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	IL6002265	A. BUILDING: _____ B. WING _____	C 05/16/2024

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CRESTWOOD REHABILITATION CTR	14255 SOUTH CICERO AVENUE CRESTWOOD, IL 60445

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S 000	Initial Comments Complaint Investigation: 2493539/IL172803 2493585/IL172866	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 300.3240e) 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	S9999		

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S9999	Continued From page 1 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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 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 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 requirements were not met as evidenced by:	S9999		

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Based on interviews, and record reviews, the facility failed to follow its abuse prevention policy and failed to effectively supervise/monitor a resident with a diagnosis of physical aggression, and dementia to prevent a resident-to-resident physical assault. This affected two of four residents (R1, R4) reviewed for physical abuse. This failure resulted in R4 entering R1's room and physically assaulting R1. R1 sustained a 3cm (centimeters) laceration to the center of forehead, a 4cm laceration of left upper eyelid, a 3cm laceration just distal to left lower eyelid, left eye swollen shut, left ear redness, and swelling, and a fracture of nasal bone. R1 was transported to the hospital to receive 10 sutures to repair facial lacerations.

Findings include:

R1's BIMS (Brief Interview of Mental Status), dated 3/2/24, R1's cognitive decision making skills are severely impaired.

On 5/7/24 at 10:45 AM, there is signage observed in the men's village noting on no occasion during the shift should men's village be left with no staff, staff must be present all the time, if scheduled to work in men's village and you are going on break, charge must make sure a CNA (Certified Nurse Aide) is moved to stay in men's village until the assigned CNA returns.

On 5/9/24 at 2:00 PM, R1 was observed to be pleasantly confused. R1 was unable to answer simple questions.

On 5/7/24 at 1:30 PM, V2 DON (Director of Nursing) stated that at 5:30 AM on 5/3/24, V3 LPN (Licensed Practical Nurse) reported to V2

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that R1 fell. V2 stated that V2 initiated a fall investigation. V2 stated that later that same day this investigation noted R1 did not fall, but rather R1 had a physical confrontation with R4. V2 stated that when R1 returned from the hospital with facial injuries, V1 and V2 determined these injuries were not possible from a fall. V2 stated that R1 communicated to V2 that R1 was in a fight. V2 stated that R1's story never changed with subsequent interviews. V2 stated that R5, R1's roommate, was able to communicate the same story as R1. V2 stated that R4 jumped R1.

On 5/7/24 at 1:55 PM, V1 (Administrator) stated that staff that are assigned to the men's village are expected to remain in there to monitor residents at all times. V1 stated that there is signage that has been posted in the men's village since before she started at this facility in February 2024.

On 5/7/24 at 2:00 PM, R5 stated that on Friday in the early morning R4 came into R5 and R1's room. R5 stated that he was in bed at the time. R5 stated that R4 approached him and wanted to hit R5 but he played ignorant so R4 did not hit him. R5 stated that R4 left his bedside and went into bathroom where R1 was and just started hitting R1. R5 stated that R1 was saying "please, please, please". R5 stated that V3 LPN came in and separated the residents and removed R4 from the room.

On 5/8/24 at 9:30 AM, V4 CNA (Certified Nurse Aide) stated that she worked 5/2/24, 11:00 PM until 7:00 AM on 5/3. V4 stated that V4 was sitting down in the men's village (dementia unit). V4 stated that she was getting ready to do her rounds at 4:00 AM. V4 stated that R4 came out of his room and was being combative towards V4.

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S9999	Continued From page 4 V4 stated that she tried to calm him down, tried to re-direct R4. V4 stated that R4 kept saying 'these B****** trying to kill me'. Then R4 put his hands up and walked towards V4, V4 told R4 again to go back to his room. V4 stated that at the same time, R5 started calling out to be changed. V4 stated that she went to R5's room and informed R5 she needed to get supplies and she would be right back. V4 stated that she closed R5's door because R4 was following behind her. V4 stated that there weren't any supplies in the men's village so she started walking towards the exit door. V4 stated that R4 was following her. R4 then began running after her so she started running to get away from R4 and exited the men's village. V4 stated that V3 LPN was sitting at the nurses' station when V4 informed V3 that R4 was being combative with her and that V3 needed to go check on R4. V4 stated that V3 did not look up from the computer. V4 stated that she said 'are you going to go check?' V4 stated that V3 still did not get up. V4 stated that she informed V3 that she was not going back into the men's village until V3 went there to address the situation. V4 stated that 10 minutes later, V3 and V4 heard screaming coming from the men's village. V4 stated that she and V3 ran into the men's village and saw R4 standing by R1's room and R1 was bleeding. V4 stated that V3 told her "to get a sheet, we need to clean up this blood". V4 stated that R4 was still walking around talking crazy. V4 stated that she did not know she was supposed to call the abuse coordinator to report this incident. On 5/9/24 at 2:00 PM, V1 (Administrator) stated that she was not aware that V4 left the residents in the men's village unattended and did not return for 10 minutes until after R1 was injured by R4.	S9999		

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S9999	Continued From page 5 On 5/10/24 at 9:30 AM, V2 DON stated that she was not aware that V4 left the residents in the men's village unattended and did not return for 10 minutes until after R1 was injured by R4. On 5/10/24 at 10:34 AM, V3 LPN stated that V4 CNA came to V3 and stated that she was going on break. V3 stated that he asked V4 if she had rounded on the residents in the men's village and if the residents were okay. V3 stated that V4 stated that all of the residents were okay and V4 left for break. V3 stated that after V3 administered medication to a resident, he returned to the nurses' station to continue charting on residents. V3 stated that he heard yelling from the men's village and found R1 sitting on the bathroom floor. V3 stated that R4 was near R1. V3 stated that he thought R4 was trying to help R1 get up from floor. V3 stated that he asked R1 what happened, R1 responded he fell. V3 stated that he could see that R1 hit his head on door frame when he fell. V3 stated that he went to another nursing floor to get assistance from another nurse. V3 stated that he called for an ambulance to transport R1 to the hospital for further treatment. V3 then stated that he witnessed R1 fall in the bathroom and that R1 kept repeating thank you. R1's care plan, dated 3/19/24, notes R1 is at risk for abuse due to language barrier, dementia, difficulty in communicating and understanding others. R1 was involved in an altercation with another peer on 5/3/24. Interventions identified on 3/19/24 include, but are not limited to, report all instances of alleged abuse to the abuse coordinator. On 5/7/24, 1:1 sitter. R4's pre-admission psychiatric evaluation, dated 7/27/2023, notes R4's judgement is fair, insight is	S9999		

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fair to poor, thought processes - loosening of associations, visual delusions, and visual hallucinations. Diagnoses include, but not limited to, dementia with psychotic disturbances and visual hallucinations.

R4's care plan, dated 2/8/24, notes R4 is at risk for abuse due to generalized weakness and being at a nursing facility. R4 displayed physical aggression towards peer on 5/3/24. Interventions identified on 2/8/24 include, but are not limited to, report all instances of alleged abuse to the abuse coordinator.

R4's care plans, initiated 5/6/24, note R4 has a diagnosis of hallucinations and a mood problem due to dementia and severe mental illness.

There is no documentation found in R4's medical record noting care plans related to R4's psychiatric diagnoses were initiated prior to 5/6/24.

This facility's abuse prevention policy, undated, notes this facility is committed to protecting our residents from abuse by anyone including, but not limited to, residents. Abuse means any physical assault inflicted upon a resident other than by accidental means. Staff orientation and training and on an annual basis will include how to assess, prevent, and manage aggressive residents in a way that protects residents. As part of the resident's life history on the admission assessment and comprehensive care plan, staff will identify residents who have needs, triggers, and behaviors that might lead to conflict. Employees are required to report any incident, allegation, or suspicion of potential abuse to the administrator immediately or to an immediate supervisor who must then immediately report it to

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S9999	Continued From page 7 the administrator. (B)	S9999		