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 12/31/2025

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

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S0000	Initial Comments Complaint Investigation: 25812827/2703247	S0000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.3240b) 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 300.1210 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	S9999		

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

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S9999	Continued from page 1 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. Section 300.3240 Abuse and Neglect b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act) Based on interview and record review the facility failed to prevent resident to resident verbal and physical abuse for one [R1] out of three residents reviewed for abuse. This resulted in R1 sustaining physical pain and mental anguish. Findings Include: R1's clinical record indicates the following in part: R1's medical diagnoses of post -traumatic stress disorder, chronic obstructive pulmonary disease, anxiety disorder, schizoaffective disorder, and overactive bladder. R2's clinical record indicates the following in part: Medical diagnoses: Schizoaffective disorder and major depressive disorder. R2's progress notes in part: V6 [Licensed Practical Nurse] note: 12/26/2025 3:46 AM Note Text: This writer heard loud yelling in R2's room around 1:45 AM. R2 noted to be verbally aggressive with her roommate [R1]. R2 pulling back her roommate privacy curtains, playing loud music on her phone and putting on bright lights. R2 noted to be highly agitated. This remains to be a threat to staff and other residents. resident sent for psych eval. R2's Petition for Involuntary Judicial Admission: 12/26/25 at 2:18 AM R2 is verbally and physically agitated with other resident [R1] R2 remains a threat to staff and other	S9999		

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S9999	Continued from page 2 residents. R2's Care plan in part: On 11/13/25, 11/26/25, 12/1/25, 12/2/25, and 12/26/25 R2 was sent to the hospital for psych evaluation due to behaviors. On 12/30/25 at 11:40 AM, R1 stated, "On Christmas night, I was sleeping when my roommate [R2] hit me all in my back, everywhere on my body. Then R2 started throwing items at me, and some of the items hit me on my arm. R2 was cursing at me and yelling, she called me names I never been called before. I finally was able to get out of bed, and then I was yelling and screaming for help. I got out of bed and grabbed my walking cane to help me walk so I could get out of the room. R2 then tried to grab my cane out of my hands as she was pushing the cane towards my face trying to hit me with my own cane. I was holding on to my cane for my life. I knew if R2 got my cane she was going to bust my head open. I was so afraid, upset and in pain, my body was hurting. It took three staff members to pull R2 off me. My body was hurting all over very sore for a week. I do not know why she jumped on my like she did. I was crying every night, afraid to sleep. I felt so bad about myself and embarrassed, because I did not do anything to R2." On 12/31/25 at 12:00PM V7 [Certified Nurse Assistant] stated, "I worked on 12/25/25 night shift. I saw R1 and R2 arguing. I went into the room. I told them to stop arguing. That was it, I did not report the arguing. I don't know nothing else. I received abuse training a while ago, the abuse coordinator is the administrator. R1 and R2 was just nip picking each other, no cursing it was not verbal abuse." On 12/30/25 at 2:00 PM V5 [Agency-Certified Nurse Assistant] stated, "I worked on 12/25/25 night shift rolling over to 12/26/25. I heard yelling from R1's room. I saw R2 hitting R1. It took V6 [Licensed Practical Nurse], V7 [Certified Nurse Assistant] and myself to pull R2 off R1. Once we separated R2 from R1, R2 kept charging at R1 and all of us then started throwing items at us. R2 broke loose from V6 and R2 started hitting R1 again. We separated them and removed R1 from the room. During the attack, R2 was throwing a jar of petroleum jelly, lotion, deodorant like personal items. The items were hitting all of us. R1 called the police and told them R2 attacked her, which was the truth. R2 was sent out to the hospital." Surveyor read V5 her written witness statement:	S9999		

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S9999	Continued from page 3 [Read: To whom it may concern; I V5, heard arguing coming from resident room. I [V5] and other staff immediately went to see what happened. Residents [R1, R2] were having a verbal disagreement, staff separated residents to calm them down.] V5 stated, “I never wrote or gave any one my statement. That statement is not the truth. No one asked me what happened or what I witness.” On 12/30/25 at 3:30 PM, V2 [Director of Nursing] stated, “On 12/26/25 early morning I received a phone call from V6 [Licensed Practical Nurse], told me R1 and R2 had a verbal argument and R2 was throwing items in the room. R2 refused to take medication to help calm her down, so R2 was petitioned out to the hospital. Later that day 12/26/25 I spoke to R1, and she did not tell me R2 hit her or any of the items that was thrown around hit her. I did not ask R1 if she was hit by R2 or any items hit R1. R2 was transferred back to the facility after the emergency room visit. R2 was moved to another room.” On 12/30/25 at 4:00 PM, V1 [Administrator] stated, “The incident occurred on 12/26/25. I was made aware R1 and R2 had an argument on 12/26/25. R2 was still agitated after the incident, offered medication to help calm down R2, but she refused the medication. R2 psychiatrist gave an order to send R2 to the hospital for psych evaluation. R2 was petition to the hospital. I was notified R1 phoned 911. I did not know what she told the police. I do not know why R1 phoned 911. I do not have a copy of the police report. I spoke with R1 on 12/26/25, R1 did not tell me she was struck by R2. I was not aware of the severity of the argument until 12/29/25 during morning meeting. I learn the argument was serious and I tried to report to IDPH. R2 returned back to the facility on 12/26/25 and was moved into a different room.” Policy document in part: Abuse Policy [9/2025] All reports of resident abuse are reported to local, state, and federal agencies and thoroughly investigated by facility management. Findings of all investigation are documented and reported. Resident abuse is suspected, the suspicion must be reported immediately to the administrator and other officials.	S9999		

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S9999	Continued from page 4 Immediately defined as within two hours of an allegation involving abuse Abuse, is defined at §483.5 as the willful infliction of injury, unreasonable confinement, intimidation, 483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. or punishment with resulting physical harm, pain or Resident Rights: All residents have the right to be free from abuse. (B)	S9999		