STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145718	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestwood Rehabilitation Ctr	14255 South Cicero Avenue Crestwood, IL 60445

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 34072 Based on interviews, and record reviews, the facility failed to follow its abuse prevention policy 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 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. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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. 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. 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. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 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 the administrator.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 34072 Based on interviews, and record review, the facility failed to effectively supervise/monitor a resident with a diagnosis of physical aggression, and dementia from physically assaulting a peer. This affected two of four (R1, R4) residents reviewed for supervision of aggressive residents. This failure to monitor and supervise resulted in R1 being physically assaulted by R4. 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 requiring 10 sutures; 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: On 5/7/24 at 10:45 AM, the nurses' station for the men's village is located on the adjacent nursing unit. The men's village is a locked unit. 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 on the morning of 5/3/24, V3 LPN (Licensed Practical Nurse) reported to V2 that R1 fell and needed to go to the hospital. 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 there is signage posted in the men's village noting staff that are assigned to the men's village are expected to remain in there monitoring residents. V1 stated that this signage has been posted there 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 room. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 on the men's village. 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. 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 for the mens village. V4 stated that R4 was following her. R4 then began running after her so she started running to get away from R4, she put code in to open the door and exited leaving R4 in the men's village. V4 stated that V3 LPN was sitting at the nurses' station. V4 stated that she 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 gonna go check? V4 stated that V3 still did not get up. V4 stated that she informed V4 that she was not going back into the men's village until V3 went there. 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. 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. 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 the nursing unit on another floor to get assistance from another nurse. R1's BIMS (Brief Interview of Mental Status), dated 3/2/24, notes R1's cognitive skills for daily decision making is severely impaired. R4's pre-admission psychiatric evaluation, dated 7/27/2023, notes R4's judgement is fair, insight is 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 3/19/24 include, but are not limited to, report all instances of alleged abuse to the abuse coordinator. (continued on next page)

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