| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 14E392 | A. Building<br>B. Wing | 03/29/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| West Chicago Living and Rehab Center | 928 Joliet Road<br>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) |
|---|---|
| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to keep R1 free from abuse. This applies to 1 of 3 (R1) residents reviewed for abuse. The findings include:R1's final incident investigation report dated 3/11/26 shows On 3/6/26 at 9:40 PM, in the dining room area, (R1) was pushing a chair when (R2) was walking around the dining room and came up to him and pushed (R1) for no apparent reason, at which time (R1) fell to the ground. No verbal argument or words were exchanged prior to the incident. Both residents were immediately separated by staff that were in the dining room area and (R2) was placed one-to-one staff monitoring. (R1) was assessed by charge nurse and presents with no redness, bruising, complaints of pain or discomfort, and reports feeling safe in the facility. The medical doctor for both residents was notified, and police were called. Both residents' representatives were notified of incident. Investigated initiated. Physical abuse is founded. Conclusion: (R1) had moved (R2)'s phone from the table, not just a chair, which caused (R2) to verbally confront (R1). (R1) stated that, I don't want your phone on my table. He also called (R2) a curse word. This action caused (R2) to grab (R1)'s body and push (R1) to the ground and was standing over him until staff immediately separately residents. (R2) was witnessed continuing to be verbally and physically abusive towards staff while trying to be redirected and remained on a 1:1 staff monitoring until discharged to hospital per physician order. Police were notified of incident and report was made. (R1) was assessed at the time by charge nurse and no redness, bruising, or injury noted or complaint of pain. During investigation progress, (R1) noted with redness and bruise to right elbow which (R1) stated occurred when he landed on the floor.(R2) was admitted to (hospital) for evaluation and treatment where he currently resides. (R2) has had no behaviors or history of aggression at facility.R1?s face sheet shows diagnoses of schizophrenia, major depressive disorder, recurrent, moderate, and generalized anxiety disorder. R1s MDS (Minimum Data Set) dated 1/5/26 shows that he is cognitively intact.R1's progress note dated 3/7/26 at 12:13 AM shows: At approximately 10:00 PM, (R1) was grabbed and pushed down on the floor by (R2). He was assisted to get up. He verbalized that he was okay, and he was not hurt. Upon assessment, (R1) sustained no injuries. Denied pain or discomfort. Slight redness was noted on his left elbow, which he stated he used to support himself when he was pushed down.On 3/27/26 at 10:45 AM, R1 stated that on 3/6/26 in the evening he was hanging out in the dining room with his friends. He stated that R2 kept walking back and forth, rapping really loud, swearing and using words like bitch and the n-word. R1 asked R2 if he could be quiet because residents were talking and trying to watch a movie. Instead, R2 started running back and forth. R2 took his phone and slammed it on the table that he was sitting at. R1 took R2's phone and put it on next table. R2 then jumped me from behind. He grabbed me and threw me on the ground. R2 was yelling something. He bruised by right elbow. I had pain in my lower back and elbow. Staff took me to the nursing station. R2 climbed on the table and then he came to the nursing station. V5 (CNA) came and took R2 out of the nursing station. R2 got angy and started punching the wall in the dining room. When the police came, I heard he tried to take one of the police officer's gun. R2 is not here anymore. They took him somewhere.On 3/27/26 at 11:44 AM, V4 (RN) stated on 3/6/26 she worked from 7pm<br>(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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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | to 7am. She was the assigned nurse for both R1 and R2. She said R2 was singing loudly in the hallway, running around and was not redirectable. She called V2 and told her that R2 was disturbing the residents. V2 came to the facility. R2 attacked R1. R2 jumped on R1, grabbed and pushed R1 down. R1 had some redness on his shoulder. I heard from staff that R2 put his phone on R1's table. R1 took it and put it on another table. We called the police and R2 was sent to the hospital. It's our job to prevent abuse in the facility. On 3/27/27 at 1:19 PM, V1 (Administrator) stated that she received a phone call at home that there was an incident between R1 and R2. She said I immediately did the initial report and sent it to IDPH (Illinois Department of Public Health). Then I went out of town. Yes, it is physical abuse and it's the facility's job to prevent abuse.On 3/27/26 at 11:01 AM, V2 (DON--Director of Nursing) stated that on 3/6/26 at 9:40 PM, V4 (RN-Registered Nurse) who was R1 and R2's nurse called her at home. She stated that R2 was running and walking fast down the hallways and talking to himself. V2 told V4 to keep an eye on him. She instructed V4 to call her if he starts escalating. V2 stated I came in eventually. I saw R2 walking between the main isle in the dining room. R2 put his phone on the table and then R1 picked it up and moved it to another table. By the time I got there, R1 was on the floor. V5 (CNA-Certified Nursing Assistant) brought R2 down to the tv area. R1 was taken to the nursing station. I talked to R2 and he told me that R1 took his phone. I told him that he shouldn't have handled it the way he did. I told him that I'm going to have to send you out. R2 started to get upset. He walked back to his room and came out. He said that he was going to get the cop's gun and blow things up. I called 911. When the officers came, R2 tried to go after their gun. They restrained him. R2 kept saying that R1 should not have taken his phone. R2 was sent to the hospital and he never came back. R2 should not have attacked R1 and put him to the floor, but he was instigated by R1. It is physical abuse. I know it's the facility's job to prevent abuse.R2's progress note dated 3/7/26 at 12:04 AM shows, At approximately 9:55 PM, R2 was heard singing loudly in the dining area. Staff advised him to keep his voice down as the other residents started to complain about the noise. (R2) was non-redirectable, and he was seen running back and forth in the dining area. (R2) became physically aggressive and grabbed (R1) and pushed him to the floor. Staff immediately separated the residents and (R2) was placed on 1:1. (R2) was sent to the hospital for further evaluation to prevent harm to self and others. R2 was unable to be interviewed as he was transferred to the hospital on 3/7/26 and never returned to the facility. R2's face sheet shows a diagnosis of schizoaffective disorder, bipolar type. R2's MDS dated [DATE] shows that he was cognitively intact.Facility's policy titled Abuse Prevention Policy (10/24/24) shows the following: Physical abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment.This facility desires to prevent abuse.by establishing a resident sensitive and resident secure environment. The facility affirms the right of our residents to be free from abuse.The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse.The facility is committed to protecting our residents from abuse. |