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 04/18/2023

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 investigations: 2392937/IL158519	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. 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: Based on interviews and record reviews, the facility failed to follow its abuse policy to prevent a resident-to-resident physical assault. This affected 2 of 3 residents (R2, R3) reviewed for physical abuse. This failure resulted in R2 being assaulted by R3. R3 hit R2 in the face multiple times causing R2 to sustain facial lacerations and facial fractures. Findings include: On 4/13/23 at 3:50pm, V7 CNA (certified nurse aide) stated that V7 worked on 4/6/23 from 3:00pm to 11:30pm. V7 stated that R2 will occasionally curse at staff or peers if R2 does not like what the person is saying to R2. V7 denied R2 involved in any resident-to-resident physical altercations previously. V7 stated that R2 uses a cane and can ambulate with some difficulty. V7 stated that R2 usually goes between R2's room and dining room. V7 stated that R3 was being very vocal on 4/6/23. On 4/14/23 at 7:41am, V10 (nurse) stated that V10 worked 11:00pm 4/6 to 7:30am 4/7. V10 stated that V10 did not witness the event involving R2 and R3. V10 stated that V10 was at the nurses' station getting ready to pass medications. V10 stated that R2 was moving	S9999		

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S9999	Continued From page 2	S9999		

around a lot that night in his wheelchair. V10 stated that the last time she saw R2 was at 2:30am. V10 stated that the CNA during rounds, saw what happened and came and got her. V10 stated that she went to room immediately with the CNA. V10 stated that V10 observed R2 sitting on R2's bed with blood on face, cuts to left eyebrow and below left eye. V10 stated that R3 was standing not far from R2's bed; appearance was threatening. V10 stated that R3 was next to R2's bed, directly facing the door, and smiling with fists clenched at sides of his body. V10 stated that it was difficult to get into room to assess R2's injuries. V10 stated that V10 called EMS (emergency medical services) 911 requesting police and ambulance services. V10 stated that police came and took control of the situation. V10 stated that the police officers had to barricade R3 against the wall with R3's bed so paramedics could get to R2. V10 stated that V10 asked R2 what happened, R2 responded 'he did it' pointing at R3. When V10 asked R3 what happened, R3 just smiled. V10 stated that the paramedics took R2, and the police officers took R3 out of the building at the same time.

On 4/14/23 at 8:10am, V11 CNA stated that she worked on D wing on 4/6/23 from 11:00pm to 7:30am. V11 stated that R2 was awake all night, self-propelling in wheelchair from R2's room to dining room. V11 stated that V11 did hourly rounding on all residents in D wing. V11 stated that R3 was in bed awake all night. V11 stated that V11 was assigned three residents to assist with their showers. V11 stated that she got these residents starting at 4:30am. At that time, R2 was coming from dining room to his room. V11 stated that after showers were completed, V11 rounded on residents; between 5:30am and 6:00am. V11 stated that before she did rounds at 6:00am, V11

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S9999	Continued From page 3	S9999		

informed V12 CNA on adjacent wing she was going to the bathroom. V11 stated that V12 found R2 bleeding during that time. V11 stated that V11 heard overhead page for code white and ran to R2 and R3's room. V11 stated that R3 appeared mean, and no staff could get into room to assist R2. V11 stated that when the police arrived, they had to barricade R3 against wall using R3's bed in order to get to R2.

On 4/14/23 at 8:20am, V12 CNA stated that V12 worked on the E wing, which is adjacent to D wing on 4/6/23. V12 stated that on night of 4/6, R2 didn't sleep. V12 stated that R3 remained in R3's room all night. V12 stated that V12 observed R2 bleeding during code white. V12 stated that V12 rounded on all residents on D and E wing at 6:00am.

R2:
Review of R2's medical record notes R2 was admitted to this facility on 9/9/2022 with diagnoses including schizoaffective disorder-bipolar type, major depressive disorder, borderline personality disorder, and schizophrenia.

Review of R2's risk for abuse screening, dated 4/13/23, notes R2 is at risk for abuse as evidenced by mental illness diagnoses and requiring extensive assistance with ADLs (activities of daily living).

Review of R2's BIMS (brief interview of mental status) score, dated 3/2/23, notes R2's score is 14 out of 15. R2 is able to make needs known.

Review of R2's hospital medical record, dated 4/7/23, notes R2 presented to the emergency room with complaints of headache after an

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S9999	Continued From page 4	S9999		

assault. R3 assaulted R2. R2 was being punched with R3's fists. R2 is normally alert and oriented x 4 at baseline but currently disoriented. Complaining of diffuse headache. Assessment noted multiple lacerations to face with associated swelling and bruising. Nose swollen and bruised. Eyes with conjunctival bleeding. Left eyebrow laceration is 9cm (centimeters) and was sutured. Right eyebrow laceration is 4cm and was sutured. Left cheek laceration is 1cm and was sutured. CT (computed tomography) of R2's head and face noted displaced fractures of the left orbital floor, left lateral orbital wall and left lamina papyracea (medial orbital wall) with extraconal soft tissue gas and bleeding in the inferior left orbit. Associated bleeding is also seen in the left maxillary sinus. Mildly displaced bilateral nasal bone fractures are seen. R2 was admitted to the hospital for further evaluation.

R3:
Review of R3's medical record notes R3 was admitted to this facility on 3/14/23 with diagnoses including schizoaffective disorder-bipolar type, schizophrenia, psychosis, and alcohol abuse. R3 was hospitalized 3/21-4/3 for psychiatric evaluation.

Review of R3's medical record notes:
On 3/15/23, R3 walked around facility during most of the shift. R3 had to be redirected repeatedly.
On 3/21/23, R3 displayed behaviors of yelling/ screaming, hallucinations, delusions, verbally threatening, responding to internal stimuli, and rejection of care. Interventions attempted: R3 was re-directed, assisted to office, and removed from situation. R3's behaviors continued and rejected redirection. R3 then attempted to kill himself - tied a linen around his neck with a knot standing

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S9999	Continued From page 5 behind the door thereby attempting to commit suicide. On assessment, R3 states that he is fine and wasn't planning on harming himself. R3 was placed on 1:1 until he was transported to the hospital for psychiatrist evaluation. EMS (emergency medical services) reported R3 became highly suicidal during transport and needed to be re-routed to the closest hospital due to R3's acuity. On 4/4, nurse noted R3 needs to be continuously redirected before R3 follows directions. On 4/7 at 6:15am, V10 (nurse) was called by the CNA into R2's room while passing medication. Nurse noted R3 standing very close to R2 holding the room curtain and pacing. V10 asked R3 what happened, no verbal response. R2 was noted bleeding from the face; no initial explanation was received from either R2 or R3. Review of this facility's abuse policy, dated 04/2020, notes this facility affirms the right of our residents to be free from physical abuse. Physical abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. (A)	S9999		