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	12/10/2024

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 0689 Level of Harm - Minimal harm or potential for 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** 49740 Based on interviews and record review, the facility failed to prevent a physical altercation between a resident (R1) with a history of delusions, agitation, and aggressive behavior towards peers, and his roommate (R2) by failing to adequately monitor the two residents inside their room with the door closed, during lunchtime. This lack of supervision resulted in a failed opportunity to identify delusional and aggressive behavior from R1 that led to R1 hitting R2 in the head with his hands, grabbing him by the shirt, and pulling him out of his room. Findings include: R1 is a [AGE] year-old former resident of the facility with diagnosis listed in part, but not limited to, schizoaffective disorder, schizophrenia, suicidal ideations, alcohol abuse, and cannabis abuse. On 12/09/2024 at 10:52 AM, V1 (Administrator) said on 10/20/2024, R1 had an altercation with his roommate, R2. V1 said R2 wanted to use their bathroom, but R1 had placed a sheet on the floor in front of the entrance to the bathroom. V1 said R1 told R2 not to move his sheet; however, R2 picked the sheet up to be able to walk into the bathroom. V1 said R1, then, started to scream at R2 and walk towards him. V1 said when R2 tried to open the bathroom door, R1 hit him, grabbed him by his shirt, and tried to pull him out of their room. V1 added once R1 and R2 were in the hall, staff stopped what they were doing, and ran to break up the altercation. V1 said both residents were separated and placed on increased monitoring. V1 said the facility doctor was notified, and ordered R1 be sent to a local psychiatric hospital for evaluation and R2 be sent to a local hospital for medical evaluation. V1 said when the ambulance arrived, R1 refused to go, and threatened the paramedics, saying, if you touch me, it's not going to end well. V1 said R1, then, opened an emergency exit door, setting off the alarm, and ran out of the facility; but the paramedics had called the police, who were already outside, and were able to subdue R1 and accompany him to a nearby hospital for medical evaluation. On 12/10/2024 at 9:55 AM, R2 said R1 would always get mad after placing a sheet on the floor. R2 said on 10/20/2024, R1 attacked him, straight on, when he tried to go into the bathroom, and hit him on the left side of his face. R2 said he, then, pushed R1 back, and R1 knocked his TV down. R2 said R1 didn't hurt him, but made him mad. R2 said R1 also grabbed him by his shirt, but did not recall if R1 tried to throw him out of the room. R2 said staff stopped the fight when he and R1 were in the hallway. R2 said he ended up with a black eye. Finally, R2 said he felt better at the facility now that R1 was gone. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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	12/10/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/2024 at 11:16 AM, V5 (CNA) said she was there the day of the altercation between R1 and R2. V5 said she and the staff were in the dining room when a staff member went over to let them know there was an altercation between R1 and R2. V5 said she went to the hallway and saw R1 pulling R2 by the shirt in the hallway. V5 said staff separated R1 and R2 and that was it. V5 added R2 looked like he had been in an altercation and R1 was worked up. V5 said she was not sure what caused the altercation. On 12/10/2024 at 10:45 AM, V3 (Psychiatric Rehabilitation Services Coordinator) said she was at the office on 10/20/2024 when she heard something, and went to investigate. V3 said R1 had put something on the floor, R2 had removed it, they got into an argument, and started to fight. V3 said she and the staff, then, separated R1 and R2, and she called her supervisor. V3 said R2 had a swollen eye, so they sent him to the hospital to have his eye treated. On 12/10/2024 at 2:20 PM, V1 said she was not aware that R1 had a habit of placing a sheet on the floor; had never seen it, herself; and no one had ever reported that type of behavior to her. V1 said she believed it may have been one of the housekeepers delivering laundry that first noticed the altercation between R1 and R2. V1 said the altercation happened on 10/20/2024 during lunchtime. V1 said the laundry lady and V5 were on the floor, and the rest of the staff was helping out with lunch. V1 said R1 and R2's door was closed when they began yelling at each other. V1 said the laundry lady delivering clean clothes to the residents passed by the room where R1 and R2 were fighting, heard them, went to their door, and motioned V5 for help. V1 said she felt that the staff responded quickly, and handled the situation, pretty well, considering that they were passing food at the time. V1 added the two residents were separated, and there was no injury. Finally, V1 said R2 had some redness on the side of his face, but there were no fractures and no new orders from the hospital for R2. Per progress notes in R1's electronic health record, hallucinations, delusions, increased agitation, and aggressive behavior towards peers were noted on 04/21/2024 (involved in altercation with peer); 08/04/2024 (tried to take food from a peer); and 09/29/2024 (physically aggressive towards peer). A facility educational in-service titled, Supervision and Monitoring of Residents, provided to staff members on 11/26/2024 stated, in part, the facility's goal was to prevent any altercation and/or physical contact before it happened; monitor the halls during meals; walk to each room to check residents; and monitor the halls between walking rounds.