STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0035782	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINSTON MANOR CNV & NURSING	2155 WEST PIERCE , CHICAGO, Illinois, 60622

(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 Complaint Investigations: 2587255/2586297	S0000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.690a) 300.690b) 300.690c) 300.1210b) 300.1210d)6) 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 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident.	S9999		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0035782	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/25/2025

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S9999	Continued from page 1 b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. 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. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These Regulations are not met as evidenced by: Based upon interviews and record review the facility failed to conduct head counts (every two hours); failed to provide supervision for one resident, failed to report that one newly admitted (R7) eloped from the facility, failed to follow Doctor’s pass order for one resident (R5); failed to report that two residents (R5 and R6) left the facility unauthorized and did not	S9999		

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S9999	Continued from page 2 return to the facility, and failed to implement the elopement and pass policies for three residents in a sample of 15 (R5, R6 and R7) . These failures have the potential to affect 123 residents that reside in the facility. Findings include: R7 is a 33-year-old with diagnoses including but not limited to: Suicidal Ideations, Major Depressive disorder, Bipolar disorder and Generalized Anxiety disorder, tachycardia, and insomnia. R7's Admission Record documents an admission date of 8/11/25. On 8/11/2025 during 2:00pm smoke break R7 (newly admitted resident) eloped from the facility and has not returned as of 8/20/2025. On 8/12/2025 at 11:15 am, V1 (Administrator) stated the following, "R5 left the facility alone on yesterday (8/11/2025) at 1:30 pm and has not returned to the facility. R7 eloped during a smoke break on yesterday (8/11/2025). R6 left out on pass on 8/9/2025 and has not returned yet. I have been in contact with the police department and there is no new information regarding their whereabouts." On 8/12/25 at 12:21pm, V2 Director of Nursing (DON) stated that a Physician's order is needed for any resident to leave the facility and that if a resident does not return by 4:00 pm, Administration should be notified immediately for further instructions to be carried out. On 8/13/25 at 12:23pm V1 stated that he had been in contact with the police department and that there was no information regarding the whereabouts of R5 and R6. At that time V1 also stated that he was not aware that he had to report missing residents to IDPH. Front Door List dated 8/12/2025 documents: pass privileges for R1 with Supervision; pass privileges for R5 with Supervision; pass privileges for R6 without Supervision; no pass privileges documentation was located for R7. On 8/13/25 at 3:37 pm, V6 (Smoking Monitor) stated the following, "On Tuesday (8/11/25) during the 2:00 pm smoke break, a new resident (R7) was outside smoking and began walking off. Another smoking monitor was following him (R7) and he crossed the street. I came in the building and announced a code 99 (elopement code)	S9999		

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S9999	Continued from page 3 because he (R7) was away from the smoking area. At that time, staff members ran out to try and get him but couldn't find him. I have not seen him since." On 8/13/25 at 4:30 pm, V12 (Social Service Director) stated the following, "R7 had just been admitted to the facility. Usually, a smoking and elopement assessment is done within 24 hours of admission. In certain cases, I will allow the resident to smoke with supervision prior to the assessments (smoking and elopement). Residents who are elopement risks and new admits are scheduled a specific time to smoke (apart from the other smokers) to have special supervision. I had allowed R7 to smoke with the regular smokers and smoking monitor because he was agitated and stated that he had not smoked in days." On 8/18/25 at 4:55 pm, V26 (Medical Doctor) stated the following, "When a patient is admitted to the facility, the patient should have an evaluation prior to being allowed to go out and smoke or to go out on pass. If no evaluation is done, there is a great risk taken when a resident is allowed out of the facility because we don't know that patient. If a patient elopes, especially a psych patient, we don't know what can happen because they are mentally unstable." Employee statement written by V6 (Smoking Monitor) on 8/11/25 documents, V27 (Smoking monitor) had lit R7's cigarette and sat down. I (V6) was bringing the wheelchair (residents) up (the ramp back into the facility) and as I was focusing on that, R7 started to get up and walking away from the smoking area. V27was following him and asking where he (R7) was going. The moment R7 passed the curb of the sidewalk. I had went up the ramp and yelled out to the receptionist to announce a code 99 over the intercom. A code 99 stands for a resident who is fleeing or running away. On 8/20/25 at 11:30 am, V1 (Administrator) stated that R7 had not returned to the facility. R7's Medical Chart excludes an elopement assessment, elopement care plan, smoking assessment/ agreement or smoking care plan. Facility Census report dated 8/11/25 excludes R7 as an active resident. R6 is 46-year-old with diagnoses including but not limited to: Suicidal Ideations, acute embolism thrombosis of unspecified deep veins of bilateral lower extremity, Gastroesophageal reflux disease, major depressive disorder, bipolar disorder and	S9999		

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S9999	Continued from page 4 schizoaffective disorder. On 8/9/2025 at 9:00 am, R6 left the facility unauthorized and did not return to the facility until 8/16/2025. R6 signed out on Resident's sign out sheet dated 8/9/2025 at 9:00 am but never signed back in to the facility on the document. During investigation on 8/12/25 at 2:00 pm, V4 (LPN/ Licensed Practice Nurse) stated the following, "when R6 went out on pass on 8/9/25 I gave him a pass. R6 came to the nursing station and said that he was leaving the facility and coming back at 4:00 pm. Once he takes the pass to the front desk, he is supposed to sign out and back in by 4:00 pm. My shift ended at 3:30 PM. When I was leaving that day (on 8/9/25), I (V4) informed V5 (LPN) that R6 had not returned yet since V5 was R6's night nurse. When I came in the next day (on 8/10/25), I also notified management once I realized that R6 still had not returned to the facility. I am not sure if management was notified prior to my notification." On 8/12/25 at 12:48 pm, V2 (Director of Nursing/ DON) stated the following, "We (facility staff) are responsible for the residents, and it is important to recognize early if a resident is missing so that the resident can be searched for and reported to the police. Most residents take medication and have medical conditions and psychiatric issues. We want to make sure that they are safe. I am mainly concerned with their safety and them committing suicide. The receptionist is contacted between 4:30pm and 5:00 pm by the assigned nurse if a patient has not returned on a unit. At that point, the receptionist can verify whether or not the resident has signed back into the facility. If the patient has not signed back in, I (V2) or V1 (Administrator) are notified and a head count is done. V5 texted me at 8:18 pm (on 8/9/25) and notified me that R6 was missing. Everyone (staff) on each floor check for the missing resident. We notify the family in case the family may know where the resident may be, we call nearby hospitals, and the physician is also notified at that time. It is imperative that we are notified of a missing resident as soon as possible. If a resident does not sign back in by curfew at 4:00 pm, management should be notified." On 8/13/25 at 3:00 pm, V7 (Receptionist) stated the following, "I work 7:30 am- 3 pm. V10 (Receptionist) works from 3:00 pm – 11 pm. Any residents that come in and out has to sign in and out. The residents' curfew is 4:00 pm and the times that they stay out of the	S9999		

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S9999	Continued from page 5 facility overnight is prearranged by family or friends. The family or a friend will have to sign the resident out and it will be documented in the system that the resident is out overnight and for a certain period. If a resident is not in the facility by 4:30 PM, the receptionist informs the nurse and also the social worker." On 8/13/25 at 3:45 pm, V10 (Receptionist) stated that if a resident is not back by 4:00 pm, that she notifies the nurse on duty at 4:00 pm so that the nurse can initiate the notification process. On 8/20/2025 at 2:35 pm, V5 (LPN) stated the following, "Normally the curfew is 4:00 pm. If I don't see a resident after dinner at 4:30 pm, I am alarmed to look for the resident. During dinner, we are supposed to do head counts and the CNAs (Certified Nurse Assistants) do head counts every two hours. The CNAs have a piece of paper (roster) with resident's names (per floor) and they (CNAs) check off the residents' names. I realized that R6 was missing at 6:30 or 7 pm (on 8/9/25). I thought that his pass was extended or something, so I didn't worry too much about R6. I notified management around 8:30 pm but I don't know if I documented it or not. It is important to notify management immediately so that they can start the investigation process early to see if they (the residents) are hurt or in the hospital. Management should be notified immediately." On 8/18/25 at 4:55 pm, V26 (Medical Doctor) stated the following, "mentally unstable residents are at risk for danger and their safety should be a priority. Routine head counts are important to recognize if a patient is not present in the facility." On 8/20/25 at 3:30 pm, V1 stated that he could not locate the resident rounding checklist (roster) for the third floor (R6's floor) for 8/9/25. R6s' Nurse's Note dated 8/10/2025 at 12:27 pm and authored by V4 (LPN) documents, writer called 911 of missing person since yesterday. R6 did not return to the facility by 4:00 pm. R6s' Nurse's Note dated 8/10/2025 at 10:34 pm documents, R6 has not returned back to the facility. Facility's Resident Sign-out Sheet dated 8/9/2025 documents exclude R6's signature. R6's Nursing Progress notes excludes any documentation on 8/9/25 of R6 signing out of the facility.	S9999		

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S9999	Continued from page 6 Missing Persons Police Report dated 8/9/2025 documents R6 missing as of 8/9/2025 at 9:00 am. R6's nursing progress note dated 8/10/2025 at 11:07 am documented by V4 (Licensed practical nurse): Resident is out on pass. On 8/20/2025 at 3:30 pm, V1 stated that R6 returned to the facility on 8/17/25 (eight days later). R5 is a 63-year-old with diagnosis including but not limited to: Schizoaffective disorder, schizophrenia, essential hypertension and chronic obstructive pulmonary disorder. On 8/11/2025 at 1:30pm, R5 left the facility without physician order and has not returned to the facility as of 8/20/25. R5 signed out on Resident's sign out sheet dated 8/11/25 at 1:30pm but never signed back in to the facility on the document. R5's nursing progress note dated 8/11/2025 at 22:19 pm documented by V5 (Licensed practical nurse): Resident left on pass and failed to return. During investigation on 8/12/25 at 11:15 am, V1 (Administrator) stated the following, "R5 left the facility alone on 8/11/25 at 9:00 am and has not returned to the facility. I have been in contact with the police department and there is no new information regarding R5's whereabouts. I was notified at 9:15 pm (on 8/11/25) that R5 was missing. " On 8/12/2025 at 12:48 pm, V2 (DON) stated that all residents required a doctor's order to leave the facility independently and that she (V2) was not aware that R5 did not have a doctor's order for independent pass privileges. At that time, V2 also stated that she was new in her role and was not totally sure of whose responsibility it was to update pass orders. On 8/13/2025 at 3:00 pm, V7 (Receptionist) stated the following, "R5's pass privileges are posted on the pass list at the front desk. His pass privileges are with supervision meaning that he may not leave the facility without supervision. He signed out on 8/11/25 without supervision." On 8/13/2025 at 4:30 pm, V12 (Social Service Director) stated the following, "I update the pass list for the	S9999		

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S9999	Continued from page 7 front desk according each residents current doctor's orders. I was not aware that R5 did not have a doctor's order to go out on pass. Any nurse in the facility has the authorization to update a resident's orders per Doctor." On 8/18/2025 at 4:55 pm, V26 (Medical Doctor) stated the following, "All patients need a doctor's order to go out on pass and In order to go out overnight, the patient's family would have to sign the patient out of the facility. If a patient does not sign back into the facility after being out, the Doctor, family and facility administrator should be notified immediately. Anything could happen to the resident in a short period. I personally know of an incident involving a resident getting hit by a train after leaving a facility unauthorized." On 8/20/2025 at 2:50 pm V11 (Registered Nurse/ RN) stated the following, "We (nurses) usually give the resident the pass to leave. I gave R5 a pass on the day that he left (8/9/25). I was not aware that R6 did not have a physician's order to leave the facility. Before we (nurses) were not checking the pass privileges before resident leaves but now we do. When a resident goes out on pass, they have be back at the facility by 4:00 pm. There is a two-hour rounding documented by the CNAs. If a resident is not here by 4:00 pm, we must notify the DON (Director of Nursing) immediately and investigate." On 8/20/25 at 3:30 pm, V1 stated that he could not locate the resident rounding checklist (roster) for the third floor (R5's floor) for 8/11/25. R5's Nurse's Note dated 8/11/25 at 10:19 pm documents, R5 left on pass and failed to return. R5 Physician Order sheet documents the following active order as of 7/22/25, may not go out on pass. Facility Front Door List dated 8/12/25 documents R5's pass privileges as 'with supervision'. Facility's Resident Sign-out Sheet dated 811/25 documents, R5 signed out of the facility at 1:30 pm. Missing Persons Police Report dated 8/12/25 documents R5 missing as of 8/11/2025 at 1:30 pm. On 8/21/25, IDPH (Illinois Department of Public Health) was notified of R7's 8/11/25 elopement and R5's unauthorized leave on 8/11/25 (10 days after incidents occurred).	S9999		

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S9999	Continued from page 8 On 8/21/25, IDPH (Illinois Department of Public Health) was notified of R6's unauthorized leave on 8/9/25 (12 days after occurrence). Reviewed reportable binder for the month of August 2025, no reportable for missing persons was completed for R5, R6 or R7. Facility's undated policy titled "Accidents and Incidents-Investigating and Reporting" documents in part: All accidents or incidents involving residents, employees,visitors,vendors,etc.,occurring on our premises shall be investigated and reported to the administrator; Policy Interpretation and Implementation:2.(a)The date and time the accident or incident took place;(b) The nature of the injury/illness;(g) The time the injured person's physician was notified, as well as the time the physician responded and his or her instructions;(h)The date/time the injured person's family was notified and by whom;(n)The signature and title of the person completing the report;(4)The nurse supervisor/charge nurse and/or the department director or supervisor shall complete a Incident report and submit the original to the director of nursing services within 24 hours of the incident or accident. Facility Policy titled Wandering and Elopements documents, the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents; if identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. Facility Smoking policy documents, the resident will be evaluated on admission to determine his/ her ability to smoke safely with or without supervision (per a completed smoking evaluation); The staff shall consult with the attending physician and the director of nursing services to determine if safety restrictions need to be placed on a resident's smoking privileges based on the smoking evaluation. Facility Outside Pass Policy documents, residents may not be considered for community outside pass privileges without physician order. Facility policy titled Missing Resident documents, at the beginning of each shift, during med pass, and each meal the staff shall account for all at-risk residents under their perspective care.	S9999		

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S9999	Continued from page 9 Facility Census dated 8/12/2025 documents a total of 123 active residents. (A)	S9999		