STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E306	A. Building B. Wing	01/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Aurora Living & Rehab Ctr	310 Banbury Road North Aurora, IL 60542

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 - 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** 48308 Based on interview and record review the facility failed to protect a resident's rights to be free from sexual and physical abuse by another resident in accordance with facility policy. This applies to 2 of 5 residents (R2 and R5) reviewed for abuse in the sample of 8. This failure resulted in psychological harm to R2 and R5. Both R2 and R5 expressed being scared of their peer who was the perpetrator of the abuse. The findings include: 1). R2's EMR (Electronic Medical Record) showed R2 was [AGE] years old, admitted to the facility on [DATE], with diagnoses of schizoaffective disorder, bipolar type, and tachycardia. On January 3, 2024, at 4:06 PM, R2 stated on December 9, 2024, a female peer R1, came to his room uninvited and would not leave when asked. R1 was a [AGE] year-old female. R2 stated while he was escorting R1 out of his room, while they were both walking toward the door, R1 turned and grabbed R2's genitals through his clothing. R2 stated he pushed R1's hand away. R2 stated he felt scared because after R1 left his room, R1 remained in the hallway outside R2's room and kept staring at him. R2 stated he did not know what R1 would try to do next. R2 stated on previous days, R1 had been following him in the facility and came to his room uninvited at different times, while he was brushing his teeth or laying in his bed at different days and times. R2 stated he felt uncomfortable and felt weirded out because R1 was an old lady and R2 was trying to nicely ask R1 to leave him alone. R2 stated he went to report to V8 (Activity Director) after R1 had touched him inappropriately on December 9, 2024. R2 stated when he saw R1 in the common day room on December 12, 2024, R2 wanted the police to be called to ensure R1 would not follow him and try to grab him again. R2 stated he was scared R1 would try and grab him again. On January 2, 2025, at 4:06 PM, V4 (Police Detective) stated the police officer came to the facility on [DATE], at the request of R2. V4 stated R1 admitted to grabbing R2. V4 stated R2 declined to press criminal charges against R1. (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 - Actual harm Residents Affected - Few	2). R5 EMR showed R5 was admitted to the facility on [DATE], with multiple diagnoses including schizoaffective disorder, psychotic disorder with delusions, type 2 diabetes, chronic obstructive pulmonary disease, foot drop, right foot, essential hypertension, hyperlipidemia, and dry eye syndrome of unspecified lacrimal gland. R5's MDS (Minimum Data Set) dated October 21,2024 showed R5 was cognitively intact. On December 31, 2024, at 4:35 PM, R5 stated she was scared of a male peer, R3. R5 stated about a week ago, while R5 was sitting in the day room, she was startled awake by R3 who had slapped her in the face for no reason. R5 stated she told staff the next day she wanted to be discharged from the facility to get away from R3. R5 stated she told staff she was scared to live in a place that had residents hit people for no reason. R3's medical record showed a progress note written by V2 (Director of Nursing) dated December 17, 2024, that showed R3 had raised a hand towards a female peer, and the female peer had a red mark on her cheek. V2 identified the female peer as R5. R5 stated R3 had slapped her while she was resting on the couch in the day room. R5's medical record showed a progress note written by V6 (Social Services Director) on December 18, 2024, that showed R5 was requesting discharge from the facility. There was no assessment in R5's medical record of R5's reddened cheek or any injury after December 17, 2024, and no assessment of reason R5 was requesting a discharge from the facility. The facility's policy titled Illinois Abuse Prevention Policy showed .The facility is committed to protecting our residents from abuse .by anyone including but not limited to facility staff, other residents .Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means .the term willful in the definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48308 Based on interview and record review the facility failed to report one incident of resident-to-resident physical abuse to local law enforcement in accordance with facility policy. This applies to 1 of 5 residents (R4) reviewed for abuse in the sample of 8. The findings include: R4's EMR showed R4 was admitted to the facility on [DATE], with multiple diagnoses including schizoaffective disorder, bipolar disorder, chronic obstructive pulmonary disease, generalized anxiety disorder, impulsiveness, Tourette's disorder, type 2 diabetes, and neuralgia and neuritis. R4's MDS dated [DATE], showed R4 was cognitively intact. On December 31, 2024, during the entrance conference all resident-to-resident incident investigations for the past three months was requested. V1 (Administrator) provided one incident investigation dated December 13, 2024. involving R1 and R2. V1 stated there was an incident involving R3 and R4 being in a physical altercation last week but he did not have an investigation report and did not report the incident to local law enforcement. On January 2, 2025, at 2:25 PM, V7 (Restorative Aide) stated on December 24, 2024, around 6:30 AM, V7 heard loud noises coming from the TV lounge and went to the area and found R3 and R4 in a physical altercation. On January 2, 2025, at 11:25 AM, R4 stated when he was in the TV lounge playing his hand-held video game, R3 approached him and hit R4 in the face and walked away. R4 stated that R3 did not say anything prior to or at the time R3 hit R4. R4 stated he got up and followed R3 and asked R3 why did you just hit me? R4 stated R3 turned around and lunged at R4 and R4 stated they then hit each other. R3's EMR (Electronic Medical Record) showed R3 was admitted to the facility on [DATE], with multiple diagnoses including schizoaffective disorder, chronic obstructive pulmonary disease, bipolar disorder, gastro esophageal reflux disease, unspecified osteoarthritis, diabetes mellitus with unspecified complications, and hypertension. R3's MDS (Minimum Data Set) dated December 9, 2024, showed R3 was cognitively intact. R3's and R4's medical records did not contain any documentation of resident assessment of physical or mental condition in response to the incident on December 24, 2024. V1 did not provide an investigation report or copy of the police report when requested regarding the incident on December 24, 2024, involving R3 and R4. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy titled Illinois Abuse Prevention Policy dated October 24, 2022, showed VIII External Reporting .Informing local law enforcement the facility shall also contact local law enforcement authorities in the following situations: physical abuse involving physical injury inflicted on a resident by another resident . when there is reasonable suspicion of a crime .if there is reasonable suspicion that a crime has been committed that is not listed above and does not involve serious bodily injury then a report to local law enforcement as soon as possible but within 24 hours of when the suspicion was formed.

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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** 48308 Based on interview and record review the facility failed to report two incidents of resident-to-resident physical abuse to the State Agency in accordance with facility policy. This applies to 2 of 5 (R4, and R5) residents reviewed for abuse in the sample of 8. The findings include: R3's EMR (Electronic Medical Record) showed R3 was admitted to the facility on [DATE], with multiple diagnoses including schizoaffective disorder, chronic obstructive pulmonary disease, bipolar disorder, gastro esophageal reflux disease, unspecified osteoarthritis, diabetes mellitus with unspecified complications, and hypertension. R3's MDS (Minimum Data Set) dated December 9, 2024, showed R3 was cognitively intact. R5's EMR showed R5 was admitted to the facility on [DATE], with multiple diagnoses including schizoaffective disorder, psychotic disorder with delusions, type 2 diabetes, chronic obstructive pulmonary disease, foot drop, right foot, essential hypertension, hyperlipidemia, and dry eye syndrome of unspecified lacrimal gland. R5's MDS dated [DATE] showed R5 was cognitively intact. R3's progress note written by V2 (Director of Nursing) showed R3 had a raised hand over R5 and R5 had a reddened cheek, while they were both in the dayroom on December 17, 2024. The incident was witnessed by V11 (CNA). On December 31, 2024, at 2:50 PM a request for the incident report and the assessment following the incident between R3 and R5 was requested from V2. V2 stated there was no incident report and no assessment of R5 following the incident. On December 31, 2024, at 4:45 PM, R5 stated she was resting on the couch in the lounge with her eyes closed when R3 slapped her in the face for an unknown reason. R5 stated she was scared of R3 and wanted to discharge from the facility as a result. On December 31, 2024, at 3:34 PM, V1 (Administrator) stated he does not have an incident report of the altercation between R3 and R5 on December 17, 2024, and stated he did not report the incident to the State Agency. R4's EMR showed R4 was admitted to the facility on [DATE], with multiple diagnoses including schizoaffective disorder, bipolar disorder, chronic obstructive pulmonary disease, generalized anxiety disorder, impulsiveness, Tourette's disorder, type 2 diabetes, and neuralgia and neuritis. R4's MDS dated [DATE], showed R4 was cognitively intact. (continued on next page)

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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	On January 2, 2025, at 11:25 AM, R4 stated when he was in the TV lounge playing his hand-held video game, R3 approached him and hit R4 in the face and walked away. R4 stated that R3 did not say anything prior to or at the time R3 hit R4. R4 stated he got up and followed R3 and asked R3 why did you just hit me? R4 stated R3 turned around and lunged at R4 and R4 stated they then hit each other. On January 2, 2025, at 2:25 PM, V7 (Restorative Aide) stated on December 24, 2024, around 6:30 AM, V7 heard loud noises coming from the TV lounge and went to the area and found R3 and R4 in a physical altercation. V7 stated they separated in response to V7's verbal redirection. V7 stated she instructed R3 to go to his room and R3 did. V10 (LPN) documented on December 24, 2024, at 7:10 AM that R3 was transferred to the hospital. There was no assessment in the progress notes of either R3's or R4's physical condition or mood in response to the incident on December 24, 2024. On December 31, 2024, at the entrance conference all resident-to-resident altercations incident reports were requested from V1 (Administrator) for the past three months. V1 provided one incident involving R1 and R2 dated December 13, 2024. V1 stated there had been an incident of a physical fight last week between R3 and R4, but he did not report the incident to the state agency or the local police. V1 stated he probably should have reported the incident between R3 and R4 because it was abuse. The facility's policy titled Illinois Abuse Prevention Policy, dated October 24, 2022 showed V . report to the state survey agency any allegation of abuse, neglect .and to local law enforcement or other state agency if they have a suspicion that a crime has been committed .reports will be documented and a record kept of the documentation .any allegation of abuse or any incident that results in serious bodily injury will be reported immediately .or within 24 hours .VIII External Reporting 1. Initial reporting of Allegations. When an allegation of abuse exploitation, neglect, mistreatment .has been made the administrator or designee shall notify the department of Public Health's Regional Office immediately by telephone or fax.

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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 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** 48308 Based on interview and record review the facility failed to investigate two incidents of resident-to-resident physical abuse in accordance with facility policy. This applies to 3 of 5 residents (R3, R4, and R5) reviewed for abuse in the sample of 8. The findings include: On December 31, 2024, during the entrance conference all resident-to-resident incident investigations for the past three months was requested. V1 (Administrator) provided one incident investigation dated December 13, 2024. involving R1 and R2. V1 stated there was an incident involving R3 and R4 being in a physical altercation last week but did not have an investigation report. On December 31, 2024, at 2:50 PM, V2 (Director of Nursing) identified a physical altercation between R3 and R5 that occurred on December 17, 2024, but stated there was no incident report. V1 stated there were no incident investigation reports for December 24, 2024, involving R3 and R4 and no incident investigation report for the incident on December 17, 2024, involving R3 and R5. R3's EMR (Electronic Medical Record) showed R3 was admitted to the facility on [DATE], with multiple diagnoses including schizoaffective disorder, chronic obstructive pulmonary disease, bipolar disorder, gastro esophageal reflux disease, unspecified osteoarthritis, diabetes mellitus with unspecified complications, and hypertension. R3's MDS (Minimum Data Set) dated December 9, 2024, showed R3 was cognitively intact. R5's EMR showed R5 was admitted to the facility on [DATE], with multiple diagnoses including schizoaffective disorder, psychotic disorder with delusions, type 2 diabetes, chronic obstructive pulmonary disease, foot drop, right foot, essential hypertension, hyperlipidemia, and dry eye syndrome of unspecified lacrimal gland. R5's MDS dated [DATE] showed R5 was cognitively intact. On December 31, 2024, at 4:45 PM, R5 stated she was resting on the couch in the lounge with her eyes closed when R3 slapped her in the face for an unknown reason. R3's progress note written by V2 (Director of Nursing) showed R3 had a raised hand over R5 and R5 had a reddened cheek, while they were both in the dayroom on December 17, 2024. R4's EMR showed R4 was admitted to the facility on [DATE], with multiple diagnoses including schizoaffective disorder, bipolar disorder, chronic obstructive pulmonary disease, generalized anxiety disorder, impulsiveness, Tourette's disorder, type 2 diabetes, and neuralgia and neuritis. R4's MDS dated [DATE], showed R4 was cognitively intact. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On January 2, 2025, at 11:25 AM, R4 stated when he was in the TV lounge playing his hand-held video game, R3 approached him and hit R4 in the face and walked away. R4 stated that R3 did not say anything prior to or at the time R3 hit R4. R4 stated he got up and followed R3 and asked R3 why did you just hit me? R4 stated R3 turned around and lunged at R4 and R4 stated they then hit each other. On January 2, 2025, at 2:25 PM, V7 (Restorative Aide) stated on December 24, 2024, around 6:30 AM, V7 heard loud noises coming from the TV lounge and went to the area and found R3 and R4 in a physical altercation. V7 stated they separated in response to V7's verbal redirection. V7 stated she instructed R3 to go to his room and R3 did. R3's progress note dated December 24, 2024, at 7:10 AM showed R3 was transferred to the hospital after the altercation with R4. The facility's policy titled Illinois Abuse Prevention Policy dated October 24, 2022, showed .VII .2. Any incident or allegation involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property will result in an investigation .VIII 2. Five-day final investigation report within 5 working days the report of the occurrence, a complete written report of the conclusion of the investigation including steps the facility has taken in response to the allegation will be sent to the Department of Public Health. The final investigation report shall contain the following: Name age, diagnosis .original allegation .summary of the facts .conclusion of the facts .police report .