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	04/18/2025

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 - 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** 35267 Based on interview and record review, the facility failed to prevent the physical abuse of residents per facility policy. This applies to 2 of 3 residents (R1 and R2) reviewed for abuse in a sample of 3. The findings include: Face sheet, dated 4/17/25, shows R1's diagnoses included Schizoaffective disorder, bipolar type, anxiety disorder, attention-deficit hyperactivity disorder, Major depression disorder, insomnia, obesity, and chronic obstructive pulmonary disease. MDS (Minimum Data Set), dated 3/17/25, shows R1 was cognitively intact. Face sheet, dated 4/17/25, shows R2's diagnoses included dementia with other behavioral disturbance, schizophrenia, difficulty walking, unsteadiness on feet, weakness, foot drop, abnormality of gait and mobility, disorganized schizophrenia, major depressive disorder, and insomnia. MDS, dated [DATE], shows R2 was cognitively intact. Facility Final Incident Investigation Report, dated 4/15/25, shows on 4/12 25 at 10:10 PM, R2 entered the community bathroom where R1 was taking a shower. R1 told R2 to get out of the bathroom and R2 ignored R1's request. R1 did not pull a call light for staff to assist and R2 bumped R1's shower chair in which R1 was sitting. R1 began yelling at R2 to leave but R2 would not leave. R1 dried himself off and attempted to leave the bathroom when R2 began harassing R1 and R2 threw his urinal full of urine at R1. R1 became upset and struck R2 on the back of the head and left the bathroom. R1 slipped on the urine while leaving the bathroom and landed on his buttocks. When interviewed, R2 stated he did not remember why he did not leave the bathroom when R1 asked him to do so. The residents were separated and both were placed on 1:1 monitoring by staff. V1 (Administrator) and 911 was called. The residents were assessed and no physical concerns were identified. R1 was sent to the hospital for a psych evaluation and returned to the facility. The allegation of abuse was substantiated. On 4/17/25 at 11:30 AM, R1 stated he was taking a shower in the shower room and R2 came into the room while R1 was naked. R1 stated he yelled at R2 to leave the shower room but R2 would not leave. R1 stated eventually R2 left and R1 dried off, dressed, and walked out into the hall and saw R2. R1 stated he hit R2 and R2 threw urine at R1 which caused R1 to slip and fall to the floor. R1 stated he was not injured in the incident. (continued on next page)

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	On 4/17/25 at 11:45 AM, when asked about R2's altercation with R1, R2 stated, It's over and done with. R2 stated he was not hurt during the incident with R1. On 4/17/25 at 10:40 AM, V3 (Registered Nurse) stated she heard yelling while at the nursing station and saw R2 sitting by his room door in his wheelchair holding his urinal which contained urine. V3 asked if R2 needed to use the bathroom and he would not reply. V3 stated V4 (CNA - Certified Nursing Assistant) also asked R2 if he could assist and R2 wound not reply to V4. V3 stated she and V4 were not yet aware R1 and R2 were arguing prior. V3 stated R1 came out of the bathroom, looked left and right, and began punching R2. V3 stated she tried to intervene but R1 was too large to remove from the area. V3 stated she called for staff to assist and the staff attempted to break up R1 and R2 but R1 was very strong and was resisting. V3 while she called 911, R2 dumped his urinal on R1, R1 slipped on the urine on the floor and fell . V3 stated while staff were attempting to separate the residents, R1 flipped R2's wheelchair while R2 was in the wheelchair. V3 stated the two residents were eventually separated and no injuries were identified. Both residents were placed with 1:1 supervision and R1 was involuntarily petitioned to the hospital for aggressive behavior. V3 stated neither of the residents were injured. On 4/17/25 at 6:43 PM, V4 stated he heard yelling and realized it was coming from a shower room with two residents in the room. V4 stated the residents exited the shower room and V4 thought the residents were fine until R2 threw urine from his urinal on R1 and R1 began hitting R2. V4 stated he was able to separate the residents and there were no injuries. Progress notes, dated 4/12/25, shows R2 went to the bathroom to dump his urinal and R1 was already using the bathroom. R1 told R2 to get out of the bathroom but R2 refused. The note shows that R1 hit R2 because R2 would not leave the bathroom. The note shows R2 was assessed for injury and no concerns were identified. The note shows 911 was called and R2 refused to go to the hospital. Progress note, dated 4/13/25, shows close monitoring and assessment of R2 continued until he was involuntarily sent to the hospital related to his aggressive behavior. Progress notes, dated 4/13/25, show R1 was using the bathroom to shower and R2 walked into the bathroom. The progress note shows R1 told R2 to leave the bathroom but R2 refused. R1 stated he hit R2 because R2 refused to leave the bathroom. The note shows R2 dumped urine from his urinal on to R1 which made R1 fall on the floor. The note shows the residents were separated and R1 was placed on 1:1 supervision until he left the hospital. Facility Abuse Prevention Policy, dated 10/24/22, shows, This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect exploitation, misappropriation of property and mistreatment of residents . Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident