STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007603	A. BUILDING: _____ B. WING _____	C 12/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER PLACE	3200 GRANT STREET EVANSTON, IL 60201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Investigation of Facility Reported Incident of October 20, 2022/IL153106	S 000		
S9999	Final Observations Statement of Licensure Violations: 330.710a) 330.4240a) 330.4240b) Section 330.710 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. Section 330.4240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. This REQUIREMENT is not met as evidenced by: Based on interview and record review, facility staff failed to operationalize the facility Abuse Prohibition and Reporting Policy by failing to immediately report their concerns of suspected resident abuse to the Facility Abuse Prevention Coordinator. This failure affects one (R1) of five residents reviewed for abuse.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 Findings include: The facility Abuse, Neglect, and Exploitation, Prevention of Reporting Policy dated 2/1/22 documents: "All staff are required to immediately report any occurrence or suspicion of potential abuse, neglect, misappropriation of resident property or exploitation, including corporal punishment and involuntary seclusion to the Abuse Coordinator. In the Abuse Coordinators absence, staff should immediately report to the Director of Nursing or their supervisor." On 12/3/22 at 10:25am V3 (Certified Nursing Assistant/CNA) stated, that on 10/8/22 V3 asked V5 (CNA) to assist V3 with changing R1. V3 said, V3 and V5 brought R1 to R1's bathroom to change R1's incontinence pad. V3 said, V5 was standing next to R1 and V3 bent over to remove R1's incontinence pad when V3 heard a slapping noise. V3 said, V3 observed R1 swinging R1's arms which is a normal behavior R1 exhibits when R1 gets changed. V3 said, V3 observed V5 slap R1 in the face. V3 then said V3 never observed V5 slapping R1. V3 said, V3 didn't report it as V3 should have, because V3 was scared that V3 would be retaliated against. V3 said, V3 should have immediately reported it to V3's supervisor. V3 said, on 10/20/22 V3 told V6 (CNA) and then V3 reported it to V7 (Director of Nursing/DON). V3 said, V3 receives yearly abuse and neglect training, and knows that V3 should have reported it right away. On 12/3/22 at 11:20am V1 (Administrator) said, on 10/20/22 at 2:00pm V1 was notified by V7 (DON) of an abuse allegation between V5 (CNA) and R1. V1 said, V1 immediately started an investigation and V5 was placed on leave pending the investigation. V1 said, V3 (CNA)	S9999		

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S9999	Continued From page 2 informed V1 that on 10/8/22 V3 asked V5 to assist V3 in changing R1's incontinence pad. V1 said, V3 and V5 brought R1 to R1's bathroom and V3 was bending over when R1 became combative and began swinging R1's arms towards V5. V1 said, V3 further informed V1 that when V3 looked up, V3 saw V5 strike R1. V1 said, V3 acknowledged that V3 did not follow the facilities policy which requires immediate notification to a supervisor of an abuse allegation. V7's (DON) Witness statement dated 10/20/22 documents V3 (CNA) completed Abuse and Neglect Training on 3/8/22. On Saturday 10/8/22 V3 violated the facilities policy prevention of Abuse, Neglect and Exploitation Policy. V4's (Registered Nurse/RN) witness statement dated 10/20/22 at 2:00pm documents V6 (CNA) informed V4 that V3 (CNA) saw V5 (CNA) slap R1 on the face 2 weeks ago. V3 did not tell anybody until today when V3 told V6. V4 asked V3 why V3 did not report it right away and V3 said V3 got scared to report it, but when V3 saw V5 again today V3 felt guilty. V4 immediately advised V6 and V3 to report it to V7 (DON) or V1 (Administrator). "C"	S9999		