STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000456	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ELGIN LIVING & REHAB CENTER	746 WEST SPRING STREET , SOUTH ELGIN, Illinois, 60177

(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) COMPLETION DATE
S0000	Initial Comments Incident Report Investigation to Incident of June 15, 2025 / IL195431	S0000		
S9999	Final Observations Statement of Licensure Findings 300.610a) 300.3210t) 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 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 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to prevent resident-to-resident physical abuse. This applies to 2 of 3 residents (R1, R2) reviewed for abuse in the sample of 3. This failure resulted in R2 striking R1 on the nose, resulting in R1 being transferred to the hospital and found to have a fractured nose. Findings include:	S9999		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 R1's Face Sheet shows R1 admitted to the facility on 6/9/2025 with diagnoses including paranoid schizophrenia, mild intellectual disability, and bipolar disorder. R2's Face Sheet shows R2 admitted to the facility on 3/19/2012 with diagnoses including diabetes, seizures, and depression. The facility's 6/19/25 Final Incident Investigation Report shows an incident between R1 and R2 occurred on 6/15/2025 (Sunday) at approximately 5:15 PM. The report showed, the R1 and R2 were roommates and "resident-to-resident contact was reported." The report shows R1 and R2 had a disagreement over the thermostat in the room and that R2 struck R1 on the bridge of his nose, which resulted in R1 receiving a broken nose (closed fracture). The 6/15/25 Reporting Officer Police narrative shows R1 and R2 were arguing about the climate control of their room. The report shows R2 admitted to striking R1, with a closed fist, on the bridge of R1's nose. The facility's investigation shows a statement from R2 dated 6/16/2025. The statement shows, "My roommate (R1) turned the air conditioner up to 83 degrees. I told him to turn it down and he said no, so (R2) punched (R1). (R1) pushed (R2) into the dresser ..." The facility's investigation showed a statement from R1 dated 6/16/2025. The statement showed, "My roommate (R2) got mad because (R1) wanted the air in the room warmer. (R1) tried to walk out of the room, then (R2) punched me. I don't remember what happened after that. I feel safe in the facility. (R1) don't want to be (R2's) roommate anymore." R1's 6/15/2025 hospital records showed he sustained a broken nose. On 7/2/25 at 10:47 AM, V4 Certified Nursing Assistant (CNA) stated she was working on 6/15/25. V4 said, at approximately 5:20 PM on 6/15/2025, another CNA and she responded to a door that was slammed shut. V4 said as	S9999		

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S9999	Continued from page 2 they walked down the hallway, they witnessed R1 in the hallway with blood on his nose. V4 said they opened the door to R1 and R2's room and observed R2 on one knee in the room. V4 said R2 reported that R1 had "punched" him. V4 said R1 was outside the room, heard this statement from R2 and R2 responded, "I punched you because you punched me." V4 said the argument was over climate controls in the room. V4 said the only cause of R1's broken nose was due to being hit in the face by R2. V4 said R1 had not fallen. On 7/2/25 at 11:28 AM, V7 Nurse Practitioner stated he knows R2 well; however, he was less familiar with R1. V7 said he was not aware of any reason R2 should not have a roommate. V7 said the only possible cause of R1's broken nose was from R2 punching R1 in the face. The facility's abuse prevention policy (dated 10/24/2022) showed that the facility affirms the right of our residents to be free from abuse. The policy defines abuse as "physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury... 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 ..." (B)	S9999		