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 11/19/2023

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 FRI of 8/31/2023/IL164457 & FRI of 9/23/2023/IL165395	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610)a 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 Requirements were not met as evidenced by: Based on interview and record review, the facility failed to protect the residents' right to be free from physical abuse by other residents. This failure applied to four of four (R1, R2, R3, and R4) residents reviewed for abuse and resulted in R3 sustaining a nosebleed after being punched by R4 and resulted in R2 sustaining a closed fracture of the right ankle, which required a surgical procedure, after being involved in a physical altercation with R1. Findings include: R2 is a 32-year-old male who was admitted to the facility on 8/28/2023, past medical history includes, but not limited to schizoaffective disorder bipolar type, bacterial infection unspecified, Epilepsy, unspecified fracture of right lower leg subsequent encounter for closed fracture with routine healing, conversion disorder with seizure or convulsion, etc. On 11/17/2023 at 11:35AM, R2 was observed sitting in the dining area, alert and oriented and stated that he just returned from an orthopedic appointment, they removed the staples from his leg. R2 was noted with a cast to his right leg and	S9999		

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S9999	Continued From page 2 crutches for ambulation. R2 stated that the day his leg got injured, he got into a fight with his roommate who has always been picking on him; R2 could not remember what the argument was all about but he said that they both got loud and started fighting. R2 said that he punched R1 real hard, he got dizzy and pushed him, R2 fell to the floor, his right leg was sticking out and R1 fell on his leg with his weight. R2 stated that the fight went on for a while before staff came and separated them, his leg was so painful, the nurse gave him some pain medicine, but it did not help, he was then taken to the hospital. Aggressive behavior assessment dated 8/28/2023 shows that R2 does not have history of aggression. Risk for abuse assessment dated 8/29/2023 scored R2 as 1, at risk for abuse. Progress note dated 9/24/2023 at 07:30 by V7 (RN) reads: The resident was involved in a physical altercation with his peer roommate this evening. Resulted in a possible dislocation of the right ankle. Ambulance called and pending transfer to hospital emergency room at this time. At 09:56:58, V7 documented, observed the resident sitting upright on the floor complaining of pain after a physical altercation with his former peer roommate. Both residents reported the incident began over a television. The resident complained of 10/10 pain at this time and received acetaminophen 650mg PO PRN at 20:59 for his right ankle pain and reported ineffective an hour later. Other vital signs within normal limits. Writer immobilized the right leg. Attending physician called and requested that resident be sent to the Emergency room for evaluation. Progress note dated 10/25/2023 states: Resident	S9999		

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S9999	Continued From page 3 returned to facility from hospital. alert and oriented x3. V/S 116/72-78-20-97.8-97% on room air. Resident is NWB to Rt leg. Surgical wrap in place, not to be removed until follow up appointment with surgeon in 2 weeks. On 11/17/2023 at 3:51PM, V10 (Attending physician/ Medical Director) said that he is the attending physician for R2, he was called the day he had an incident with another resident, they reported that R2 broke his ankle, he was seen by the orthopedic doctor who recommended surgery due to some displaced fragments. A cast would not be sufficient to heal the injury, resident had some staples and screws and had a cast on his right leg the last time V10 saw him. V10 added that R2 is not aggressive and he is not aware that the other resident is aggressive, if someone was watching them, this may not have happened. R1 is a 35-year-old male who resided at the facility since 2022, with past medical history of schizoaffective disorder bipolar type, opioid abuse uncomplicated, generalized anxiety disorder, congenital deformity of feet, other hyperlipidemia, vitamin D deficiency, etc. R1 is no longer at the facility at the time of the investigation, he was transferred to the hospital on 10/2/2023 for psychiatrist evaluation after documented behavior of increased agitation, yelling/screaming, kicking hitting, verbally threatening etc. Aggressive risk assessment dated 4/6/2023 documents that R1 has history of aggression. Care plan initiated 11/25/2022 states the following R1 has a history of aggressive behavior and has exhibited verbally/physically abusive behavior related/manifested by: Ineffective coping	S9999		

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S9999	Continued From page 4 mechanisms and physically abusive behavior when agitated. 8/9/23 sent out to hospital due to a physical altercation with a peer The resident got into a physical altercation with peers-9/24/2023. The resident got into a physical altercation with peers on 10/03/2023. Interventions include assist in identifying coping skills for anger control, avoid getting in power struggle with resident, encourage verbalization of concern and make clarification if needed, etc. On 11/17/2023 at 3:11PM, V1 (Administrator) said that it was reported to her that R1 and R2 were involved in altercation over a TV that was loud, they got into a fight, both fell and R2 broke his leg. V1 said that R1 has been involved in verbal and physical altercation before, nobody was in the room but someone from social services was in the dining room, The way the incident was explained to her, it seems like an accident but if the fall resulted in an injury, it could be considered an abuse. On 11/17/2023 at 2:43PM, V7 (RN) said that the assigned CNA reported to her that R1 and R2 got into a physical altercation. R2 was on the floor when she got to the room, he was complaining of pain and holding his ankle, she took his vitals and assessed him to realize that he was in severe pain, she called the doctor and got an order, called the ambulance, and put resident on 1:1 and told him to immobilize his leg. V7 said that she is not sure if the CNA was in the room before she got there or if there is anyone monitor the hallway. The monitors are supposed to be in the hallway all the time, R1 has been involved in altercation numerous times with other residents, he is always agitated. On 11/17/2023 at 1:28PM, V4 (CNA) said that	S9999		

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S9999	Continued From page 5 she has worked at the facility for one year. The day R1 and R2 had an altercation, she was coming down the hallway from hall A going to hall C to get some towels for a resident when another resident informed her that R1 and R2 were fighting; by the time she got to the room they were already separated , she does not remember seeing any monitor in the hallway. On 11/17/2023 at 1:38PM, V5 (CNA) said that she was assigned to monitor the C hall the day R1 and R2 had an altercation, she went to get towels from the A hall and was asked to assist with two residents over there, she was assigned to monitor the C hall but also responsible for two residents on the A side. V5 went to check on those (A hall) residents when the incident occurred and by the time she got to the room the nurse was already there, she stayed with R2 until paramedics arrived. V5 added that R1 is always involved in an altercation with other residents and staff. R3 is 47 years old and has resided at the facility since 2008, past medical history includes schizoaffective disorder, depressive type, Epilepsy, unspecified involuntary movements, major depressive disorder, other polyosteoarthritis, other asthma, etc. On 11/17/2023 at 3:40PM, R3 was observed in the common area and interviewed privately at the office, alert and oriented and stated that he is doing okay. R3 said that he recalls the day he was attacked by R4, he was sitting in the dining area, he looked at him and got up and (R4) hit him three times in the back of his head and his nose started bleeding. R3 said that he did not say anything to R4, staff were in the dining area and just walking around, they eventually separated	S9999		

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S9999	Continued From page 6 them. Progress note dated 8/31/2023 20:42:46, documented by V6 (RN) reads: CNA reported resident was hit on the face and the back of his head by another resident. Resident was observed bleeding from his right nostril. Resident was assisted to a sitting position, RN applied pressure to the right nostril. Doctor contacted, ordered PRN extra strength Tylenol Q8HRS, cold compress on the nostril. RN to keep monitoring resident. Aggressive risk assessment dated 7/8/2022 documented that R3 does not have any history of aggressive behavior. R4 is 52 years old and has resided at the facility since 2022, with past medical history of schizoaffective disorder bipolar type, iron deficiency anemia, major depressive disorder severe with psychotic symptoms, paranoid schizophrenia, etc. On 11/17/2023 at 11:44AM, R4 was observed ambulating around the facility, surveyor interviewed him in the office regarding the resident-to-resident altercation. R4 appears alert and oriented but with some confusion, stated that he recalls the incident, he hit the other resident (R3), but it was a mistake, he did not provoke him or say anything to him before the incident. Aggressive risk assessment dated 5/29/2023 indicated that R4 has a history of aggressive behavior, care plan initiated 10/10/2022 states that R4 has a history of aggressive behavior and has exhibited verbally/physically abusive behavior related/manifested by: Ineffective coping mechanisms, and physically abusive behavior when agitated. R4 became physical with a peer in the dining room while dinner was being served on	S9999		

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S9999	Continued From page 7 08-31-23. Interventions include assist in identifying coping skills for anger control, avoid getting into a power struggle with residents, encourage verbalization of concern and make clarifications if needed, etc. On 11/17/2023 at 12:28PM, V3 (PRSC) said that the day R3 and R4 had an altercation, R3 was eating in the dining area, R4 was having behaviors, talking to himself, he stood up and went behind R3 and punched him on his head. V3 said that she was not in the dining area, she was in her office but could see the dining area through the window. V3 added that both residents were sitting at the same table, R4 was waiting for his tray, the security was in the dining area but she could not see him at the time of the incident. R4 is always involved in verbal altercations with other residents and staff, have not witnessed R3 in any altercation with anybody. On 11/17/2023 at 3:11PM, V1 (Administrator) said that the incident between R3 and R4 occurred because R4 did not want to sit at the same table with R3, he stood up and hit him, R3 did not provoke him in any way; that is considered abuse. On 11/17/2023 at 2:37PM, V6 (RN) said that she recalls the incident between R3 and R4, was the assigned nurse for both resident but did not witness the incident. The CNA reported to her that R4 hit R3, she does recall who the CNA was. Both residents were in the dining area. R3 had some blood coming from his nose, she applied pressure on the nose and used a cold pack to stop the bleeding. R4 was sent to the hospital for evaluation. On 11/17/2023 at 3:32PM, V9 (PRSA/Security) said that he was helping in the dinning room the	S9999		

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S9999	Continued From page 8 day R3 and R4 had an incident. V9 heard the altercation, went, and separated the two residents, both were sitting at a table with no other resident. R3 was eating at the time and R4 was still waiting for his tray. V9 said that he made R4 sit at the office until the ambulance came; he was taken to the hospital for evaluation. Abuse policy with an effective date of 4/2020 states in part, the facility affirms the right of our residents to be free from verbal, physical, sexual...misappropriation of property and mistreatment of residents. To do this, the facility has attempted to establish a sensitive and resident secure environment. (A)	S9999		