STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002273	A. BUILDING: _____ B. WING _____	C 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD TERRACE	13301 SOUTH CENTRAL AVENUE CRESTWOOD, IL 60445

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S 000	Initial Comments Complaint Investigation #2298306/IL152362	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 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 300.1210 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.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 Section 300.1210 General Requirements for Nursing and Personal Care 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 300.3210 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 regulations were not met as evidenced by: A. Based on interview and record review, the facility failed to protect a resident's right from being sexually abused by other residents and failed to have interventions in place to prevent a resident from being manipulated/coerced into having sex with other residents. R1 remains at risk for sexual assault due to an inappropriate behavior of trading sexual activities for cigarettes and/or money. This failure affected one resident (R1) who was assessed as being at risk for abuse, and who was sexually assaulted by other residents (R2 and R3). R1 was found unresponsive in a bathroom located in the male residential area of the facility. R1 was transported to the hospital where she reported the sexual assault incident to hospital staff and the police. B. Based on interview and record review, the	S9999		

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S9999	Continued From page 2	S9999		

facility failed to have an effective monitoring or supervision system in place for those resident identified as needing supervising, to alert staff when residents are engaging in appropriate sexual behavior to prevent possible sexual abuse.This failure affected three of four residents (R1, R2 and R3) reviewed for supervision. As a result, R1, R2, and R3 engaged in sexual favors for money and cigarettes, which lead to R1 being sexually assaulted by another resident (R2). Facility staff members were unable to identify when R1 entered R2's room, despite R1 being on hourly monitoring.

Findings include:

1. According to an initial abuse report dated 10/15/2022, the local police department came to the facility requesting to take the bed sheets of resident R1 and face sheets information of four residents (which included: R2, R3, R4). Initially the police officer stated that it was a confidential investigation and would not disclose why he was requesting items from the facility. A few minutes later a sergeant from the local Police Department called this writer explaining that there was an allegation of sexual assault and that the police would need the items for an investigation. Shortly after, a nurse from local community hospital called the facility informing the nurse that resident R1 made an allegation at the hospital. The facility started an investigation. Resident R2 was placed on increased monitoring.

According to the final abuse report received by the state agency on 10/24/2022 undated included but not limited to the following: the determination of investigative findings indicate that both residents stated during interview that they consented to an exchange of a sexual favor for

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S9999	Continued From page 3 cigarettes. The allegation of sexual assault is unfounded. R1 went to the room of R2 on her own free will, was not forced. When she went into the room, accepted a deal with co-resident R2. Both residents have intact cognition based on their BIMs score for cognitive evaluation. All assessments have been reviewed and care plans have been updated for both. Groups and individual counseling will be offered to both residents for support and education. 2. R1 is a 42-year-old female who have resided at the facility since March of 2022. R1's medical history includes, but not limited to schizoaffective disorder bipolar type, unspecified psychosis not due to substance or known physiological condition, drug induced subacute dyskinesia, iron deficiency anemia, major depressive disorder, and generalized anxiety disorder. During the investigation on 10/17/2022 at 11:20AM, R1 was observed in her room, awake and alert and on a one-to-one monitoring by staff who was outside her door. R1 did not want to answer any questions but told surveyor to come back after lunch and smoke break. At 2:30PM, R1 was interviewed, and she said that she went to R2's room to look for her friend (R4) who always hangs out there, R4 was not there but R2 told R1 that he will tell R4 not to give anything to R1 anymore unless she had sex with him. R2 also offered R1 some cigarettes in exchange. R1 admitted to having sex with R2 who was holding her hand down, she told him to stop and pleaded with him not to discharge inside her. R1 said it happened for a while and she did not tell the staff but reported it at the hospital. R1 asked the	S9999		

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S9999	Continued From page 4 surveyor not to tell anyone about it. Police report dated 10/15/2022 states in part: R1 was forced by R2 to have sex, R1 told him to stop but he did not, he held her down, made her perform oral sex on him and penetrated her for 10 to 15 minutes. R1's Minimum Data Set (MDS) assessment dated 6/6/2022, section C (Cognitive) coded R1 with a BIMS score of 15. The same assessment section G coded R1 as requiring staff supervision for all ADLs including locomotion on and off unit. MDS assessment dated 10/9/2022 section C1000 (Cognitive skills for daily decision making) coded R1 as 2, indicating moderately impaired, decisions poor, cues/supervision required. Hospital record dated 10/24/2022 stated the chief complaint as hyperventilation and sexual assault of adult. R1 was also listed as one of the residents to be monitored hourly by the C.N.As and the PRSAs/security. Care plan initiated 3/05/2022 states that resident is at risk for abuse and neglect based on the comprehensive assessment as evidenced by a diagnosis of dementia or mental illness, history/current behavior of physical abuse or threatening physical aggression towards others. Goals include Resident will be treated with respect, dignity and free from mistreatment while residing in the facility. Resident will remain safe and will be free of abuse/neglect through next review. Care plan initiated 3/05/2022 states that R1 is at risk for abuse and neglect based on the comprehensive assessment as evidenced by a diagnosis of dementia or mental illness, history/current behavior of physical abuse or threatening physical aggression towards others. Goals include Resident will be treated with	S9999		

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S9999	Continued From page 5 respect, dignity and free from mistreatment while residing in the facility. Resident will remain safe and will be free of abuse/neglect through next review. The resident will identify and practice coping strategies that will prevent mistreatment from peers through the next review. Interventions include the following: Assure the resident that he/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, provide supervision during visits, as necessary, etc. R1 was also listed as one of the residents to be monitored hourly by the C.N.As and the PRSAs/security. R2 is a 55-year-old male who has resided at the facility since 1/23/2022, with past medical history including, but not limited to schizoaffective disorder, major depressive disorder, psychotic disorder with delusions due to known physiological condition, cocaine abuse, pain in the right foot, etc. R2's MDS assessment dated 8/9/2022 section C (cognitive status) coded R2 with a BIMs score of 15, section G of the same assessment coded R2 as requiring supervision for all ADLs, including bed mobility and ambulation on and off unit. 10/17/2022 at 11:35AM, R2 was interviewed, and he said that R1 came into his room and wanted to have sex, he asked her if she want to do something in exchange for a cigarette and she said yes, they had sex and he gave her some cigarettes, this is not the first time, last time he gave her $3.00 in exchange for sex. Surveyor asked R2 if he used any type of protection and he said no. R2 added that R1 also had sex with R3 who was sharing a room with R2.	S9999		

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S9999	Continued From page 6 R3 is a 69-year-old-male who have resided at the facility since 8/12/2021, with the following past medical history: Paranoid schizophrenia, bipolar disorder current episode hypomanic, major depressive disorder, unspecified psychosis not due to a substance or known physiological condition, other psychoactive substance abuse uncomplicated, tremor, etc. R3 MDS assessment dated 8/09/2022 scored R3 with a BIMs score of 15, section G (Functional status) coded R3 as requiring supervision for ass ADLs, including locomotion on and off unit. Care plan dated 5/16/2022 states: R3 has demonstrated deficiency in grooming and basic self-maintenance skills due to the following: Cognitive deficit Lack of hygiene awareness. 10/17/2022 at 11:40AM, R3 said that he is familiar with R1 and admitted to having sex with R1 before she had sex with R2. R3 said that this is not the first time, he has had sex with R1 before and he gave her $5.00, this time he did not give her anything. 3. 10/17/2022 at 2:50PM, V5 (C.N.A) said that she worked morning shift on the E wing and was the one who found R1 in a bathroom in the male section of the facility, she called the nurse who came and assessed resident, she was then sent to the hospital for evaluation. V5 said that she did not see R1 entering any room in the E wing, she went on a break and after that she was in the dining room charting, she then went to make round after charting that's when she found R1 unresponsive. V5 said that no one covers or monitors the hallway when the assigned staff take a break, she did not check the rooms after lunch	S9999		

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S9999	Continued From page 7 so she cannot say how long the resident has been in the male section. R1's nurse's progress note dated 10/15/2022 at 15:00 states: Resident noted on the floor in room #E7 bathroom floor hyperventilating with her tongue sticking out and not responsive to verbal stimuli at this time. Vital signs done, B/P 138/88, P 115, Room air saturation 99%, resident remain warm to touch and dry. Dr called and informed of resident's change in condition. Respond with order to monitor 1:1 and if condition worsen transfer out as needed. order noted and carried out. All necessary administrative personnel notified. 10/15/2022 at 15:15, nurse's progress note reads: Upon continued monitoring, resident's condition noted to be deteriorating, resident's pulse continued to elevate at an alarming rate. 911 called and resident was transferred out of the facility via stretcher with 911 crew members. Dr notified, ADON and administrator notified. 10/2/2022 at 19:48, nurse's progress notes states: Resident was found in the bathroom breathing heavily and not responding. Resident was noted with change in status. Resident was assisted to a nearby chair where the vitals were taken. Vital sign was BP 159/116. pulse 137. Dr was contacted and 911 emergency assistance were contacted. Resident was also found smoking in another resident's room on 10/5/2022 as documented in social service note and care plan. 2. 10/17/2022 at 3:11PM, V3 (PRSD) said that he works with 3 PRSC and three PRSA/security staff. The PRSA are supposed to monitor residents, help with smoking times, and help get residents ready for groups. Residents are also monitored by Certified Nurse Assistants (C.N.As) who are stationed in the hallways. The facility	S9999		

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S9999	Continued From page 8 assesses residents for abuse risk upon admission and every three months, those identified to be at risk are monitored using the security sheet every hour. 10/17/2022 at 2:50PM, V5 (C.N.A) said that she worked morning shift on the E wing and was the one who found R1 in a bathroom in the male section of the facility, she called the nurse who came and assessed resident, she was then sent to the hospital for evaluation. V5 said that she did not see R1 entering any room in the E wing, she went on a break and after that she was in the dining room charting, she then went to make rounds after charting that's when she found R1 unresponsive. V5 said that no one covers or monitors the hallway when the assigned staff take a break, she did not check the rooms after lunch so she cannot say how long the resident has been in the male section. 10/17/2022 at 3:45PM, V7 (Security) said that he was the one monitoring R1 the day of the incident, resident is always walking back and forth, this is the third time R1 was being sent out for similar episode. V7 said that when she was found in the bathroom on the men's side of the building, he helped the nurses transfer resident to the nursing station and was told that she was having an allergic reaction, no one knows how long she was in there. V7 said he was not sure the last time he saw R1, he marks her in the dining room if he does not see her anywhere, resident is always going to the men's wing by herself, she is always looking for her only friend R4 who gives her coffee all the time. 10/18/2022 at 10:00AM, V8 (C.N.A) said that she worked on Saturday 10/15/2022 on the A hall but left about 1:30PM after lunch for an appointment.	S9999		

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S9999	Continued From page 9 V8 said that R1 was in the dining room for breakfast, was in her room after breakfast when she made the beds, but she did not see her again between 9:30AM and 12:PM when she was in the dining room charting. V8 said she saw R1 again around 12PM, she left shortly after lunch and told the nurse that she was leaving for the day. V8 said that when they take a break, the C.N.A on the opposite hallway was supposed to cover but no one covers when they are charting in the dining room. 10/18/2022 at 10:24AM, V9 (LPN) said that she was the assigned nurse to R1 the day she was sent to the hospital, it was close to 3PM, C.N.A reported that resident was found in the bathroom in room #E7, the two residents who occupy the room were present and said that they did not know what happened to her. V9 assessed the resident who was hyperventilating, but her oxygen level was 99% on room air, resident was transported to her room with staff assistance. V9 said they were monitoring resident, but her heart rate was increasing, she already has an order to send resident out if her condition worsens, the ambulance was called, and resident was sent to the hospital. 10/17/2022 at 1:27PM, V1 (Administrator) said that all the residents are over 21 years, they can visit each other if there is no conflict, they are not supposed to spend a night, they must go back to their rooms. Residents are supposed to be monitored but they also have a right to privacy. 11/19/2022 at 2:00PM, V1 said that she spoke to the clinical team this morning, nurses are to create a care plan for the residents that express the desire to have sex, they are planning on a relationship group and increase monitoring by adding more staff.	S9999		

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S9999	Continued From page 10 10/17/2022 at 1:27PM, V1 (Administrator) said that a nurse from the hospital called the facility stating that a resident alleged sexual assault and V1 later found out that it was R1. The facility nurse reported that R1 was sent to the hospital because she was having difficulty breathing and abnormal vitals. V1 said that she initiated investigation and sent out the initial report to IDPH (Illinois Department of Public Health) the following day. V1 said she spoke R1 when she returned from the hospital and she said that nothing happened, she admitted going to R2's room but was there looking for her friend (R4), she was not there and R1 said she went back to her room. R1 was asked if she had sex with R2 and she said no. V1 said that she spoke to R2 and he admitted knowing R1, she comes to his room all the time to ask for money, coffee, and cigarette, R1 was in his room yesterday, asked for a cigarette, took off her clothes and laid on his bed and they had sex, R1 did not say no. V1 said that they do not have any resident under the age of 18, so they are all adults and can intermingle. She is aware that R2 and R4 are boyfriend and girlfriend, but she is not aware that R1 have any sexual relationship with R2. V1 added that residents are supposed to be monitored but they also have a right to privacy. The male residents can visit the females so long as the female comes out and walk with them to their room. The females are always monitored by staff, those who have boyfriends and girlfriends are offered condoms. V1 said that residents are screened for abuse and background check is done upon admission, those found to be at risk for abuse are placed under increased monitoring by staff using facility monitoring tool. Surveyor told V1 that the sexual assault of R1 is a concern and she said, "Even when she consented?	S9999		

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S9999	Continued From page 11 10/18/2022 at 4:20PM, V1 said that she spoke to R3 who also admitted to having sex with R1, but according to what he said, it was about a week ago and it happened one time. 10/19/2022 at 5:00PM, V11 (Psychiatrist) said that he is familiar with R1, he is not aware of the sexual assault allegation, V11 said that R1 does have a mental history and has been unstable, she has made such allegation in the past but if another resident is saying that it happened, then it is the truth and R1 is not being delusional. V11 said that at this time, R1 is not capable of making such decision of consenting to a sexual relation based on her diagnosis. 10/24/2022 at 1:22PM V14 (Psychiatrist for R3) said that he had a thorough Initial assessment on R3, and he does not have the capacity to make decisions, based on his last evaluation, he cannot operate normally, his judgement is impaired, and he does not have the capacity to consent to sexual activity. The facility does not have any policy on supervision per V1 (Administrator). A document provided by V1 (Administrator) titled behavior management with an effective date of 3/2021states in the guidelines that mental and psychosocial adjustment difficulties may be experienced by a resident, due to problems adapting to changes in life's circumstances. A resident may have trouble adjusting and therefore demonstrate signs and symptoms of mood distress or behavioral disturbance. Under standards, the document states in part: residents who display mental or psychosocial adjustment difficulty should receive appropriate services, to minimize risks. (B)	S9999		

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