STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **0055715**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/27/2025**

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

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S0000	Initial Comments Complaint Investigation: 25912677/2700755 - 300.1210a) 300.1210b) 300.1210c) 300.12010d)6)	S0000		01/14/2026
S9999	Final Observations Statement of Licensure Violation: 300.1210a) 300.1210b) 300.1210c) 300.3210t) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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	S9999		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 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. 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 adequately supervise one resident (R3) who was at risk for abuse. This failure affected one (R3) of seven residents (R1, R2, R3, R4, R5, R6, and R7) reviewed for abuse. This failure resulted in R3 being physically and sexually assaulted and suffering psychosocial harm stating feelings of fear and nightmares. Findings include: R3's face sheet documents diagnoses that include but are not limited to major depressive disorder and suicidal ideations. R3's BIMS (brief interview mental status) score, dated 11/20/25, is 14 which indicates R3 is cognitively intact. R3's Final Report titled, "Final Investigation of Allegation of Abuse, dated 12/24/2025," documents, in part, "R3 reported that on 12/20/25 she (R3) went into the shower room after breakfast to take a shower. Reportedly while in the shower R3 stated that she (R3) heard the door open and that she (R3) saw some shoes. R3 stated that she (R3) yelled "get out I'm in here. R3 stated that the male co- resident R2 came into the shower and forced himself (R2) on her (R3). R3 stated that she (R3) yelled for help and another co-resident opened the door, R5 stated that he (R5) yelled for staff. Staff intervened immediately and separated both residents. Conclusion of Investigation: Based on the investigation conducted, review of the medical records,	S9999		

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S9999	Continued from page 2 and the residents involved, it could be concluded that R2 did enter the shower while female co-resident (R3) was taking a shower. R2 reported that they had sex. Resident (R3) stated that she (R3) did not consent and that she (R3) was forced. Resident (R2) appeared to be having symptoms related to his (R2) diagnosis of mental illness schizoaffective disorder." On 12/25/2025 at 12:28pm, R3 said that R3 was showering and had drawn the shower curtain when the bathroom door opened. R3 observed someone wearing black shoes enter the area. R3 told the person to leave; however, the individual did not comply and drew the shower curtain back. R3 then seen R2 and then R2 removed R2's pants. R3 reported that R2 used physical force to restrain R3 against the wall and grabbed R3 by the neck, causing fear of "I thought he (R2) was going to snap my neck." R3 stated that R2 demanded a kiss, and R3 complied due to fear. R3 reported being forced into a corner and that a sexual assault occurred. R3 said, "I'm (R3) not sure if he (R2) penetrated the anus or vagina. I was so scared." R3 stated that another resident (R5) entered the shower room and ran for help. Staff came and helped. R3 stated that R3 then went to the bathroom and observed blood when wiping both the front and back of the body's private area. R3 stated that the blood was collected by staff. R3 reported that law enforcement responded and that R3 was transported by ambulance to the hospital, where an interview was conducted. R3 stated that a sexual assault forensic examination was completed. R3 reported that staff typically supervise residents during showering but could not recall which staff member provided shower supplies on that date. R3 stated that shower supplies are accessed through staff. R3 expressed feeling unsafe in the facility and stated concern that the incident could occur again. R3 said, "I'm scared someone else might do this to me again. The nightmares are horrible." R3's "At Risk for Abuse Assessment," dated 6/08/25, is 3 which indicates R3 may be at risk for abuse. R3's "At Risk for Abuse Assessment," dated 12/22/25, is 2 which indicates R3 may be at risk for abuse. R3's care plan, dated 6/08/2025, documents, in part, "(R3) is at risk for abuse/neglect based on the comprehensive assessment as evidenced by: (R3) has a diagnosis of mental illness. (R3) has experienced recent incident of sexual assault." R2's face sheet documents diagnoses that include but are not limited to schizoaffective disorder, mild neurocognitive disorder due to known physiological condition with behavioral disturbance, suicidal	S9999		

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S9999	Continued from page 3 ideations, and pervasive developmental disorder. R2's BIMS (brief interview mental status) score, dated 11/30/25, is 15 which indicates R2 is cognitively intact. R2's progress note, dated 12/20/25 at 10:40am, per V9 (Licensed Practical Nurse/LPN) documents, in part, "Writer was notified that resident (R2) enter the shower room where a female resident (R3) was taking a shower and force himself (R2) on her (R3). Resident (R2) was immediately place on one-on-one monitoring and 911 called. Police arrived and resident (R2) was taken into custody." R2's "Aggression and Violence History and Screening Assessment, dated 1/15/25, documents, in part, "Did resident (R2) have a recent/have a history of aggressive/agitated behavior? (destruction of property, physical altercation with others, fire setting, or other violent acts): YES." R2's CHIRP (Criminal History Information Response Process," dated 8/05/25, documents, in part, HIT: Charges of Battery/Makes Physical Contact; Burglary; and Criminal Trespassing. R2's care plan, dated 1/15/2025, documents, in part, "(R2) displays socially inappropriate and maladaptive behavior. R2 attempted to come out from shower room undressed." R2's care plan, dated 3/30/2025, documents, in part, "(R2) display aggressive, inappropriate, attention-seeking behavior. (R2) has verbal altercation with staff." R2's progress note, dated 12/22/25 at 2:16pm, documents, in part, "Psych doctor, medical doctor, and medical director informed about residents sexually inappropriate behaviors. New order was given for involuntary discharge." R2 no longer resides at the facility. R2 was issued a notice of involuntary discharge. R5's face sheet documents diagnoses that include but are not limited to schizoaffective disorder and major depressive disorder. R5's BIMS (brief interview mental status) score, dated 11/30/25, is 10 which indicates R5's cognition is moderately impaired.	S9999		

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S9999	Continued from page 4 R5 is a witness to the sexual assault, however R5 was unable to be interviewed due to R5 being on community pass during the time of the survey. R5's interview per V1 (Administrator) during the investigation, dated 12/20/25, documents, in part, "Resident (R5) stated that he (R5) saw R3 go into the shower, then he (R5) saw co-resident R2 go into the shower after R3. Resident (R5) reported that he (R5) was pacing in the C wing hall, he (R5) reported hearing some yelling for help coming from the shower door. Resident (R5) reported that he (R5) opened the door and saw female resident (R3) standing in the shower naked with male resident (R2) with her. R5 stated "I (R5) went to get the staff for help"." On 12/25/25 at 1:32pm, V1 (Administrator) stated that V1 is the abuse prevention coordinator and completed the investigation regarding R2 sexually assaulting R3. V1 stated that the facility substantiated that sexual abuse occurred to R3 and R2 will not be returning to the facility. V1 (Administrator) said, "Usually the residents are able to say that they are going to take shower. There are linen carts as well that the residents can take supplies needed to shower. It's the central shower. The central shower is not in the men's wing, its preceding the men's wing. Staff are usually there. A CNA (certified nursing assistant) is assigned to the C wing to monitor the central shower as well as another CNA that is assigned to the dining room. A and B wings are women and C, D, and E wings are all men. C wing is in the middle of the building right by the dining room. The CNA is usually standing right at the entrance of the hall, where the bathroom is. They (staff) are supposed to be monitoring the whole hall. Yes, that included the bathroom. I questioned V11 (Certified Nursing Assistant/CNA) who was assigned to monitor the central bathroom, and V11 told me (V1) that at some point he (V11) went to the bathroom. There's another CNA right in the dining room that V11 should have notified before going to the bathroom to get coverage. If they (staff) go to the bathroom, there is a CNA for A wing and a CNA for B wing that V11 could have asked to cover his (V11) monitoring while he (V11) went to the bathroom. I mean, The CNA is right in the dining room, V11 should have asked her. We (facility) have staff. There is activity staff, social services, they are here to help with coverage and monitoring. Yes, That is my expectation. They (staff) need to get someone to cover. It's a behavior health facility. Coverage and monitoring are very important." On 12/25/25 at 2:02pm, V7 (Medical Records) said, "So on Saturday (12/20/25), breakfast just finished, helped	S9999		

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S9999	Continued from page 5 clear out the dining area, went back to my (V7) office, got a knock on my (V7) door, that a resident (R3) was raped. Went and had R3 explain to me (V7). R3 said that R2 went in the shower room, R3 told him (R2) to get out, R3 was screaming for help, R2 pinned R3 against wall, and raped R3. I talked with R2 and R2 said R2 went in. I asked what “went in” meant, and R2 said had sex. I spoke with R5. R5 said he (R5) heard R3 in the bathroom screaming for help, and R5 got V5 (Psychiatric Rehabilitation Services Coordinator/PRSC) who was in the office.” On 12/25/25 at 2:14pm, V8 (Registered Nurse/RN) said, “I was one of the nurses that day. I was working on the part of D and E wing. 3 nurses for the day. I finished my med pass in the E wing when the manager on duty, V7 (Medical Records), came to me (V8) to see what happened. We (V8 and V7) came back to the nurse’s station and confirmed the same information that R2 raped R3 in the shower room. We (staff) reached out to Administrator and called the police and EMS (emergency medical services). EMS took her (R3) to hospital and the cops took R2. Been here since 2023 and never experienced a rape here before. “ On 12/25/25 at 2:25pm, V9 (Licensed Practical Nurse/LPN) said, “Okay, I was one of the nurses working when R2 raped R3. I finished passing meds, came back and seen staff talking to R3. R3 said R2 entered the bathroom and forced himself (R2) on her (R3). We (staff) then called police and called the administrator. The police and police came and left with the male resident (R2).” On 12/25/25 at 2:24pm, V10 (Certified Nursing Assistant/CNA) said, “I worked that day. The day was Saturday I was in the dining room monitoring. I was watching a patient. I was monitoring in the assistant area of the dining room, sitting in a chair. I didn’t hear any screaming. Where I was is not close to the bathroom. It’s more by the kitchen area. I don’t know where V11 (Certified Nursing Assistant/CNA) was. He (V11) never said to watch his post or told me (V10) he (V11) was going to go to the bathroom. V11 was assigned to that area to see who is going in and out of the bathroom. Someone is always supposed to be on your wing until you come back from break or bathroom.” On 12/26/25 at 9:51am, V11 (Certified Nursing Assistant/CNA) said, “We (staff) had finished passing meal trays. I usually work afternoon shift, but I was working a double that day. Breakfast was served around 8:00 a.m., but some residents arrived late, so we (staff) were still collecting trays. While I was in C	S9999		

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S9999	Continued from page 6 wing near the supply store, where lotions, diapers, and other items are kept, R3 approached me and stated that she (R3) wanted to take a shower. I asked her (R3) to get her (R3) CNA, but she (R3) said that the staff were very busy and asked if I could help her (R3) instead. I went to the supply store to get soap, and she (R3) then requested washcloths and towels. I had to go to the laundry room to retrieve them. Then some residents go for cigarettes. I usually go to bathroom, a number 2, around 7:30am, 8:00am, or 9:00am every morning. I was pressed. I had to rush to go to bathroom. I was gone 5 minutes. I was later told that during that time, R2 went into the bathroom and raped R3. I was not present when this occurred, and I was not responsible for monitoring the bathroom at that time. No, I didn't tell anyone I was going to the bathroom, I was pressed and went fast. The bathroom is not locked for safety reasons, in case a resident has a seizure. Staff are responsible for ensuring the bathroom is clean and for checking residents' skin, but at that time, staff were very busy. Even if I had not stepped away to use the restroom, I would still have been occupied with collecting trays and cleaning up." On 12/26/25 at 10:27am, V5 (Psychiatric Rehabilitation Services Coordinator/PRSC) said, "The resident (R5) came to my (V5) office and said I need to check the shower room and because R5 heard a woman screaming help me. I went to the shower room and seen R3 was naked, and the male resident (R2) was trying to put on his (R2) clothes. I escorted them out. I did not hear any screaming. R2 admitted it to me (V5) and V4 (Activity Director) that he (R2) raped R3. She (V4) asked him (R2) and R2 admitted that he did do it. He (R2) said he (R2) wanted sex. V4 asked R2 if R3 asked R2 to come in and R2 said no. V4 asked R2 did R3 say she (R3) wanted to engage in sexual activity and R2 said no, but R2 said he (R2) went in and kept going. R2 admitted that he (R2) was not invited to shower room and not invited into R3's personal area." On 12/26/25 at 11:10am, V4 (Activity Director) said, "I called R3 into the office and asked R3 if R3 was okay and to explain to me (V4) what just happened. She (R3) was rattled, and I had to slow her (R3) down. She (R3) said she (R3) went to take her shower, and when taking shower, someone opened door. She (R3) told them to get out cause someone is there. She (R3) seen shoes and recognized the shoes. R2 pulled the curtain open and started kissing her (R3). She (R3) told him (R2) that she (R3) didn't want him (R2), and he (R2) continued and raped R3. She (R3) said that she (R3) was burning in her (R3) behind and in pain and bleeding. She (R3) had a tearful sound in her (R3) voice as if she (R3)	S9999		

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S9999	Continued from page 7 was trying to fight back the tears." On 12/26/25 at 12:26pm, V3 (Registered Nurse/RN) said, "I was completing medication pass on A wing, and was told to go see R3. R3 stated that while she (R3) was taking a shower, R2 forced himself (R2) on her (R3). She (R3) was screaming at the time. I provided her (R3) with a clean towel and instructed her to wipe from front to back. There was some blood noted on the towel. We (staff) then contacted the administrator, followed by calling 911, and the doctor was also notified." On 12/26/25 at 3:04pm, V12 (Psychiatric Mental Health Nurse Practitioner) said, "At this time, she (R3) appears to be doing well. She (R3) stated that she (R3) just wants to "move on with my life now." She (R3) also stated that "it doesn't feel good," and that she (R3) was given several STD (sexually transmitted disease) medications and is moving forward. I am going to prescribe some medications because she (R3) is experiencing nightmares. I will meet with her (R3) once a week to process these experiences with her (R3) so that she (R3) can work through them and continue to heal." Record review of pamphlet titled, "RESIDENTS' RIGHTS' For People In Long-Term Care facilities," revised date 11/18, documents, in part, "Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life… Your facility must provide equal access to quality care regardless of diagnosis. You must not be abused, neglected, or exploited by anyone - financially, physically, verbally, mentally, or sexually. Your facility must provide services to keep your physical and mental health, at their highest practical levels. Your facility must be safe, clean, comfortable, and homelike. You may participate in developing a person-centered care plan which states all the services your facility will provide to you and everything you are expected to do. This plan must include your personal and cultural choices. Your facility must make reasonable arrangements to meet your needs and choices. You should receive the services and/or items included in the plan of care." (A)	S9999		