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	03/23/2025

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 - 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** 46066 Based on interviews and record review, the facility failed to protect a resident's right to be free from physical abuse (R2) from another resident with known history of aggressive behavior (R3) for one (R2) of five residents reviewed for abuse in a sample of eight. This failure resulted in R2 being physically assaulted and emergently transferred to the hospital for evaluation of facial trauma. Findings include: R1 is a [AGE] year-old female admitted to the facility on [DATE] with diagnosis including but not limited to Schizoaffective Disorder, Bipolar Type; Malignant Neoplasm Of Skin; Morbid (Severe) Obesity Due To Excess Calories; Age-Related Nuclear Cataract, Bilateral; Hypermetropia, Bilateral; Presbyopia; Major Depressive Disorder, Recurrent, Severe With Psychotic Symptoms; Schizophrenia; And Chronic Viral Hepatitis C. According to R1's MDS (Minimum Data Set) assessment dated [DATE] under section C, R1 has BIMS (Brief Interview of Mental Status) score of 14 indicating, indicating intact cognition. R2 is a [AGE] year-old female admitted to the facility on [DATE] with diagnosis including but not limited to Major Depressive Disorder, Recurrent, Severe with Psychotic Symptoms; Other Polyosteoarthritis; Polyp of Colon; Unspecified Hemorrhoids; Unspecified Abdominal Pain; Hypertensive Heart Disease Without Heart Failure; and Other Hyperlipidemia. According to R2's MDS (Minimum Data Set) assessment dated [DATE] under section C, R2 has BIMS (Brief Interview of Mental Status) score of 15 indicating, indicating intact cognition. R2's abuse care plan dated 09/10/2024 reads in part, (R2) is at risk for abuse/neglect based on comprehensive assessment as evidenced by: (R2) has a diagnosis of mental illness. (R2) is not able to make her needs known. Interventions: Assure (R2) that she is in safe and secure environment with caring professionals. Explain psychosocial adjustment is often facilitated by developing a trusting relationship with another person and verbalizing thoughts, needs and feeling. (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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	R2's anxiety care plan dated 09/12/2024 reads in part, (R2) has exhibited or has history of anxious behavior such as: Evidenced by Apprehension in response to severe and persistent mental illness. Excessive and persistent daily worry about life circumstances. Concentration difficulty such as losing a train of thought. Persistent and unreasonable fear of a specific object or situation. Interventions: Assist in identifying actual life situations. R3 is a [AGE] year-old female admitted to the facility on [DATE] with diagnosis including but limited to Schizoaffective Disorder, Bipolar Type; Major Depressive Disorder, Recurrent, Severe with Psychotic Symptoms; Hypertensive Heart Disease Without Heart Failure; Morbid (Severe) Obesity Due To Excess Calories; Chronic Obstructive Pulmonary Disease, Unspecified; Suicidal Ideations; and Insomnia, Unspecified. According to R3's MDS (Minimum Data Set) assessment dated [DATE] under section C, R3 has BIMS (Brief Interview of Mental Status) score of 15 indicating, indicating intact cognition. According to R3's MDS (Minimum Data Set) assessment dated [DATE] section E shows R3 has been demonstrating potential indications of psychosis such as hallucinations and delusions, and daily occurrence of threatening and screaming at others. R3's aggression care plan dated 06/26/2024 reads in part, (R3) has a history of aggressive, inappropriate, attention seeking behavior due to Severe mental illness. (R3) becoming physical inappropriate and verbal aggressive with peer. (R3) becoming verbally aggressive with staff when redirected. Interventions: Intervene when any inappropriate behavior is observed. Communicate assertively that (R3) must exercise control over impulses and behavior (Social skills training). R3's delusional statements care plan dated 3/16/2028 reads in part, (R3) has shown evidence of making delusional statements related to diagnosis of severe mental illness. Interventions: Assess ability to maintain reality orientation. Provide reality orientation as needed. Per record review, R2 was discharged from the facility on 01/10/2025 and is not available for observations or interview during this investigation. Per record review, R3 was hospitalized for behavioral evaluation on 12/22/2024 and later discharged the facility and is not available for observations or interview during this investigation. On 03/20/2025 at 1:41 PM V8 (Certified Nurse Assistant) said, I worked 7:00 AM - 3:00 PM on 12/22/2024. R3 was walking and talking to herself, like usual. I was monitoring A wing which is right across from B wing. R3 got to the end of B wing and that's where R2 was. Out of nowhere, R3 grabbed R2 from behind, put her in a choke hold and started punching her head and then face. R2 did not say anything to R3 before R3 attacked her. I was standing maybe 5 feet away from them. There was no other staff there. I was trying to pull R3 off R2, but I couldn't. I started to yell, Help! Help! Help!. After about 5 minutes, V9 (Certified Nurse Assistant) and R4 came up and we were able to pull R3 off R2. R2 was beat up pretty bad. I didn't see any blood and R2 didn't lose consciousness, but it was pretty extreme. After more staff showed up, I had to step away, the incident upset me. R3 attacked R1 a few months prior to December 2024. R1 had a concussion because of the attack. There was nothing special we had to do for R3 as far as monitoring. PRSAs (Psychiatric Rehabilitation Service Aids) is supposed monitor R3, that's what they're there for. R3 was acting like always that day, I didn't see any signs that she might attack someone. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 03/20/2025 at 02:34 PM V11 (Psychiatric Rehabilitation Service Coordinator) said, I worked as a PRSA (Psychiatric Rehabilitation Service Aids) on 12/22/2024. PRSAs are considered security in the facility. I saw the incident between R2 and R3 but didn't see the escalation of it. Code orange was called shortly after lunch. I responded to the code and saw R2 yelling, Get off me! while R3 was pounding on her. Other staff and I separated R2 and R3, and R3 was escorted to the social service office. I think, R2 suffered concussion after the incident. I've never seen R3 to have a behavioral outburst like that, but I heard that she's aggressive. There was nothing special related to R3's monitoring, all I was told was not to come too close to R3 because she might have aggressive behaviors. It was like walking on eggshells around R3. On 03/21/2025 at 10:29 AM V12 (Psychiatric Rehabilitation Service Director) said, I wasn't here at the time of the incident (12/22/2024) because it happened on a Sunday, and I don't work on Sundays. When I came on 12/23/2024, R2 came to talk to me and told me that R3 was talking to herself and thought R2 was talking to R3 and then R3 attacked R2. R2 was in the facility for only 3 months (admitted [DATE]) whereas R3 had been a long-term resident in the facility, admitted in 2018 at the time of the incident. R3 was hospitalized for behavioral evaluation multiple times while in the facility. Surveyor asked about R3's previous physical attack on R3's roommate, V12 (PRSD) said, It might have happened, I don't remember. R3's behavior was always deceitful, she didn't really have escalating behaviors, so it was hard to tell when R3's aggression might escalate. You would ask R3 if everything is ok, and R3 would respond, Yes, everything is fine. Some of the interventions to prevent R3's behavioral escalation were group therapy, 1:1 tele-health program with psychiatrist, and day program. If R3 refused any of the interventions, it was a good indication that she might escalate her aggressive behaviors. On 03/21/2025 at 12:06 PM V14 (Family Nurse Practitioner) said, R3 had delusions at the baseline. R3 was taking psychotropic medications. R3 was often hiding her symptoms or downplayed them, you could tell she's responding to an internal stimulus but when asked, R3 would deny. R3's medications could manage her behaviors unless R3 refused them. R3 didn't refuse her medications often but it happened on occasion, and that's when she would act out. We don't put in an order for behavioral monitoring, the nurses should document in progress notes if any behavioral changes occur. With R3, it was hard to predict behavioral outbursts because she was downplaying her stimuli. R3's more frequent monitoring would be recommended. Staff should definitely place someone like R3 on 1:1 observation if they saw any concerning behaviors. Before a resident with mental illness hits someone, they usually show signs such as pacing and talking to self. Staff should request PRN (as needed) medications from us as well to help manage the symptoms. On 03/21/2025 at 12:20 PM R1 said, In June (2024), R3 punched me in my eye. I didn't do nothing. R3 came up to me while I was sleeping, around 3:00 AM and just hit me. We were roommates at the time. R3 was aggressive. They didn't do anything about it. On 03/21/2025 at 12:28 PM V9 (Certified Nurse Assistant) said, On 12/22/2024, I was in the dining room, on resident's 1:1 monitoring. I heard code orange, so I responded to the code and broke up R2 and R3. I was under the impression V8 (CNA) was getting attacked. R3 always walked up and down the hallway, it was the norm for her. If anything, R3 was talking to herself a little more than usual that day. I don't really know what triggered R3 that day. After the two residents were separated, I walked away and went back to monitoring. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 03/21/2025 at 12:38 PM V6 (Registered Nurse) said, I worked on 12/22/2024. R3 was really quiet, except for when she would have an outburst in her room. R3 usually was yelling and cursing in her room. I don't remember R3 talking excessively or pacing on the day of the incident. The only thing that I remember that day, was seeing R2 sitting at the nursing station and R3 in the social service office. I was told what had just happened. Generally speaking, we document residents' behaviors in progress notes. We document when resident displays abnormal behavior, but it also depends on the nurse. Some nurses document both, abnormal and normal residents' behaviors. R3 was generally compliant with taking her medications and she took her psychotropic medication on the day of the incident (12/22/2025). On 03/21/2025 at 1:09 PM V1 (Administrator/Abuse Prevention Coordinator) said, On 12/22/2024, staff called me and told me that there was an incident, that R3 hit R2. I asked if there was a CNA in a monitoring spot at the time of the incident, I was told that V8 (CNA) was there. I assured that both residents are safe, nobody is hurt, and all staff is monitoring their areas. I asked for V8 (CNA) to talk to me then. V8 (CNA) told me that R2 was walking and R3 came up to her, said something out loud, hit R2 from behind, and pushed R2 to the floor. V8 (CNA) was trying to intervene, and other staff responded to code orange and came to help. The following day (12/23/2024), I interviewed V8 (CNA) and R2. I did speak to few more staff, but they all stated that they came after the escalation. There were no residents who witnessed the incident. I did not have a chance to talk to R3 because she was hospitalized for behavioral evaluation at that time. R2 was hospitalized for medical evaluation and returned to the facility after a few hours. R2 called the police while she was getting assessed by the nurses before facility staff had a chance to do so. R2 came to me after she returned from the hospital and said she wanted to go home for holidays, and she said that she doesn't know why R3 attacked her. R2 said she felt safe in the facility because R3 was not there. The conclusion of the internal investigation was that R2 was hit by R3 as a result of R3 exhibiting symptoms of her mental illness. R3's Medication Administration Record for December 2024 does not show any requests for PRN psychotropic medications for behavioral management. Absent are any progress notes or behavioral assessments to show R3's escalating behaviors that led to an altercation on 12/22/2024. R1's progress note dated 06/26/2024 reads in part, Writer was informed by social service that (R1) was punched on her face by her roommate. Upon assessment (R1) stated that she was on the toilet when roommate walked up to her and punched her on her face, leaving her with left cheekbone swelling. Ice was applied. (R1) room was changed, and MD ordered that resident go to the ER for medical evaluation of her face. R3's progress note dated 06/26/2024 reads in part, This writer was informed that (R3) punched her roommate on the face, and left roommate's face swollen. (R3) stated that roommate was verbally aggressive towards her, and she proceeded to call her names, she ask her to stop but she didn't and she punched her on the face. At this time (R3) was separated from her roommate, roommate is assigned to a new room and her swelling is treated with ice. We will continue to monitor and document. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	R2's progress note dated 12/22/2024 reads in part, Writer was informed of the altercation between (R2) and (R3). Situation was immediately deescalated, head to toe assessment done. Skin discoloration and a scratch noted to the right side of the face. Vitals are (Blood Pressure) 128/86, (Temperature) 98.3, (Pulse) 82, (oxygen level) 98% on room air. (R2) denied pain. Police called. (Physician) notified. (R2) transferred to (local hospital) via EMS (emergency medical service) for medical evaluation. R3's progress note dated 12/22/2024 reads in part, (R3) was reported for initiating an altercation with another resident. Removed the receiver (R2) of the altercation from the initiator (R3) of the altercation. Writer assessed the initiator (R3) of the altercation for any injuries or cognitive changes. Resident that initiated the altercation (R3) VS's (vital signs) were (Blood Pressure) 156/97, (Respiratory Rate) 18, (Temperature) 97.5 (Oxygen level) 98%, (Pulse) 92. (R3's) eyes were round and equal, normal chest rise, skin intact and warm & dry. No bruising, lacerations, scratches or abrasions. (R3) is verbally responsive. Psychiatric physician was called. Initially, writer was ordered to send the resident to (local hospital). (Local hospital) rejected intake of the initiator (R3) because facility capacity was full. (R3) taken to (another local hospital) via (transport) ambulance. R2's hospital record dated 12/22/2024 reads in part, (R2) presenting for evaluation of physical assault. (R2) report that she was walking down the hallway at (the facility) and got assaulted by another resident. (R2) reports of the resident slammed her face to the ground. (R2) is complaining of pain to the right side of the face and her jaw. Physical exam: (R2) appears anxious but non-toxic; multiple bruises noted to the right side of the face, tenderness to palpation to the right maxilla. Police report requested on 03/20/2025, unable to obtain it during course of the survey. The facility Abuse policy dated 03/2022 reads in part, The facility affirms the right of our consumers to be free from verbal, physical, sexual, mental abuse, neglect, exploitation, misappropriation of property, involuntary seclusion, or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of consumers. In order to do so, the facility has attempted to establish a consumer sensitive a consumer 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 consumers. This will be done by establishing an environment that promotes consumer sensitivity, consumer security, and prevention of mistreatment; identifying occurrences and patterns of potential mistreatment.