STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009757	A. BUILDING: _____ B. WING _____	C 10/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERFRONT TERRACE	7750 SOUTH SHORE DRIVE CHICAGO, IL 60649

(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) COMPLETE DATE
S 000	Initial Comments Facility Reported Incident (FRI) of 8/18/2021/IL137829	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b)6 300.3240e) 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. Restorative measures shall include, at a minimum, the following procedures 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 e) When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act) These finidings were not met as evidenced by: Based on interview and record review, the facility failed to protect a demented and cognitively impaired resident from physical abuse. The resident, (R2), was hit repeatedly in the head by R3 with R3's leg brace. This failure resulted in R2 sustaining multiple wounds to his head, requiring wound treatment and hospitalization. This failure affects one of four residents reviewed for physical abuse in a total sample of four residents. Findings include: R2 is an 82 year old male. R2's diagnoses are but not limited to: dementia, mood disorders, and altered mental status. R2's BIMS (Brief Interview of Mental Status), dated 06/25/2021, notes that R2 is not alert or oriented. R2's care plan notes that R2 has impaired cognition, R2 needs supervision and care due to medical and psychological needs. R2 has an altered mental status and poor confusion. R3 is a 66 year old male. R3's diagnoses are but not limited to: diabetes, schizophrenia, and anxiety disorder. R3's BIMS (Brief Interview for Mental Status), dated 06/25/2021, notes R3 is alert and oriented. R3's care plan notes that R3 is able to make R3 needs known.	S9999		

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S9999	Continued From page 2	S9999		

Facility incident report dated 08/18/2021, notes V2 (Director of Nursing) was informed by a nurse that R3 hit R2 in the head with a leg brace because R2 had taken R3's doughnuts and cheese that was in R3's bag. R2 and R3 were immediately separated. R2 was noted with a laceration to the head.

On 09/29/2021, at 11:23AM, R4 stated, "I do not like going to the lunch room because I have almost gotten hit before. I saw R2 get hit before. I do not recall the resident's name. The resident hit R2 before because R2 was chewing too loud. The resident has thrown orange juice across the table."

On 09/29/2021, at 11:40AM, R2 could not recall the incident or the name of the resident that hit him. R2 is very confused and could not recall the day of the week or where R2 is at.

On 09/29/2021, at 11:47AM, R3 stated, "R2 stole my food. I came back to the room and R2 had my stuff. I hit R2. Every time I tell someone they do not do anything about it. There was no staff around. I hit R2 in the head with my leg boot. I took matters into my own hands."

On 09/29/2021, at 12:16PM, V2 stated, "I was notified about the incident. I was not in the building at the time. R3 has a diagnosis of schizophrenia. R2 was noted with a small opening on R2's head after the incident. When R3 hit R2, it was physical abuse."

On 09/29/2021, at 1:32PM, V5 (Licensed Practical Nurse) stated, "I recall the incident between R2 and R3. I did not witness anything. It occurred at the beginning of my shift. R2 was in

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S9999	Continued From page 3 the second bed. R3, his roommate, was in the first bed. After dinner, an aide called me. The aide stated that R2 was bleeding. I went to their room. I saw R2 bleeding. R2 could not verbalize anything. R2 does not say much. R2 is confused and wanders. R2 was bleeding from the right side of his head. R2 was also bleeding on the top and left side of the head. The right side wound was much bigger. I tried to stop the bleeding and asked what was going on. R3 stated when R3 came back to the room, R2 had his bag of doughnuts and cheese. R3 then grabbed R3's leg brace and beat R2 with it. I told R3 I could have gotten him more doughnuts. R3 stated I took matters into my own hands." Facility Abuse Policy, dated, 10/2017, notes abuse means any physical, mental, or sexual assault inflicted upon a resident other than by accidental means in a facility. Abuse is the willful infliction of injury. Physical abuse refers to the infliction of injury on a resident that occurs other than by accidental means. This includes but is not limited to, hitting, slapping, pinching, and kicking. (B)	S9999		