STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E177	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestwood Terrace	13301 South Central 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 - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40066 Based on interviews, observations, and records reviewed the facility failed to prevent one resident (R3) from being physically attacked by another resident with identified anger problems and mood swings. This affected two of four residents (R3, R4) reviewed for physical abuse. This failure resulted in R4 physically attacking R3 resulting in visible, bleeding, scratches on her chest, arms, and head. The findings include: The facility Final Investigation date of incident 4/19/24 states R3 sustained a small scratch on her chest. R4 did swing at R3 with her left arm. R3 did sustain a small scratch. R3's diagnosis includes, but are not limited to, Schizoaffective Disorder, Bipolar Type, Major Depressive Disorder, Generalized Anxiety Disorder, and Suicidal Ideations. R3's Cognitive assessment dated [DATE] notes a score of 14, intact. R4's diagnosis includes, but are not limited to, Bipolar Disorder, Major Depressive Disorder Severe with Psychotic Symptoms, Alcohol Abuse, and Hemiplegia Affecting Right Dominant Side. R4's Cognitive assessment dated [DATE] notes a score of 15, intact. On 5/23/24 at 10:27AM R3 said on 4/19/24 when I opened the bathroom door, R4 was there screaming at me what's your problem! R3 said she started hitting me and I fell on my roommate's bed. R3 said, I got scratches on my chest and head. R3 is able to ambulate without devices and independently. R3 pointed to the top of her head along her right hairline/forehead region. R3 pulled her t-shirt neck and showed the surveyor a raised, flesh tone, T-shaped scar to her right chest. On 5/23/24 at 12:11PM R4 said I went into R3's room. R4 said when I saw R3, I started hitting her. R4 said I was jealous of R3. R4 said I'm over it! It just happened. R4 said she had got a call and they said something to me. R4 becoming agitated and interview was ended. R4 observed to have right arm tucked near her body and not using right arm. R4 making gestures with her left arm/hand. R4 observed wearing a ring on her left hand with a white stone and raised setting. R4 able to ambulate without devices and independently. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/23/24 at 10:32AM V2, Certified Nursing Assistant, said R4 thought R3 was with her boyfriend and went to R3's room to see about it. V2 said we (staff) were all in the dining room and not able to see when R4 went into R3's room. V2 said I didn't see any of the fight. On 5/23/24 at 11:12AM V4, Housekeeping Manager, said when I walked into the room, I saw R4 swinging on R3. V4 said they were pressed up against the wall by the dresser. V4 said R4 has use of one arm. V4 said R4 said R3 got smart with her. V4 said both R3 and R4 were standing and R3 had her arms up (V4 demonstrating her arms crossed over her face) and R4 was swinging. V4 said no one else was in the room. V4 said we were getting ready for lunch, that is why no CNAs were on the unit. V4 said R3 was returning to the facility when R4 saw her and went after her. On 5/23/24 at 11:29AM V1, Licensed Practical Nurse (LPN), said I was notified by V4 that R3 and R4 had an altercation. V1 said V4 brought R3 to the nurses' station. V1 said I asked R4 what happened, and she said she was asking R3 to use the room mates phone. V1 said R3 would not say anything. V1 said when I went to the room there was no one in the room. V1 said this happened around the lunch time, around 12:00 or 12:30PM. V1 said I was surprised that R4 was in the room asking to use someone else's phone, they are not usually friends. At 11:39am V1 said I looked at the scratches on R3's chest. When I saw them on 4/19/24 it was red, raised, and had been bleeding, we cleaned it up. Surveyor asked V1 to look at R3's chest and if it is the same injury from the altercation on 4/19/24. V1 said the scratches are now healing, it now looks like a scar on her chest. V1 said yes, those are from 4/19/24. On 5/23/24 at 1:45PM V3, Assistant Director of Nursing, said R3 had scratches on her, one on her chest and a couple of on her face. V3 said I spoke to R3 and helped clean her up. V1 said R3 said she didn't know why R4 started hitting on her. V1 said the residents are not supposed to share phones, they know they can use the phone in the social services office. V1 said the resident should not have the opportunity to hit another resident. V1 said one CNA needs to be observing the hall, one should be always watching. On 5/23/24 at 1:55PM V7, CNA, said on 4/19/24 when R3 and R4 had the incident, I was in the dining room. V7 said V2 was with her in the dining room. V7 said I saw R3 after the incident and she had blood on the front of her shirt. On 5/23/24 at 2:25PM V6, Administrator, said R3 said R4 scratched her. V6 said I don't know if R3 was bleeding from the scratch. On 5/24/24 at 11:16AM V5, (PRSC), Psychiatric Rehabilitation Service Coordinator, said I only saw R4 after the incident. V4 said R4 was in the office, she said she was trying to use the phone and R4 had got hostile with her. V5 said R4 does not have a history of being physically aggressive. V5 said R4 has had verbal exchanges with R3 before. V5 said the verbal altercation happened once before. V5 said R4 curses when she is angry, she has no other anger symptoms, just cursing. The surveyor asked V5 what is a potential striker as mentioned in R4's care plan. V5 said because R4 has one good arm and was using it on R3. The surveyor said the intervention is dated November 2022, V5 said striker means to start a physical altercation. The surveyor asked V5 about the ring observed on R5 and V5 said yeah, she wears that ring. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's progress notes dated 4/19/24, written by V1, sates a fell ow peer was aggressive towards R3. Upon assessment R3 has some scratches on her chest area, right eyebrow area, and left arm. R3 sent to hospital. R3 returned the same day. R3's 72 hour follow up record states R3 has new injuries on her chest, no other description is listed. R3's Behavior assessment dated [DATE] indicates she has delusions, hallucinations and verbal behaviors directed towards others. R3's care plan initiated on 9/24/23 stated R3 is at risk for abuse based on comprehensive assessment, R3 has diagnosis of mental illness. R3 is disruptive, insensitive, and disrespectful to staff and peers. R3 displayed disrespect towards a peer. R3's hospital record dated 4/19/24 states chief complaint cough and abrasion. Patient with scratches and abrasion to the right forehead and right arm. R4's progress notes dated 4/19/24, written by V1, states resident was being aggressive towards a peer. Physician ordered a psych evaluation at the hospital. R4 hospitalized thru 4/23/24. R4's Behavior assessment dated [DATE] indicates she has delusions and verbal behaviors directed towards others. R4's Functional Abilities dated 4/30/24 identifies she has impairment on one upper extremity. R4's care plan dated 9/24/23 indicates she has mood swings and impulsive behaviors. R4's care plan dated 11/11/22 identifies she has anger problems and is also a potential striker. R4's care plan dated 4/19/24 (the date of the incident) stated R4 became verbal/physical with a peer. Care plan identifies R4 has history of aggressive behavior with verbal and physical abusive behavior when agitated. R4's hospital record, provided by the facility, dated 4/19/24 states sent for having increased delusional thinking, hallucinations, mainly witnessed because she has been more agitated, aggressive with peers, not being redirectable. Patient states she is here because I was fighting. The facility policy titled Abuse dated 4/2020 denotes in-part this facility affirmed the right of all residents to be free from verbal, physical, sexual, mental, neglect, exploitation, misappropriation of property, involuntary seclusion, and mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents in order to do so the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property and mistreatment of residents. The resident rights for people living in long term care denotes in-part as a long-term care resident in Illinois, you are guaranteed certain rights, protections, and privileges according to state and federal laws. You must not be abused, neglected, or exploited by anyone - financially, physically, verbally, mentally or sexually.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38796 Based on interview and record review the facility failed to provide effective supervision to monitor and intervene before a resident-to-resident verbal altercation escalate into an avoidable physical altercation. This affected two of four residents reviewed for supervision and monitoring. This failure resulted in R1 and R2 having a verbal disagreement, escalating into a physical altercation, resulting in R1 observed with bleeding at back of head. R1 was sent to hospital with diagnosis of subdural hematoma and facial contusions. Findings include: R1 face sheet shows R1 has diagnosis of mild intellectual disabilities, disruptive mood dysregulation disorder, impulsive disorder and schizophrenia. R1's quarterly MDS assessment dated [DATE] section C for cognitive pattern denotes a score of 8 (cognitive impairments), section E for behavior, potential indicators of psychosis denote hallucinations and delusions. Zero (behavior not exhibited) is noted for physical behavioral symptoms directed towards others and zero (behavior not exhibited) is noted for behavioral symptoms not directed toward others. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Facility final report sent to the department dated 4/26/24 denotes in-part R1, R2 resident to resident altercation, date of incident 4/21/24, time of occurrence 10:00am, location of incident resident room, immediate action taken resident separated and monitored, residents assessed for injuries, MD (medical doctor) notified, family notified, administrator notified, investigation initiated. Brief description of original allegation: resident R2 reported that co-resident R1 approached him stating that he was [NAME] and that he would fight him, R2 reported being hit by co-resident. Residents were separated both residents were placed on increased monitoring. The facility started an investigation. Medical doctor and families' guardians notified. No injuries. Both residents declined a police report. R1 is alert with a BIMs (brief interview mental status) score of 15 and is able to make his needs known. R1 displays behaviors related to his diagnosis. R1 presents with increased agitation, hallucinations, verbal delusions and physically aggressive with staff and peers. R1 is medication compliant and attends groups and activities. All behaviors are addressed in his plan of care. R2 is alert with a BIMS of 15 and is able to make his needs known. Resident displays behaviors related to his diagnosis. R2 presents with increased agitation, verbalized delusional thoughts, isolative behavior and physical aggression. R2 is medication compliant and attends activities with encouragement. All behaviors are addressed in the plan of care. Summary of investigation/ facts determined: according to resident R2 Co-resident walked up to him stating I am [NAME] Ali; I will fight you, then hit him, so he hit back. According to R1 co-resident he does not remember what happened. Staff reported that resident R1 approached co-resident, R2, and stated I am [NAME] Ali, I will fight you then hit R2. Reportedly resident R2 was wearing his superhero cape at the time and stated I handle things around here, then hit R1 back. Staff intervened. While attempting to box R1 loss his balance and fell to the floor. R1 sustained a small cut to the back of his head as a result of the fall. First aid given by the nurse. R1 was assessed and treated for pain. R1 was sent to the hospital for medical evaluation per medical doctor orders. R1 admitted to the hospital with a diagnosis of subdural hematoma. R1 return to the facility and remains on increased monitoring. R2 was assessed by the nurse and was given medication per MD (medical doctor) orders for increased agitation. Both residents have been counseled regarding seeking staff assistance as needed. Residents room assignment are in opposite halls of the facility and both residents were placed on increased monitoring, all behaviors were addressed in the plan of care. Based on investigation conducted, review of the medical records and interviews of staff and residents involved, it could be concluded that both residents did not have any willful intent of causing harm or physical abuse. Both appear to be exhibiting behaviors related to their diagnosis. Both to be verbalized delusional thoughts, one believing that he is [NAME] and the other believing that he is a superhero. Necessary, care plans, medication reviews and assessments were completed and updated for both residents. Both residents have been notified of the outcome of investigation. Family and medical doctors notify accommodation. Both residents remain on increased monitoring. V6 (administrator) name is noted at bottom of page. On 5/23/24 at 11:48am R1 was escorted to the conference room guided by V11 (social services), R1 observed alert to person, R1 observed with confusion. R1 said a guy came in his room and began hitting him. R1 don't recall the date, time, or who the person was. R1 touched the back of his head stating he hit his head. R1 said he lost vision in his right eye when shampoo got into his eye. R1 don't recall going to the hospital. R1 said he was ready to leave the conference room. R1 escorted back to his room by V11. R1 observed with shuffle gait, and tremors to right hand. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 5/23/24 at 1:08pm R2 observed alert and orient to person, place, time, situations, and events. R2 said he was walking up and down the hallway in the C wing, listening to his headphones, when R1 came up behind him and said, I will knock yo retarded ass out. R2 said he took off his headphones, placed them on the floor, R2 said he responded to R1 by saying do it. R2 said R1 then punched him. R2 said they began to fight. R2 said this started in the hallway. R2 said R1 landed in his room on the floor because they were fighting. R2 said he didn't walk away because R2 said I'm from the [NAME] area, you don't let anyone put their hands on you. R2 said R1 had the gall to hit him. R2 said the staff keep telling him that R1 does not have the intellect to comprehend his actions. R2 said he does get angry and is destructive of things/items. R2 said he goes to group, and he is taught coping strategies to manage his anger, R2 said he knows all that stuff. R2 said he will not hit anyone unless they hit him first. On 5/23/24 at 12:25pm V12 (CNA-certified nursing aide) said she was the aide assigned to the C on 4/21/24. V12 said a resident came and got her, he was pointing, and she followed that resident, that resident took her to R1 room. V12 said she observed R2 swearing and yelling, R2 was in the hallway. V12 said she observed R1 in his room, sitting on the floor. V12 said initially she didn't see any injuries on R1. V12 said she went and got the nurse and upon further assessment R1 was observed with some bleeding and laceration to the back of the head. V12 said R1 could not communicate what happened. V12 said it is difficult to understand R1. V12 said the nurse rendered first aide. V12 said she was sitting at the front of the C wing. V12 said the position that she was sitting in she could not see down the hall where the incident occurred. V12 said R1 does have a behavior where he is shadow boxing, and while saying [NAME] Ali. R1 would come to the doorway of his room and do this behavior also. V12 said R1 would approach staff and motion his hands like he's boxing while saying you know [NAME] Ali. V12 said R1 is a very tall man, over 6 feet tall, and if he approaches someone with his stature, it would be intimidating, V12 said R1 doesnt mean any harm to anyone. V12 said after R1 was assessed R2 was assessed but she doesn't recall the details of what R2 said how the incident occurred. V12 said she remembers R2 was in the hallway swearing, she did separate the two residents. On 5/23/24 at 2:06pm V13 (Nurse supervisor) said she was summons by V12 and when she went into R1 room she observed R1 sitting at the bedside, V13 said the staff had picked R1 up from the floor. V13 said she assessed R1 and observed laceration to the back of his head and something on his forehead, V13 said she don't recall exactly what was on R1 forehead, but R1 defiantly had bleeding to the back of his head. V13 said R1 said he hit his head on the wall. V13 said when she interviewed R2, R2 said he told R1 to hit me then. V13 said R2 asked R1 to hit him, provoking the fight. V13 said R2 made a statement about he handles things around here. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 5/23/24 at 3:18pm V11 (social services) said he is aware that R1 has this behavior of shadow boxing (punch the air) while saying [NAME] Ali. V11 said R1 would walk up to people and do this behavior, he has seen R1 come to his room door doing this behavior. V11 said this behavior can intice an altercation, it puts R1 at risk for abuse and fighting. V11 said the facility has implemented monitoring for R1 because of his behavior. V11 said staff should make rounds on R1. V11 said the staff monitor R1 by making rounds on R1 every hour, the aides monitor the hallway, and they should be observing for this behavior and intervene if they see R1 doing this. V11 said the staff should redirect R1 when R1 is doing this behavior. V11 said R1 has been referred to the psych doctor for his delusions of thinking he's [NAME] Ali. V11 said R1 care plan has been updated for this behavior with interventions. V11 said this is new behavior for R1. V11 said the interventions of monitoring R1 was not effective because R1 got into a physical altercation due to his behavior, sustaining an injury. V11 said R1 was sent to the hospital after the altercation with R2. V11 said R1 has had a decline in mental capacity during his stay at the facility. V11 said R1 was in therapeutic programing however R1 would not benefit from programming due to his decline in mental capacity. V11 said R1 BIMS score is not 15, R1 has mental function decline. V11 said R1 has been displaying this behavior of shadow boxing and approaching other with motion of shadow boxing since February 2024. Review of R1 care plan with V11, V11 said R1 care plan has not been updated with R1 behavior of thinking he's [NAME] Ali, approaching others with shadow boxing motion, and the interventions related to the plan to monitor R1 for this behavior to prevent escalation, abuse and promote safety of R1 behavior. On 5/23/24 at 3:53pm V6 (Administrator) said the facility camera located in the C wing is used to focus on the exit door, she reviewed the camera, but she could not determine if the altercation started in R1 room or in the hallway. V6 was asked how this altercation start in the hallway and the staff was monitoring the hallway 12-15 feet away from R1 room and did not observe this altercation or hear this altercation that started in the hallway. V6 said she was not there, and the staff said they did not witness the incident. V6 said she did review the cameras in the dining room and the altercation did not happen in the dining room. At 1:56pm during a tour of the C wing with V3 (ADON-assistant director of nursing), the aide V14 (CNA) was sitting with his back facing down the hall of the C wing. The front of the C wing was within 15 feet of R1 room, where R1 was found on the floor. V14 said he's watching the dining room too, when asked if he could monitor the hall from his position (back facing the hall). V3 did not respond if he could see down the hall with his back facing the hall. R1 progress note dated 4/21/24 resident involved in an altercation with co-peer. R1 noted with delusional ideations stating that he is [NAME] and is unable to give description as to how the altercation occurred. R1 and co-peer were immediately separated. R1 was assessed for injuries. Noted small laceration to occipital head and small laceration near right eye. First aid rendered. Neuro checks initiated. R1 is alert and verbal with confusion per his norm. Pupils equal and reactive to light. R1 denies pain at this time. No nausea or vomiting noted. Doctor notified and gave orders to send resident to hospital for medical evaluation. Ambulance called, ETA 45 minutes. Placed call to resident sister who is #1 emergency contact-no answer. Placed call to #2 emergency contact and made him aware of above information. R1 remains one on one with staff until arrival of ambulance. Writer received call from Hospital per resident's status update. Writer was made aware that resident's admitting diagnosis is subdural hematoma. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1 hospital records dated 4/21/24 denotes in-part chief complaint head injury without loss of consciousness, patient 54year old male with history of schizophrenia, dystonia and Diabetes mellitus presenting to ED via EMS for evaluation after a head injury without loss of consciousness. Patient currently resides at assisted living facility. Per EMS patient was in a physical altercation with his roommate and was struck in the face with fists followed by hitting his head on the wall. There was no report of loss of consciousness. Denies any other injuries or trauma. Examination: head-contusions present, multiple facial contusions and abrasions. Clinical impression subdural hematoma, contusion of face. CT impression denotes, small extra-axial hematoma along the left temporal lobe likely representing a small subdural hematoma. R2 face sheet shows diagnosis of schizoaffective disorder, schizophrenia. R2 MDS dated [DATE] denotes a score of 15 (cognitively intact). R2 plan of care denotes in-part R2 has a history of aggressive, inappropriate attention seeking behavior but has demonstrated stability during the admission screening process and is therefore considered appropriate for admission, severe mental illness and substance abuse. R2 will behave in a manner consistent with resident conduct policies. Interventions: intervene when any inappropriate behavior is observed. R2 has a history of aggressive behavior and has exhibited verbally/physically abusive behavior related to manifested by being challenged by mental illness, ineffective coping mechanism, physical abusive when agitated, poor verbal skills and inability to express self in more appropriate language. R2 will reframe from verbally and or physically abusive behavior following staff intervention to avoid getting into power struggle with residents. Facility policy titled behavior management date 4/2020 denotes in-part mental and psychological adjustment difficulties may be experienced by a resident due to problems adapting to changes in life circumstances. A resident may experience difficulty adjusting and therefore demonstrate signs and symptoms of mood distress or behavior disturbance. Residents who display mental or psychological adjustment difficulty should receive appropriate services in an attempt to minimize risk the social service department may assist with arrangements for outside professional consultation services such as psychologists or psychiatrists when ordered by the attending health care provider. Mental health disorders should be identified through MDS/RAI care planning process that is completed after admission and periodically the residence service department may conduct further assessments to identify and manage alter mental status dementia delirium and depression. The plan of care should be developed by the interdisciplinary team. The interdisciplinary plan of care communicates care instructions to staff. Problem behaviors identify in the comprehensive assessment and plan of care should be documented. New or worsening behaviors should be communicated to other departments as needed.