STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E247	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Joliet Living & Rehab Center	2230 McDonough Joliet, IL 60436

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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 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 interview and record review, the facility failed to prevent residents from verbal abuse from a staff member. This failure apples to 3 of 7 residents (R1, R2, and R7) reviewed for abuse from a sample of 7. The findings include:An Abuse Investigation report shows V3 (Psychosocial Services Rehabilitation Coordinator/Assistant) was hired by the facility 09/17/2025. On 11/05/2025, V4 (Certified Nursing Assistant) reported to the administrator R1 informed her V3 was verbally abusive to him by calling him a dick on 10/31/2025, and also during this time, V4 received a report V3 was observed mocking R2 during smoke break; upon further investigation, R1 and V3 were interviewed and confirmed the allegations, and V3 was terminated by the facility as a result.On November 17, 2025 at 3:01 PM, V4 (Certified Nursing Assistant) said she is the Resident's Ambassador and takes reports regarding negative staff or resident to resident interaction. V4 said R1 reported to her he didn't like V3 (Psychosocial Services Rehabilitation Coordinator/Assistant) because V3 called him a dick in a really loud tone and R1was offended, and V4 reported this to V1 (Administrator). V4 said she then received another complaint later in the week from peers and other staff including V6 (Psychosocial Services Rehabilitation Coordinator/Assistant) that V3 was mocking R2 while wearing a bag over his head, which she also reported to V1. V4 said she had also received prior complaints from residents about V3 saying they don't like how he talks to them and from staff reporting they did not like the tone in which V3 communicated towards the residents. V4 said she did not report this to the Abuse Coordinator as it was not severe enough, however, she spoke with V3 and gave corrective feedback explaining that the communication was not appropriate. V3 responded that he didn't feel his communication was inappropriate and she continued explaining that the communication was inappropriate for residents. V4 said on one occasion, she overheard a resident asking V3 not to talk to them in a certain tone. V3 apologized, and the issue seemed to be resolved, therefore, she did not provide V3 with any corrective feedback at the time. V4 said V3 would speak to residents in a playful and aggressive tone which some residents were confused by and expressed they didn't like. R1 is a [AGE] year-old male with diagnoses history of Bipolar Disorder, Generalized Anxiety Disorder, and Suicidal Ideations, who was admitted to the facility 01/20/2016. On November 17, 2025, at 11:34 AM, R1 said V3 (Psychosocial Rehabilitation Services Aide) told him You're a dick, when R1 tried to apologize to V3 for a miscommunication from the day prior. R1 said he originally thought V3 was joking, however, when R1 looked at V3 and saw that V3 wasn't laughing he realized V3 wasn't joking. R1 said he reported the incident to V4 (Certified Nursing Assistant) who then informed V1 (Administrator). R1 said V3 has a military background and went on to question him about his military clothing, such as asking why R1 was wearing army clothing if he was in the Navy. R1 said he felt insulted by V3's behavior. R2 is a [AGE] year-old male with diagnoses history of Depressive Type Schizoaffective Disorder, and Generalized Anxiety Disorder, who was admitted to the facility 03/03/2014.On November 17, 2025 at 12:41 PM, R6 said he had observed V3 (Psychosocial Rehabilitation Services Aide) to at times slip and swear in the presence of residents.On November 18, 2025 at 9:48 AM, R5 said he recalls V3 (Psychosocial Rehabilitation Services Aide) being verbally abusive in the way he would tell residents (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to shut up and overheard him talking badly about residents with other residents. He did not report this behavior to staff.On November 18, 2025 at 1:39 PM, V7 (Psychosocial Rehabilitation Services Coordinator) said she observed V3 (Psychosocial Rehabilitation Services Aide) to be impulsive and easily agitated. V3 would become easily overwhelmed when approached by the residents and she would have to redirect him and educate him on remaining calm. Some of the staff expressed concerns with V3's behaviors regarding the residents. V7 said she did inform V5 (Psychosocial Rehabilitation Services Director) about concerns with V3's behaviors and advised he may need some additional coaching on how to work with the residents. On November 18, 2025 at 1:50 PM, V5 (Psychosocial Rehabilitation Services Director) said V7 (Psychosocial Rehabilitation Services Coordinator) informed her V3 (Psychosocial Rehabilitation Services Aide) may need more in-services about psychosocial practices because he doesn't listen to redirection and instead enforces what he thinks should happen. V5 said she and V1 (Administrator) followed up by educating and in-servicing V3 about how to talk to and approach residents. V5 said V3 would become easily frustrated when residents approached him for things and V3 became easily agitated when a lot of residents approached him at the same time and become overwhelmed. V5 said R7 reported to V8 (Activities Aide) that she didn't like the way V3 spoke to her when she asked V3 to take her to the bank and V8 also said R7 didn't like the tone in which V3 spoke to her during their interaction. On November 18, 2025 at 2:08 PM, V5 (Psychosocial Rehabilitation Services Director) said approximately in early October, V8 (Activities Aide) reported to her R7 didn't like the tone V3 (Psychosocial Rehabilitation Services Aide) used when speaking with her and V3 was loud when speaking to R7. V5 said if V8 had communicated V3 was yelling at R7 she would have reported this immediately. V5 said V8 did not report to her V3 yelled or swore at R7. V5 said it inot ok for staff to become loud with the residents and if they are loud with the residents, she would report that to the Administrator and the Administrator would determine if it were abuse, however, she didn't report to V1 (Administrator) that V3 was loud with R7. V5 stated the next morning during morning meeting she informed V1 about the information she received about the incident between V3 and R7. Abuse Investigation reports from October to November 2025 did not include a report for R7.On November 18, 2025 at 3:50 PM, V1 (Administrator) said she and V5 (Psychosocial Rehabilitation Services Director) had a conversation with V3 (Psychosocial Rehabilitation Services Aide) on 11/03/2025 regarding how he interacts with the residents. V1 said V3 had a short and dismissive way of speaking with the residents. V1 said the information reported to her by V5 during morning meeting regarding V3 and R7's interaction was not presented as abuse. If it was reported V3 was loud with R7, V1 would have spoken further with the residents and staff to determine if there was potential for abuse and if it was discovered V3 was loud in a rude manner, then abuse would have been investigated and V3 would have been suspended immediately pending the outcome of investigation. V1 said she wasn't aware V3 yelled and swore at R7. V1 said if a resident came to her and reported they didn't like how V3 was speaking with them, she would interview the resident to get further details, and if they expressed V3 was speaking to them in an unkind or disrespectful manner, she would have investigated this and sent V3 home. V1 said she should be informed of any allegation of potential abuse and all allegations should be investigated. V1 said V3 yelling and swearing at R7 should have been reported to her and V4 (Certified Nursing Assistant) should have reported observing a resident telling V3 they didn't like the tone he was speaking to them with so this could be investigated. V1 said if she is not informed about incidents of abusive behavior, this causes all the residents to be at risk for abuse. The facility's Abuse Policy received 11/18/2025 states:The facility affirms the right of our consumers to be free from verbal abuse or mistreatment. This facility therefore prohibits abuse and mistreatment of consumers. The purpose of this policy is to assure that the facility is doing all that is within it's control to prevent occurrences of abuse and mistreatment of consumers. This will be done by:Identifying occurrences and patterns of potential mistreatment.Immediately protecting consumers involved in identified reports of possible abuse or mistreatment.Implementing systems to promptly and aggressively investigate all reports and (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	allegations of abuse and mistreatment and making the necessary changes to prevent future occurrences.Filing accurate and timely investigative reports.Verbal Abuse is the use of oral or gestured language that willfully includes disparaging and derogatory terms to consumers or withing their hearing distance regardless of an individuals age, ability to comprehend, or disability.Employees are required to report any incident, allegation or suspicion of potential abuse or mistreatment they observe, hear about, or suspect to the administrator immediately, or to an immediate supervisor who must then immediately report it to the administrator or to a compliance hotline or compliance officer. Reports will be documented, and a record kept of the documentation.Supervisors shall immediately inform the administrator or person designated to act in the administrator's absence of all reports of incidents, allegations or suspicion of potential abuse or mistreatment. Upon learning of the report, the administrator or a designee shall initiate an incident investigation.Employees of this facility who have been accused of abuse or mistreatment of consumers will be removed from consumer contact immediately. The employee shall not be permitted to return to work until the results of the investigation have been reviewed by the administrator and it is determined that any allegation of abuse or mistreatment of consumer is unsubstantiated.All incidents will be documented, whether or not abuse or mistreatment occurred, was alleged or suspected.Any incident or allegation involving abuse or mistreatment will result in an investigation.When an allegation of abuse or mistreatment has been made, the administrator, or designee, shall notify Department of Public Health's regional office immediately. Public Health shall be informed that an occurrence of potential abuse or mistreatment has been reported to the administrator and is being investigated.

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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	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report incidents and allegations of abuse and mistreatment of residents. This failure apples to 3 of 7 residents (R1, R2, and R7) reviewed for abuse in a sample of 7 residents. The findings include:R1 is a [AGE] year-old male with a diagnoses history of Bipolar Disorder, Generalized Anxiety Disorder, and Suicidal Ideations who was admitted to the facility 01/20/2016. On November 17, 2025 at 11:34 AM, R1 said V3 (Psychosocial Rehabilitation Services Aide) told him You're a dick, when R1 tried to apologize to V3 for a miscommunication from the day prior. R1 said he originally thought V3 was joking, however, when R1 looked at V3 and saw V3 wasn't laughing, he realized V3 wasn't joking. R1 said he reported the incident to V4 (Certified Nursing Assistant) who then informed V1 (Administrator). R1 said V3 has a military background and went on to question him about his military clothing, such as asking why R1 was wearing army clothing if he was in the Navy. R1 said he felt insulted by V3's behavior. R2 is a [AGE] year-old male with a diagnoses history of Depressive Type Schizoaffective Disorder and Generalized Anxiety Disorder who was admitted to the facility 03/03/2014. On November 17, 2025 at 11:14 AM, R2 said he doesn't feel safe at the facility because staff have hurt him emotionally. An Abuse Investigation report shows V3 (Psychosocial Services Rehabilitation Coordinator/Assistant) was hired by the facility 09/17/2025. On 11/05/2025, V4 (Certified Nursing Assistant) reported to the Administrator R1 informed her V3 was verbally abusive to him by calling him a dick on 10/31/2025, and also during this time, V4 received a report V3 was observed mocking R2 during smoke break. Upon further investigation, R1 and V3 were interviewed and confirmed the allegations and V3 was terminated by the facility as a result. On November 17, 2025 at 3:01 PM, V4 (Certified Nursing Assistant) said she is the Resident's Ambassador and takes reports regarding negative staff or resident to resident interaction. V4 said R1 reported to her he didn't like V3 (Psychosocial Services Rehabilitation Coordinator/Assistant) because V3 called him a dick in a really loud tone and was offended. V4 reported this to V1 (Administrator). V4 said she then received another complaint later in the week from peers and other staff including V6 (Psychosocial Services Rehabilitation Coordinator/Assistant) that V3 was mocking R2 while wearing a bag over his head, which she also reported to V1. V4 said she had also received prior complaints from residents about V3 saying they don't like how he talks to them, and from staff reporting they did not like the tone in which V3 communicated towards the residents. V4 said she did not report this to the Abuse Coordinator as it was not severe enough, however, she spoke with V3 and gave corrective feedback explaining that the communication was not appropriate. V3 responded he didn't feel his communication was inappropriate and she continued explaining that the communication was inappropriate for residents. V4 said on one occasion, she overheard a resident asking V3 not to talk to them in a certain tone. V3 apologized, and the issue seemed to be resolved, therefore, she did not provide V3 with any corrective feedback at the time. V4 said V3 would speak to residents in a playful and aggressive tone which some residents were confused by and expressed they didn't like. On November 18, 2025 at 1:39 PM, V7 (Psychosocial Rehabilitation Services Coordinator) said she observed V3 (Psychosocial Rehabilitation Services Aide) to be impulsive and easily agitated. V3 would become easily overwhelmed when approached by the residents and she would have to redirect him and educate him on remaining calm. Some of the staff expressed concerns with V3's behaviors regarding the residents. V7 said she did inform V5 (Psychosocial Rehabilitation Services Director) about concerns with V3's behaviors and advised he may need some additional coaching on how to work with the residents. On November 18, 2025 at 1:50 PM, V5 (Psychosocial Rehabilitation Services Director) said V7 (Psychosocial Rehabilitation Services Coordinator) informed her V3 (Psychosocial Rehabilitation Services Aide) may need more in-services about psychosocial practices because he doesn't listen to redirection and instead enforces what he thinks should happen. V5 said she and V1 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Administrator) followed up by educating and in-servicing V3 about how to talk to and approach residents. V5 said V3 would become easily frustrated when residents approached him for things, and V3 became easily agitated when a lot of residents approached him at the same time and become overwhelmed. V5 said R7 reported to V8 (Activities Aide) that she didn't like the way V3 spoke to her when she asked V3 to take her to the bank, and V8 also said R7 didn't like the tone in which V3 spoke to her during their interaction. On November 18, 2025 at 2:02 PM, V8 (Activities Aide) said back in early October, she was in the office with R7 and V3 (Psychosocial Rehabilitation Services Aide) and heard V3 briefly talking to R7 regarding assistance with banking. She then stepped away during this interaction and overheard V3 raise his voice to R7 while saying to R7 didn't I tell you I was going to help you. V8 said later in the day, R7 came to her and said V3 was yelling at her. V8 said during the conversation between R7 and V3, she overheard V3 saying, You can tell somebody else to take you to the damn bank. V8 said she informed V5 about this incident on the same day. V8 said V3 spoke really aggressive with the residents and on another occasion. V8 observed V3 exhibit a really aggressive demeanor with the residents, and she redirected and educated V3 about how to properly address the residents. On November 18, 2025 at 2:08 PM, V5 (Psychosocial Rehabilitation Services Director) said approximately in early October, V8 (Activities Aide) reported to her R7 didn't like the tone V3 (Psychosocial Rehabilitation Services Aide) used when speaking with her, and V3 was loud when speaking to R7. V5 said if V8 had communicated V3 was yelling at R7 she would have reported this immediately. V5 said V8 did not report to her V3 yelled or swore at R7. V5 said it is not ok for staff to become loud with the residents, and if they are loud with the residents, she would report that to the Administrator and the Administrator would determine if it were abuse. However, she didn't report to V1 (Administrator) that V3 was loud with R7. V5 stated the next morning during morning meeting, she informed V1 about the information she received about the incident between V3 and R7. Abuse Investigation reports from October to November 2025 did not include a report for R7. On November 18, 2025 at 3:50 PM, V1 (Administrator) said she and V5 (Psychosocial Rehabilitation Services Director) had a conversation with V3 (Psychosocial Rehabilitation Services Aide) on 11/03/2025 regarding how he interacts with the residents. V1 said V3 had a short and dismissive way of speaking with the residents. V1 said the information reported to her by V5 during morning meeting regarding V3 and R7's interaction was not presented as abuse. If it was reported that V3 was loud with R7, V1 would have spoken further with the residents and staff to determine if there was potential for abuse. If it was discovered V3 was loud in a rude manner, then abuse would have been investigated and V3 would have been suspended immediately pending the outcome of investigation. V1 said she wasn't aware V3 yelled and swore at R7. V1 said if a resident came to her and reported they didn't like how V3 was speaking with them, she would interview the resident to get further details, and if they expressed V3 was speaking to them in an unkind or disrespectful manner, she would have investigated this and sent V3 home. V1 said she should be informed of any allegation of potential abuse and all allegations should be investigated. V1 said V3 yelling and swearing at R7 should have been reported to her and V4 (Certified Nursing Assistant) should have reported observing a resident telling V3 they didn't like the tone he was speaking to them with so this could be investigated. V1 said if she is not informed about incidents of abusive behavior, this causes all the residents to be at risk for abuse. The facility's Abuse Policy received 11/18/2025 states:The facility affirms the right of our consumers to be free from verbal abuse or mistreatment. This facility therefore prohibits abuse and mistreatment of consumers. The purpose of this policy is to assure that the facility is doing all that is within it's control to prevent occurrences of abuse and mistreatment of consumers. This will be done by:Implementing systems to promptly and aggressively investigate all reports and allegations of abuse and mistreatment and making the necessary changes to prevent future occurrences.Verbal Abuse is the use of oral or gestured language that willfully includes disparaging and derogatory terms to consumers or withing their hearing distance regardless of an individuals age, ability to comprehend, or disability.Employees are required to report any incident, allegation or suspicion of potential abuse (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or mistreatment they observe, hear about, or suspect to the administrator immediately, or to an immediate supervisor who must then immediately report it to the administrator or to a compliance hotline or compliance officer. Reports will be documented, and a record kept of the documentation.Supervisors shall immediately inform the administrator or person designated to act in the administrator's absence of all reports of incidents, allegations or suspicion of potential abuse or mistreatment. Upon learning of the report, the administrator or a designee shall initiate an incident investigation.Employees of this facility who have been accused of abuse or mistreatment of consumers will be removed from consumer contact immediately. The employee shall not be permitted to return to work until the results of the investigation have been reviewed by the administrator and it is determined that any allegation of abuse or mistreatment of consumer is unsubstantiated.All incidents will be documented, whether or not abuse or mistreatment occurred, was alleged or suspected.When an allegation of abuse or mistreatment has been made, the administrator, or designee, shall notify Department of Public Health's regional office immediately. Public Health shall be informed that an occurrence of potential abuse or mistreatment has been reported to the administrator and is being investigated.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to investigate incidents and allegations of abuse and mistreatment of residents. This failure apples to 3 of 7 residents (R1, R2, and R7) reviewed for abuse in a sample of 7 residents. The findings include:R1 is a [AGE] year-old male with diagnoses history of Bipolar Disorder, Generalized Anxiety Disorder, and Suicidal Ideations, who was admitted to the facility 01/20/2016. On November 17, 2025 at 11:34 AM, R1 said V3 (Psychosocial Rehabilitation Services Aide) told him You're a dick, when R1 tried to apologize to V3 for a miscommunication from the day prior. R1 said he originally thought V3 was joking, however, when R1 looked at V3 and saw V3 wasn't laughing, he realized V3 wasn't joking. R1 said he reported the incident to V4 (Certified Nursing Assistant), who then informed V1 (Administrator). R1 said V3 has a military background and went on to question him about his military clothing, such as asking why R1 was wearing army clothing if he was in the Navy. R1 said he felt insulted by V3's behavior. R2 is a [AGE] year-old male with diagnoses history of Depressive Type Schizoaffective Disorder, and Generalized Anxiety Disorder, who was admitted to the facility 03/03/2014. On November 17, 2025 at 11:14 AM, R2 said he doesn't feel safe at the facility because staff have hurt him emotionally. An Abuse Investigation report shows V3 (Psychosocial Services Rehabilitation Coordinator/Assistant) was hired by the facility 09/17/2025. On 11/05/2025, V4 (Certified Nursing Assistant) reported to the Administrator R1 informed her V3 was verbally abusive to him by calling him a dick on 10/31/2025, and also during this time V4 received a report V3 was observed mocking R2 during smoke break, Upon further investigation, R1 and V3 were interviewed and confirmed the allegations, and V3 was terminated by the facility as a result. On November 17, 2025 at 3:01 PM, V4 (Certified Nursing Assistant) said she is the Resident's Ambassador and takes reports regarding negative staff or resident to resident interaction. V4 said R1 reported to her he didn't like V3 (Psychosocial Services Rehabilitation Coordinator/Assistant) because V3 called him a dick in a really loud tone and was offended. V4 reported this to V1 (Administrator). V4 said she then received another complaint later in the week from peers and other staff including V6 (Psychosocial Services Rehabilitation Coordinator/Assistant) that V3 was mocking R2 while wearing a bag over his head, which she also reported to V1. V4 said she had also received prior complaints from residents about V3 saying they don't like how he talks to them, and from staff reporting they did not like the tone in which V3 communicated towards the residents. V4 said she did not report this to the Abuse Coordinator as it was not severe enough, however, she spoke with V3 and gave corrective feedback explaining that the communication was not appropriate. V3 responded he didn't feel his communication was inappropriate and she continued explaining the communication was inappropriate for residents. V4 said on one occasion, she overheard a resident asking V3 not to talk to them in a certain tone. V3 apologized, and the issue seemed to be resolved, therefore, she did not provide V3 with any corrective feedback at the time. V4 said V3 would speak to residents in a playful and aggressive tone which some residents were confused by and expressed they didn't like. On November 18, 2025 at 1:39 PM, V7 (Psychosocial Rehabilitation Services Coordinator) said she observed V3 (Psychosocial Rehabilitation Services Aide) to be impulsive and easily agitated. V3 would become easily overwhelmed when approached by the residents and she would have to redirect him and educate him on remaining calm. Some of the staff expressed concerns with V3's behaviors regarding the residents. V7 said she did inform V5 (Psychosocial Rehabilitation Services Director) about concerns with V3's behaviors and advised he may need some additional coaching on how to work with the residents. On November 18, 2025 at 1:50 PM, V5 (Psychosocial Rehabilitation Services Director) said V7 (Psychosocial Rehabilitation Services Coordinator) informed her V3 (Psychosocial Rehabilitation Services Aide) may need more in-services about psychosocial practices because he doesn't listen to redirection and instead enforces what he thinks should happen. V5 said she and V1 (Administrator) followed up by educating and in-servicing (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V3 about how to talk to and approach residents. V5 said V3 would become easily frustrated when residents approached him for things and V3 became easily agitated when a lot of residents approached him at the same time and became overwhelmed. V5 said R7 reported to V8 (Activities Aide) that she didn't like the way V3 spoke to her when she asked V3 to take her to the bank and V8 also said R7 didn't like the tone in which V3 spoke to her during their interaction. On November 18, 2025 at 2:02 PM, V8 (Activities Aide) said back in early October, she was in the office with R7 and V3 (Psychosocial Rehabilitation Services Aide) and heard V3 briefly talking to R7 regarding assistance with banking. She then stepped away during this interaction and overheard V3 raise his voice to R7 while saying to R7 didn't I tell you I was going to help you. V8 said later in the day, R7 came to her and said V3 was yelling at her. V8 said during the conversation between R7 and V3, she overheard V3 saying, You can tell somebody else to take you to the damn bank. V8 said she informed V5 about this incident on the same day. V8 said V3 spoke really aggressive with the residents and on another occasion. She observed V3 exhibit a really aggressive demeanor with the residents, and she redirected and educated V3 about how to properly address the residents. On November 18, 2025 at 2:08 PM, V5 (Psychosocial Rehabilitation Services Director) said approximately in early October, V8 (Activities Aide) reported to her R7 didn't like the tone V3 (Psychosocial Rehabilitation Services Aide) used when speaking with her, and V3 was loud when speaking to R7. V5 said if V8 had communicated V3 was yelling at R7 she would have reported this immediately. V5 said V8 did not report to her V3 yelled or swore at R7. V5 said it is not ok for staff to become loud with the residents and if they are loud with the residents, she would report that to the Administrator and the Administrator would determine if it were abuse. However, she didn't report to V1 (Administrator) that V3 was loud with R7. V5 stated the next morning during morning meeting, she informed V1 about the information she received about the incident between V3 and R7. Abuse Investigation reports from October to November 2025 did not include a report for R7. On November 18, 2025 at 3:50 PM, V1 (Administrator) said she and V5 (Psychosocial Rehabilitation Services Director) had a conversation with V3 (Psychosocial Rehabilitation Services Aide) on 11/03/2025 regarding how he interacts with the residents. V1 said V3 had a short and dismissive way of speaking with the residents. V1 said the information reported to her by V5 during morning meeting regarding V3 and R7's interaction was not presented as abuse. If it was reported V3 was loud with R7, V1 would have spoken further with the residents and staff to determine if there was potential for abuse, and if it was discovered V3 was loud in a rude manner, then abuse would have been investigated, and V3 would have been suspended immediately pending the outcome of investigation. V1 said she wasn't aware V3 yelled and swore at R7. V1 said if a resident came to her and reported they didn't like how V3 was speaking with them, she would interview the resident to get further details, and if they expressed V3 was speaking to them in an unkind or disrespectful manner, she would have investigated this and sent V3 home. V1 said she should be informed of any allegation of potential abuse and all allegations should be investigated. V1 said V3 yelling and swearing at R7 should have been reported to her, and V4 (Certified Nursing Assistant) should have reported observing a resident telling V3 they didn't like the tone he was speaking to them with so this could be investigated. V1 said if she is not informed about incidents of abusive behavior, this causes all the residents to be at risk for abuse. The facility's Abuse Policy received 11/18/2025 states:The facility affirms the right of our consumers to be free from verbal abuse or mistreatment. This facility therefore prohibits abuse and mistreatment of consumers. The purpose of this policy is to assure that the facility is doing all that is within it's control to prevent occurrences of abuse and mistreatment of consumers. This will be done by:Implementing systems to promptly and aggressively investigate all reports and allegations of abuse and mistreatment and making the necessary changes to prevent future occurrences.Filing accurate and timely investigative reports.Verbal Abuse is the use of oral or gestured language that willfully includes disparaging and derogatory terms to consumers or withing their hearing distance regardless of an individuals age, ability to comprehend, or disability.Supervisors shall immediately (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E247	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Joliet Living & Rehab Center	2230 McDonough Joliet, IL 60436

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	inform the administrator or person designated to act in the administrator's absence of all reports of incidents, allegations or suspicion of potential abuse or mistreatment. Upon learning of the report, the administrator or a designee shall initiate an incident investigation.Employees of this facility who have been accused of abuse or mistreatment of consumers will be removed from consumer contact immediately. The employee shall not be permitted to return to work until the results of the investigation have been reviewed by the administrator and it is determined that any allegation of abuse or mistreatment of consumer is unsubstantiated.All incidents will be documented, whether or not abuse or mistreatment occurred, was alleged or suspected.Any incident or allegation involving abuse or mistreatment will result in an investigation.When an allegation of abuse or mistreatment has been made, the administrator, or designee, shall notify Department of Public Health's regional office immediately. Public Health shall be informed that an occurrence of potential abuse or mistreatment has been reported to the administrator and is being investigated.