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	IL6009856	A. BUILDING: _____ B. WING _____	04/09/2025

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S 000	Initial Comments Annual Licensure and Certification	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2: 300.626c) Section 300.626: Discharge Planning for Identified Offenders c) When a resident who is an identified offender is discharged, the discharging facility shall notify the Department. These Regulations are not met as evidenced by: Based on interview and record review, the facility failed to notify the Identified Offenders Program when an identified offender resident is discharged from the facility which affected 14 residents (R189, R190, R191, R192. R193, R195, R196, R197, R198, R199, R200, R201, R202 and R203) in the sample of 86 residents. Findings include: Identified Offenders Program document, dated 4/04/2025 and titled "Facility Report," documents, in part, a list of "Identified Offenders - Current Residents" with a total of 14 residents who are not listed on the active Census Report (resident roster), dated 4/06/25. R189's Admission Record documents, in part, R189 was discharged from the facility on 1/23/24. R189 is listed on the 4/04/25 "Identified Offenders - Current Residents."	S9999		

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R190's Admission Record documents, in part, R190 was discharged from the facility on 06/07/2024. R190 is listed on the 4/04/25 "Identified Offenders - Current Residents."

R191's Admission Record documents, in part, R191 was discharged from the facility on 08/30/2024. R191 is listed on the 4/04/25 "Identified Offenders - Current Residents."

R192's Admission Record documents, in part, R192 was discharged from the facility on 01/08/2023. R192 is listed on the 4/04/25 "Identified Offenders - Current Residents."

R193's Admission Record documents, in part, R193 was discharged from the facility on 01/28/2022. R193 is listed on the 4/04/25 "Identified Offenders - Current Residents."

R195's Admission Record documents, in part, R195 was discharged from the facility on 08/01/2023. R195 is listed on the 4/04/25 "Identified Offenders - Current Residents."

R196's Admission Record documents, in part, R196 was discharged from the facility on 10/17/2024. R196 is listed on the 4/04/25 "Identified Offenders - Current Residents."

R197's Admission Record documents, in part, R197 was discharged from the facility on 06/07/2021. R197 is listed on the 4/04/25 "Identified Offenders - Current Residents."

R198's Admission Record documents, in part, R198 was discharged from the facility on 08/11/2020. R198 is listed on the 4/04/25 "Identified Offenders - Current Residents."

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R199's Admission Record documents, in part, R199 was discharged from the facility on 4/20/2021. R199 is listed on the 4/04/25 "Identified Offenders - Current Residents."

R200's Admission Record documents, in part, R200 was discharged from the facility on 06/10/2019. R200 is listed on the 4/04/25 "Identified Offenders - Current Residents."

R201's Admission Record documents, in part, R201 was discharged from the facility on 11/02/2024. R201 is listed on the 4/04/25 "Identified Offenders - Current Residents."

R202's Admission Record documents, in part, R202 was discharged from the facility on 04/24/2019. R202 is listed on the 4/04/25 "Identified Offenders - Current Residents."

R203's Admission Record documents, in part, R203 was discharged from the facility on 03/02/2025. R203 is listed on the 4/04/25 "Identified Offenders - Current Residents."

On 4/08/2025 at 1:33pm V43 (Admissions Director) stated resident are to be discharged from the Identified Offenders program/IOP and she discharges residents from Maximus on the day the resident discharges from the facility unless they are going to the hospital and are admitted. V43 stated she had completed her monthly audit, and all residents (R189, R190, R191, R192. R193, R195, R196, R197, R198, R199, R200, R201, R202 and R203) were discharged from the Identified Offenders program and V49 (Social Services Consultant) received confirmation emails for these residents (R189, R190, R191, R192. R193, R195, R196, R197, R198, R199, R200, R201, R202 and R203) on

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04/06/2025 and 04/07/2025 by V46 (Social Services Consultant).

On 4/08/2025 at about 9:00am the facility provided the surveyor with the discharge confirmation emails sent to V49 (Social Services Consultant) for R189, R190, R191, R192. R193, R195, R196, R197, R198, R199, R200, R201, R202 and R203.

On 4/09/2025 at 2:39pm via email V1(Administrator) stated when residents are discharged from Maximus, the resident must be manually discharged from the IO program and either the facility's Social Service Director and/or the Behavioral Director will discharge the resident.

On 4/09/2025 at 2:40pm via email V1 stated we don't have a policy for discharging resident from IOP.

Policy titled Registered Sex Offenders and Identified Offenders dated 2/2024 does not documents how to discharge residents from the Identified Offenders Program.

(C)
Statement of Licensure Violations 2 of 2:
300.610a)
300.1010h)
300.1210b)
300.2070c)

Section 300.610 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 by a Resident Care Policy

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Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1010 Medical Care Policies

h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

Section 300.2070 Scheduling Meals

c) If a resident refuses food served,

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reasonable and nutritionally appropriate substitutes shall be served.

These Regulations are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide a resident with meal trays and alternative menus according to physician's orders. These failures affected one resident (R150) reviewed for Nutrition/Hydration status maintenance in a sample of 86 residents. This failure resulted in R150 feeling sad and ignored by staff.

Findings include:

Facility presented a list of weights dated 4/8/2025 with weights list as; 11/24 120.6, 12/24 118, 1/25 119, 2/25 119.6, 3/25 123.6,4/25 160.6.

R150's Face sheet dated April 8, 2025, documents that R150 was admitted to facility on February 27, 2024 with diagnosis including Schizophrenia, tachycardia, adult failure to thrive, vitamin d deficiency, paranoid personality disorder, severe protein calorie malnutrition, anemia, muscle weakness.

R150's MDS (Minimum Data Set) dated March 13,2025 section C, shows R150 has a score of 15 which means R150 is cognitively intact; section GG, shows R150 shows R150 has a score of 4 which means R150 requires supervision or touching assistance with her meals; section K, shows that on 3/13/25 R150 is recorded weighing 124 pounds.

R150's care plan dated March 11,2024 shows that R150 has nutritional problem or potential nutritional problem r/t protein calorie malnutrition.

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Interventions/Tasks: "staff to provide, serve diet as ordered, monitor intake, and record every meal", R150 care plan dated February 29,2025 states R150 has potential for dehydration related to diagnosis of protein malnutrition. Interventions/Tasks: "Staff to provide and encourage fluids unless contraindicated", R150 care plan dated March 3, 2025, shows a preference to receive her meals without a tray and independently take them to eat in her room. Interventions/Tasks: "preference for eating: dislikes receiving trays and silverware with meals."

R150's Physician order sheet dated March 31,2025 has diet orders as follows: General diet regular texture, thin liquids consistency, Med pass 2.0 three times for Nutritional supplement give 120 ml, May substitute with Two Cal HN, Ensure, Mighty shake Magic Cup or Glucerna dated February 25,2025

04/06/25 at 10:49 am, R150 was interviewed in her room while she was in bed resting, she reported she prefers to stay in her room most of the time and staff does not serve her meal trays in room even after she made the request to staff that she doesn't want to eat in dining room.

4/6/25 at 12:52pm, V23 (Activity aide) was observed in dining room sitting and eating her food. When asked was R150 offered a meal tray today, V23 stated she normally refuses her meals. When asked did R150 refuse her meals today, V23 stated she has been so busy today, it slipped her mind to ask R150 if she wanted her meal or take the tray to her room. V23 walked to room with this surveyor and asked R150 did she want her lunch tray and what meal would she like at this time, R150 stated "yes" I would like my

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meal tray, and you can bring me whatever you have. V23 apologized to R150 and stated it was oversight but R150 stated no it's not it happens all the time. V23 then came to nursing desk to speak with her nurse. At this time dining experience was finished on the unit and all trays were taken down to be washed/discarded.

On 4/6/2025 at 12:55pm, V4 (Licensed Practical Nurse) stated when residents are in room staff place trays on meal rack and take their meal trays to the room. V4 stated R150 normally refuses but she should have been asked today before her tray was sent back downstairs, she stated should call down and get R150 a tray. V4 then instructed V23 to go down to the kitchen and get the tray for R150.

On 4/08/25 at 9:54 am, R150 was interviewed in her room, she reported that she was not offered her dinner tray on 4/7/25. This surveyor observed the lunch tray from day before 4/7/2025 sitting on the dresser tabletop in room. R150 stated she was served Porkchop, carrots, mash potatoes, cake. This surveyor observed a few carrots left on her tray. R150 stated I refused breakfast this morning because I didn't want what they offered but she was not offered an alternative meal.

On 4/8/25 at 10:00am, V39 (Licensed Practical Nurse) stated she was informed at 8:55am that Jasmine refused her breakfast tray, and that R150 was not offered an alternative meal selection. When asked why an alternative wasn't offered, she stated she would have the staff go down and get her something to eat.

On 4/8/25 at 10:21am, V9 (Dietary Manager) stated R150 receives her food without the trays most of the time and with plastic utensils but

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sometimes she receives it on the tray because R150 switches up on her choices. If R150 refuses her meal staff should offer her the always available meal menu. V9 stated her staff is aware to prepare alternatives when they are called that a resident wants an alternative and refuses the original meal. A menu of the meal served on 4/7/25 was provided by V9, the lunch meal was breaded pork chop and carrots, which was the meal tray that was still in room during my observation. When asked was she informed that R150 did not receive dinner she stated she was not because she is normally off work before the residents receive dinner. V9 stated she was not informed that she did not want her breakfast this morning, so she could be offered an alternative, and stated to be honest I have not received many calls about R150 refusing her trays and wanting an alternative.

On 4/8/25 at 11:00am, V14(Licensed Practical Nurse/Unit Manager) stated staff is aware to encourage residents to eat and offer alternatives if a resident refuses a meal. She was not aware that R150 preferred to have her meals served without a tray and with plastic utensils. V14 went to room with this surveyor and observed the tray from 4/7/25 lunch meal and asked R150 did she receive dinner on last night 4/7/25, R150 stated no she did not. V14 stated it is her expectation that the nurse offers alternative meals and if the resident still refuses the meal that the physician and family should be notified.

On 4/8/25 at 11:40am, V2 (Director of Nursing) stated it is her expectation that all residents receive their meal trays and if they choose not to eat, they should be offered a substitute meal. V2 stated the family, and physician should be notified, and the nursing staff is expected to

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document in the chart. V2 was notified at this time that R150 has reported she missed two meals this week.

On 4/8/2025 at 2:30pm, R150's hospital record dated 3/20/25 from local hospital has weight listed as 74.8 kg (165 pounds)

On 4/8/25 at 2:45 pm, R150's weight in chart is 3/4/2025 123.6 no weight for April recorded in R150's chart at this time.

On 4/8/25 at 3:11pm, R150 weighed by V44 (Restorative Aide) weight is 160.6 on stand-up scale in presence of this surveyor. R150 stood up and walked over to the scale without staff assistance.

On 4/8/25 at 3:14pm, R150 was asked how it makes her feel that she is not offered a tray, R150 stated it makes her feel bad and overlooked by staff.

04/08/25 at 04:28 pm, V37 (Licensed Practical Nurse/Restorative Nurse) stated she deleted the weight for 4/3/25 of 125 pounds that she had just placed in chart because she thought that was the right thing to do since a new weight was obtained. V2 was informed that the weight for 4/3/25 was deleted by V37 and V2 was present during the conversation. V37 stated when residents readmit from the hospital staff try and get their weights the same day or next day, then weekly weights order is put in place for four weeks to check if there will be any decrease or increase in weight. When asked did V44(Restorative Aide) informed her how much R150 currently weighed, she stated no. V37 then called and received the weight of 160.6 pounds for R150 and then stated she has not had a chance to look at the hospital

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records yet, so she was not aware what her weight was from hospital. When asked what day of the month weights should be in system, V37 stated they are put in by 5th of each month. R150 was weighed by a floor aide on scale 4/3/25 weight is 125 pounds per V37.

On 4/8/2025 at 4:46 pm, V2(Director of Nursing) when asked was it a concern that R150 gained 35.6 from 3/4 to now 160.6 V2 stated yes that is a concern for her and stated they must be inputting the weights incorrectly, and it is also a concern for me that staff was not giving R150 her meal tray.

On 4/8/25 at 5:06 pm, V47 (Medical Nurse Practitioner) when asked If a resident doesn't receive a meal what could potentially happen, V47 stated weight loss could occur. When asked what your expectation is when you sign the physicians order summary for a resident's diet order, V47 stated she expects the resident to receive their meals as ordered. When asked were you made aware that R150 has not been receiving her trays and no alternatives were being offered to her, V47 stated she spoke to R150 on yesterday 4/7/25 about her meal intake but, she was only notified that when she came back from hospital on that night 3/20/25 she refused her tray. V47 stated she expects staff to offer the residents their meal trays.

On 4/9/25 at 12:37pm, V36 (Dietician) stated she was never made aware that R150 was triggering for weight concerns, she stated the facility nursing team meets with her monthly and she rounds weekly and that she makes her assessments off weights that are recorded in chart unless she is notified there is a discrepancy. V36 stated she was informed by the facility on

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yesterday 4/8/25 that R150's weight was 160.6 and that the scale may be malfunctioning. When asked was there a concern with the weight increase in less than a month for R150 would that be concerning, V36 stated yes, because I reviewed her hospitalization records and did not see and that there was anything that supported the increase even though she was started on new medications. When V36 interviewed resident today R150 informed her she is not weighed monthly or weekly, and V36 apologized to R150 because she stated she was never informed that there were concerns that she needed to address about her weights or diet refusals. When asked if the goal is to increase weight gain how should that be done, V36 stated staff should be offering the resident's their meal trays and alternatives when needed. V36 stated that R150 informed her that she doesn't want to be mistreated and prefers to have her meals in her room. V36 stated she wrote a new order to ensure that her meals be delivered to her room per R150's choice and that she would be doing rounds on her more frequently she is aware of the concerns.

On 4/8/25 at 12:00 pm, V1 (Administrator) emailed an electronic copy of Job Descriptions for Certified Nursing Assistant and Staff Nurse.
Titled: Certified Nursing Assistant dated 03/2023
Reports to: Staff Nurse
Job Summary: Provides residents with daily nursing care in accordance with current federal, state, and local standards, guideline and regulations, facility polices and as may be directed by the Charge Nurse, Supervisor, Assistant director of Nursing, Director of Nursing.
Essential Functions: Records resident food/fluid intake. Completes meal monitor form as indicated. Reports changes in residents eating habits to staff nurse. Keeps residents water

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pitchers clean and filled with fresh water on each shift unless contraindicated. Serves meals to residents.

Titled: Staff Nurse (Registered Nurse/ License Practical Nurse) dated 1/2025
Reports to: Director of Nursing
Job Summary: Responsible to provide direct nursing care to the customer, and to supervise the day -to-day nursing activities performed by the nursing assistants. Make daily rounds to ensure nursing personnel are performing required duties, and to ensure appropriate procedures are being followed. Contact the resident's physician with anything pertinent to the resident's care and wellbeing.

On 4/8/2025 at 1:00 pm, V9 (Dietary Manager) presented a Policy: Titled Serving Food dated 8/18.
Policy: Food will be prepared and served in a manner that meets the individual need of the resident.
Procedure: Residents preferring to eat in their rooms will receive hot food that is palatable;2. Nursing staff will be responsible for delivering the room trays;3. Nursing staff will collect trays after residents eating in their rooms have finished; There will be adequate number of dishes, silverware of satisfactory type to serve all the residents in facility each meal.

On 4/8/25 at 3:00 pm, V1 (Administrator) emailed an electronic copy of Residents Rights for People in Long-term Care facilities.
Policy: Titled Illinois Long- term Care Ombudsman Program dated 4/24
States in part; resident has to safety and good care. Resident's facility must provide services to keep their physical, and mental health, and sense

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009856	A. BUILDING: _____ B. WING _____	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WENTWORTH REHAB & HCC	201 WEST 69TH STREET CHICAGO, IL 60621

(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
S9999	Continued From page 13 of satisfaction. Resident's must not be abused by anyone- physically, verbally, mentally, financially, or sexually. (B)	S9999		