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	04/01/2025

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 - 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** 40718 Based on interviews and record reviews the facility failed to follow their abuse policy and procedures by restricting a resident from returning to their room with their personal items and physically restraining them against their will. This failure applies to one of three residents (R1) reviewed for abuse. Findings include: R1 is a [AGE] year-old male with a diagnoses history of Schizoaffective Disorder, Recurrent Severe Major Depressive Order with Psychotic Symptoms, PTSD, Generalized Anxiety Disorder, Brain Cancer, and Suicidal Ideations who was admitted to the facility 01/14/2025. (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: 14E177	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER Crestwood Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE 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	On 03/31/2025 at 1:00 PM V3 (Psychosocial Services Rehabilitation Services Assistant/Security Guard) stated on 03/19/2025 between approximately 7:15 AM and 7:20 AM during smoke break, he heard social services being paged to the front desk and when he arrived R1 was in the middle of screaming, yelling, and cursing at V5 (Receptionist) and stating no one could check his things and they didn't have a right to check his belongings. V3 stated the delivery driver didn't bring R1's groceries all the way in the facility and had left them in the vestibule area between the front doors of the facility. V3 stated he walked into that area and grabbed the groceries delivered for R1, brought them back near the social services office and asked R1 to give him a second because he didn't have the key to the social services office. V3 stated he turned around briefly and by the time he turned back around R1 had grabbed all the groceries in his hands and was attempting to go back to his room, so he stood in front of him and told him he couldn't go back to his room. V3 stated R1 had a case of pop that was starting to break apart and when he went to grab the can to prevent it from falling R1 thought he was attempting to take it from him and began screaming at him, lunged at him, then physically attacked him. V3 stated when he got up after being attacked by R1, R1 had grabbed all his belongings again, took his belongings to the dining room table and sat there for approximately 10 seconds. V3 stated R1 then attempted to get his belongings again and head to his room but wasn't able to and then became loud and began screaming and yelling at V4 (Psychosocial Services Rehabilitation Services Assistant/Security Guard). V3 stated V4 was in the dining room with R1 during this time he believes attempting communicate with him and keep him calm. V3 stated when R1 began approaching his room V4 stopped him and then R1 became aggressive with V4 and attempted to push his way through him. V3 stated then he and V4 took R1 belongings out of his hands, put him in a CPI hold and took him to the ground. V3 stated he and V4 had R1's arms and took him to the ground. V3 stated he had R1's arms above his head and V4 had his legs, then the police arrived. V3 stated R1 was being held for about 45 seconds to a minute before the police arrived. V3 stated when he no longer felt any resistance from R1 arms he let them go and when V4 no longer felt any resistance with R1 legs he let them go. V3 stated at this point the police were involved, they took some statements and then R1was sent to the hospital. On 03/31/2025 at 1:50 PM V6 (Registered Nurse) stated on 03/19/2025 she observed R1 and V3 (Psychosocial Services Rehabilitation Services Assistant/Security Guard) standing in the hall between the social services office and the nursing station and V3 was explaining to R1 that he needed to check in R1 belongings. V6 stated R1 became upset because he didn't want his belongings checked in while V3 continued to explain the facilities policies. V6 stated she then observed R1 physically attack V3. V6 stated afterwards V4 (Psychosocial Services Rehabilitation Services Assistant/Security Guard) and other staff gathered around and physically separated R1 and V3 and were verbally redirecting R1. V6 stated she next observed R1 on the floor in the dining room but she did not see why he ended up on the floor. V6 stated V4 had restrained R1 because he was attempting to go to his room. V6 stated V4 was in the dining room near R1 and does believe she saw V4 trying to restrain R1. V6 stated V4 had R1 pinned to the floor by his arms. V6 stated the police then arrived. The facility's Final Abuse Investigation report and corresponding witness statements submitted to the state agency on 03/28/2025 regarding an allegation of abuse from R1 against staff on 03/19/2025 documents R1 was involved in a physical altercation with an employee, does not include any witness statements from V3 (Psychosocial Services Rehabilitation Services Assistant/Security Guard) nor any information reported from V6 regarding R1 being restrained. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14E177	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER Crestwood Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE 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	On 03/31/2025 at 3:52 PM V2 (Psychosocial Rehabilitation Services Coordinator) stated residents belongings are searched whenever they place orders for outside packages or food. V2 stated they don't dig through the residents belongings but rather ask to observe their items with their assistance. V2 stated staff doesn't touch the resident's belongings such as their bags and if they receive items that are delivered, they will ask the resident to open the bag and allow them to look inside and explain this is for safety purposes. V2 stated R1's groceries that were delivered on 03/19/2025 needed to be searched for safety purposes. V2 stated the procedure for receiving groceries is to notify the resident that the groceries have arrived which are left with the receptionist. V2 stated the receptionist will page social services staff to come and search the resident's groceries with the resident present. V2 stated once social services staff respond to the page, they then notify the resident that the groceries need to be checked and after checking them offer assistance to bring groceries to their room. V2 stated while searching resident's groceries the residents are asked if any of the items are glass wares or perishable. V2 stated the staff asks the resident to open the grocery bag and they then just look through it. V2 stated R1 did have the right to collect his own groceries they just needed to be checked. V2 stated V3 (Psychosocial Services Rehabilitation Services Assistant/Security Guard) likely grabbed R1's groceries from inside the front doors for safety purposes because of where they were located. V2 stated if R1 insisted he didn't need help collecting his groceries after the items were removed from the doorway, staff should just allow him to collect them as long as he was not attempting to take his belongings to his room without being searched. V2 stated if R1 insisted on collecting his own groceries and continued refusing to have them searched staff should just monitor him and ensure he is not attempting to hurt himself or others. V2 stated no staff should be putting their hands on the resident. V2 stated staff monitoring after a behavioral incident would include speaking to them in a calm manner and checking on them once in a while because the resident may still be upset after a physical altercation and may not even want to speak to anyone. V2 stated staff should not have blocked R1 from getting to his room when attempting to take his groceries to his room after the physical altercation with staff and at that point his bags had been on the floor and all of his belongings would have been observed. V2 agreed there was no reason to physically restrain R1 when attempting to take his groceries to his room. V2 stated if V3 and V4 held R1 down on 03/19/2025 it should have been reported however it wasn't. V2 stated all physical interventions should be a last resort. V2 stated the facility does not even use the term physical restraint to describe handling residents. The facility's Abuse Policy received 03/31/2025 states: This facility affirms the right of our residents to be free from physical abuse or mistreatment. This facility therefore prohibits abuse and mistreatment of residents. Abuse is unreasonable confinement. This assumes that all instances of abuse of residents, even those in a coma, cause physical harm or pain or mental anguish. Unreasonable confinement means the separation of a resident from her/his room against the resident's will.