hours. After bedtime, most of the residents were pacing and moving around.There are all men on the unit and no men staff on the floor. I don't know if I would go back to work there (facility) because there were no managers on the floor and no support. On 2/10/26 at 12:00 pm, R14 stated the following, R4 was just admitted to here on Friday (2/6/26) and started his behaviors on the first day that he came. He was on my unit (second floor) where he does not belong, making sexual remarks about his penis size and stating that he wanted someone to suck his penis at the nurses' station. He started to get aggressive because the staff was telling him that he could not take snacks from our unit (2nd floor). He started calling us all bitches and making treats, stating that he would kill us. He would leave and come back several times. Finally, he came back down close to bedtime and proceeded to follow me to see what room I was going to, but the nurse stopped him from following me. On Sunday (2/8/26), the staff bought residents pizza and chicken during the super bowl. We were in the 2nd floor dining room when R4 got up in my face and motioned toward me with his fist balled up and tried to intimidate me. He (R4) started calling me (R14) a fat bitch, stating that he would take a cane and shove it up my butt. I told him that he is acting like a pedophile and he proudly said that he was. I went to the third floor with V13 (RN) to report his behaviors. Even after the incidents on Sunday, he (R4) kept roaming around on the 2nd floor after (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
	14E169	A. Building B. Wing	02/19/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bedtime. On 2/17/26 at 12:20 pm, R3 stated the following, On 2/6/26, I saw R4 in the hallway and he started following me, asking me to use my laptop and my headphones. I had never seen this guy (R4) before and felt uncomfortable. I told him no. At around 2:00 am, I heard my room door open and it was him trying to walk into my room. I told him to get out of my room and he started to calling me a b**** and telling me to suck his d***. He told me that he could come into my room if he wanted to. Later on 2/9/26 at around dinner time, he came back to my room and I asked him to leave. He was sent out to the hospital that night but came right back and came into my room once again around 2:00 am.On 2/11/26 at 1:30 pm, V6 (Agency Registered Nurse) stated the following, I was the nurse on the second floor on Saturday (2/7/26). R4 came down to the second floor several times during my shift making inappropriate remarks to R3 and R14. I asked him (R4) several times to return to his unit (third floor) and he became angry and began to yell. He then began call to call R3 and R14 bitches and making threats to punch them in the face. He eventually went back to the third floor after I asked him several times to leave.On 2/11/26 at 12:15 pm, V2 (DON/ Director of Nursing) stated the following, The residents have a right to not be harassed or verbally assaulted in the facility. All residents should feel safe in the facility.R4's Nursing Progress note dated 2/8/26 documents, R4 noted with agitation and aggressive behavior. R4 went to the second floor to harass a lady; Doctor was notified and gave order to send R4 out via petition (involuntary discharge) to hospital; 911 called and R4 taken to nearby hospital via paramedic.R4's Nursing Progress noted dated 2/8/26 documents, R4 returned to the facility via ambulance with no new orders.IDPH Report dated 2/9/26 documents, it was reported the R4 was verbally sexually inappropriate with persons in the facility on 2/8/26.Petition for Involuntary/ Judicial admission dated 2/8/26 documents, R4 is in need of immediate hospitalization for the prevention of such harm; R4 agitated and verbally aggressive towards peers; danger to self and others; unable to be redirected.Facility policy titled, Abuse Prevention Program documents the following, our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The following is listed as one of the protocols that Administration is responsible for implementing: protect 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.