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	IL6002273	A. BUILDING: _____ B. WING _____	C 09/29/2020

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CRESTWOOD TERRACE	13301 SOUTH CENTRAL AVENUE CRESTWOOD, IL 60445

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S9999	Final Observations Statement of Licensure Violations: 1 of 2 Violations: 2097308/ IL126820 2097604 / IL127153 Facility Reported Incident Investigation FRI of 08/24/20/ IL126346 300.610a) 300.1210b) 300.1210d)6) 300.3240a) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. Restorative measures shall include, at a minimum, the following procedures: 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) This Requirement is not met as evidenced by:	S9999		

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S9999	Continued From page 2 Based on interview and record review, the facility failed to follow their abuse policy by not preventing the physical assault of one of four residents (R1) reviewed for physical abuse. This failure resulted in R1 being physically assaulted by R2. R1 was transferred to the local hospital and treated for pneumothorax, (5) broken ribs, and 6 staples to the right side of R1's head. Findings include: R1 was admitted to the facility on 12/9/2015 with diagnosis of major depressive disorder, bipolar and diabetes. R2 was admitted to the facility on 1/27/20 with diagnosis of schizophrenia. Facility final investigation dated 9/25/20 documents a resident to resident altercation on 9/17/20 at 1200am in dining room. R1 reported she was pushed by R2. R1 sustained a cut to back of her head and sent to local hospital. R2 was taken by local police. Based on the investigation conducted review of medical records and interview of staff and residents involved, it can be concluded that R2 pushed R1. R1 fell as a result of the push. It can be concluded that R2 did not have any willful intent of causing harm or physical abuse to R1. R2 appeared to be exhibiting behaviors related to his diagnosis. V12 (CNA) statement documents she saw R2 go straight to R1 in the dining room and started beating her and pushed her on the floor and hit her head on the floor then there was blood all over the floor. V5 (social service aide/security) statement documents R1 was on the floor and said R2 pushed her. R2 was coming out of (A) wing and said he didn't know what happened.	S9999		

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S9999	Continued From page 3 Then he came back and kicked R1 and he kept kicking and punching R1. V8 (nurse) statement documents R1 was attacked, beaten and pushed down by another pacing /agitated Resident. R1 sustained an injury to back of her head and blood was noted gushing out from injured area. R1's care plan dated 1/13/07 documents R1 is at risk for abuse and neglect based on comprehensive assessment. R1 has behavior or using racial slurs, verbally aggressive, making demeaning and offensive comments. Interventions in place initiated 1/13/07 are as followed assure R1 that she is in safe and secure environment with caring professionals. Explain psychosocial adjustment is often facilitated by developing a trusting relationship with another person and verbalizing thoughts, needs and feeling. Counsel R1 on the importance of appropriate behaviors and encourage to utilize appropriate coping techniques; establish guidelines regarding visiting if persons interested in visiting have a history of inappropriate and maladaptive behavior towards R1. Provide supervision during visits, as necessary. Local police incident report dated 9/17/20 documents call related to a battery complaint. R2 said he kicked R1. R2 related he did not know R1 and R1 did nothing to upset him. R2 was detained. V12 (CNA) reported she was in the C wing when she heard a man screaming. V12 said she exited the room and observed R2 running and screaming down the hallway. V12 said she followed behind R2 and observed him enter the dayroom at which time he ran up to R1 pushed her to the ground and began kicking and punching her while she was on the ground. V5 (social service aide/security) said he entered the day room and observed R2 kicking R1. V5 was	S9999		

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able to get R2 to walk away from R1 and then R2 spun away from him and ran back to R1 and began kicking R1 again. Unable to speak to R1 due to hysterical condition.

On 9/25/20 at 9:47AM, R1 said she was going to get something from vending machine that night and said that R2 just attacked her. R1 said R2 threw her to the ground and she had to get stitches to back of her head, five or six broken ribs and one punctured her lungs. R1 reports being in pain a lot. R1 said she was scared and afraid of getting hit again. R1 said she was afraid for her life if she went back to nursing home.

R1's local hospital records dated 9/17/20 document R1 from local nursing home after being pushed by another resident. R1 fell and hit her head and has laceration to the back of her head. Laceration length of 3 cm with depth of 6mm that required 6 staples. CT of chest on 9/17/20 documents acute fractures involving the right third rib, right posterolateral fourth, fifth and sixth rib. Acute right posterior tenth and eleventh rib fracture. Right sided pneumothorax.

Facility abuse prevention program policy dated 2/7/2017 documents, "the facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. Abuse means any physical or mental injury inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury. The term "willful" in the definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Physical abuse is the infliction of injury on a

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S9999	Continued From page 5 resident that occurs other than by accidental means and that requires medical attention. Physical abuse includes hitting, slapping, pinching, kicking and controlling behaviors. (A) 2 of 2 Violations: 300.1210a) 300.1210b) 300.1210d)6) 300.1220b)3) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)	S9999		

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S9999	Continued From page 6 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. Restorative measures shall include, at a minimum, the following procedures: 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs	S9999		

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S9999	Continued From page 7 and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) This Requirement is not met as evidenced by: Based on interview and record review the facility failed to prevent or reduce the risk of fire setting for a resident with known history of setting fire for 1 of 3 residents (R3) reviewed for supervision. This failure resulted in R3 setting a pile of clothing in R3's room on fire. Based on interview and record review the facility failed to develop a plan to prevent a resident with history of poly substance abuse from obtaining unknown prescription medication from outside of the facility. This failure affected 1 of 3 residents (R5) reviewed for supervison.	S9999		

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S9999	Continued From page 8 Findings include: R3 was admitted to facility on 6/3/2020 with a diagnosis of schizophrenia and bipolar disorder. R3's Preadmission screening and Resident review Passar dated 6/15/20 documents under behavior type fire setting and arson; behavior level- high; 6/2019 burned bible under a porch. R3's Pre admission paperwork dated 5/28/20 documents, "In regards to one to one constant supervision: patient stated I don't need anyone to watch me all day. If I am about to hurt myself or anyone, I'll let the nurse know right away. Monitor patient closely every 15 minutes. Facility reportable dated 8/14/20 documents R3 was upset with co-peer because she would not let her use her phone, so she reportedly took a lighter during smoking time, then went into the room and set some clothes on fire. Resident reported that her roommate was not in the room at that time. Code initiated. Resident was placed on one to one monitoring until ambulance arrived. R3 was given an emergency discharge upon leaving the facility. On 9/25/20 at 1:15 PM, V4 (social service director) said he was not aware of R3's history with fire and there should have been a plan of care in place to ensure we are able to meet the needs and ensure they are monitored. V4 said he was not made aware of R3's PASARR was in medical record. V4 said residents rooms are searched weekly if not daily by staff. If resident has history of unsafe smoking or behaviors we would do more room searches. On 9/25/20 at 3:53Pm, V1 (administrator) said	S9999		

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S9999	Continued From page 9 she was not aware of R3's PASARR or preadmission paper work prior to admission. R3's plan of care does not document any interventions related to fire/smoking safety. R3's smoking safety risk assessment signed 6/5/20 documents a score of one indicating may be independent with smoking. Facility smoking safety policy revised 12-2018 documents, " it is against facility policy to carry a lighter. Facility is match free facility. staff are available to light cigarettes for residents during designated smoking times. R5 was admitted with the diagnosis of chronic obstructive pulmonary disease, sleep apnea, alcohol abuse, other psychoactive substance abuse and a history of respiratory failure. R5's brief interview for mental status dated 7/2/2020 document a fifteen which indicates cognitive intact. On 9/23/2020 at 1:50pm, R5 said, I went to an outside substance abuse group. My drug of choice is opioids. I asked V35 (Housekeeper) to get my medication from an outside pharmacy. I gave him my information and it was free to pick up. On 9/24/2020 at 12:21pm, V1 (Administrator) said, V34 (Activity Director) found a bag of medication in the activity room. She brought the bag to me. The medication was inside of a burger king bag. The V35 (Housekeeper) had the bag. V35 went to lunch and sat the bag down in the activity room. It was a clear bag, with a burger king bag and inside of the burger king bag were	S9999		

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prescription bags with medication inside. V1 reported that V35 said, R5 asked him to pick up the medication as a favor. V1 said, V35 said, I thought it was ok to help the resident. I went to the pharmacy, gave them the residents name, got the medication and then got my lunch. I put the medication in my food bag. V35 left the building before I could complete the investigation. V35 was terminated for failing to return to work.

On 9/24/2020 at 1:19pm, V4 (Social Service Director) said, staff was bringing R5 medication from an outside pharmacy. Staff brought the medication in the building inside a burger king bag. The facility doctors did not prescribe the medication. We did a room search and found some pills in R5's room. We discharged R5 to the hospital for a psychiatric evaluation.

On 9/24/2020 at 2:22pm, V2 (Director of Nursing) said, we do not prescribe medication to treat opioid drug addiction. We don't have a license. The nurse practitioner at an outside group prescribed R5 the medication to treat opioid addiction. R5 should have not had the script.

On 9/25/2020 at 3:03pm, V31 (Restorative Adie) said, we did a room search for R5. We found white loose pills in a bag in a sandwich bag. The bag was half full.

On 9/25/2020 at 3:30pm, V32 (Psychiatrist) said, the facility was concerned that R5 was getting a medication to treat opioid drug addiction from an outside source. R5 had a prescription from a doctor that did not work with the facility. R5 had three or four brown bags full of different medication. The medication to treat opioid drug addiction was included in those bags, it was a controlled substance. The medication was

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S9999	Continued From page 11 confiscated. On 9/28/2020 at 10:31am, V33 (Medical Doctor) said, R5 has a psychiatrist. R5 was discharged to the hospital for a drug overdose. R5 had medication that was old. I don't know where she got the medication from. I did not prescribe the medication for opioid addiction nor was I aware of it. R5's Petition for Involuntary/Judicial Admission dated 9/10/2020 documents: R5 has a lot of medication in room while a room sweep was being performed. Facility Inventory for Control Drugs date 9/11/2020 documents: R5 had one hundred and ten pills of medication for depression. (B)	S9999		