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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14E392 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/04/2025 |
| NAME OF PROVIDER OR SUPPLIER West Chicago Terrace | | STREET ADDRESS, CITY, STATE, ZIP CODE 928 Joliet Road West Chicago, IL 60185 | |

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) |
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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>41384</p> <p>Based on interviews and record reviews, the facility failed to protect R2's right to be free of abuse from another resident. This applies to 1 of 4 residents (R2) reviewed for abuse.</p> <p>The findings include:</p> <p>R2's Face Sheet showed R2 had been residing at the facility since 8/31/2022 for mental health care with diagnoses including schizoaffective disorder, depressive type, personality disorder, schizophrenia, nicotine dependence, and prediabetes. R2's 3/10/2025 MDS (Minimum Data Set) showed R2's cognition is intact.</p> <p>The facility's Incident Report of 3/27/25 to IDPH (Illinois Department of Public Health) showed that on 3/27/25 at 8:30 am R1 and R2 were standing in a line and R1 threw her cup of coffee on R2 and hit and pushed R2.</p> <p>On 4/3/25 at 1:00 PM, V1 (Administrator) showed the State Surveyor the video of the 3/27/25 incident and the video showed R1 throwing her coffee on R2 and striking and pushing R2. R1's witness statement of 3/27/25 showed that R1 admitted to punching R2 and throwing her coffee on R2.</p> <p>The facility's 3/27/25 Incident Report to IDPH did not have a witness statement from R2.</p> <p>On 4/3/25 at 2:45 PM, V2 ADON (Assistant Director of Nursing) said that R2 did not want to give a statement. On 4/3/25 the day of this investigation, R2 was out of the facility on a pass.</p> <p>On 4/3/25 at 1:23 PM, R3, who's cognition is intact, said that he was standing in the smoking line in front of R1 and R2, and when he turned around, he saw R1 throw her coffee on R2.</p> <p>On 4/3/25 at 2:23 PM, V1 (Administrator) said that the incident of 3/27/25 was resident to resident physical abuse. V1 said that R1 physically abused R2. V1 said the facility failed to provide a safe environment free from abuse for R2. V1 said R1's actions were willful, intentional, and deliberate. V1 said it is the facility's policy to have a safe environment for the residents, and for them to be free from abuse from another resident.</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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| FORM CMS-2567 (02/99) Previous Versions Obsolete | Event ID: Facility ID: 14E392 | If continuation sheet Page 1 of 2 |

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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 4/3/25 at 2:45 PM, V2 ADON (Assistant Director of Nursing) said that on 3/27/25 she was in charge of the facility. V2 said that when she came in that day, she was told by staff that there was an incident between R1 and R2. V2 said that she viewed the video tape of the incident and she saw that R1 threw her coffee on R2 and hit R2. V2 said that the incident was physical abuse from R1 to R2. V2 said that the facility failed to provide R2 with a safe environment and free from abuse. V2 said that R1's actions were willful and deliberate.</p> <p>On 4/3/25 at 12:12 PM, V3 (Nurse) said that on 3/27/25 at 8:30 AM she was in the nurses' station when she heard an altercation and ran out to the dining room and saw staff had separated R1 and R2. V3 said that she asked R2 what had happened and R2 told her that R1 had hit her in the mouth and threw coffee on her.</p> <p>On 4/3/25 at 3:05 PM, V4 CNA (Certified Nurse's Assistant) said that he was present in the dining room on 3/27/25 serving food to the residents. V4 said that he saw R1 throw coffee on R2 and that R1's actions were intentional.</p> <p>On 4/3/25 at 12:38 PM, V5 (Nurse) said that on 3/27/25 he was in the nurse's station and heard a commotion and came out and saw R1 push R2. V5 said that R1 was the aggressor. V5 said that the incident was physical abuse by R1 to R2. V5 said that he did not see R1 throw the coffee on R2, but he did see that R2's jacket was wet with coffee.</p> <p>R2's 3/27/25 at 8:28 AM Risk Management report completed by V3 showed that on 3/27/25 R2 reported to V3, that R1 struck R2 in her mouth and threw her coffee on her.</p> <p>R2's 9/9/24 care plan showed that R2 is at risk for abuse/neglect based on her comprehensive assessment related to her mental illness diagnosis with interventions including assure R2 is in a safe and secure environment.</p> <p>The facility's Abuse policy dated 3/2022 showed that the residents have a right to be free from verbal, physical, sexual, mental abuse, neglect, exploitation, misappropriation of property, involuntary seclusion, or mistreatment. The policy showed that the facility prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. The policy showed that the facility should established a resident sensitive and resident secure environment. The policy showed the definition of abuse meaning 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. 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. The policy showed the definition of physical abuse as the infliction of injury on a resident that occurs other than by accidental means. The policy showed that physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment. The policy showed that the prevention of abuse may be prevented by establishing a safe environment.</p> | | |