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	01/09/2026

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. Based on interview and record review, the facility failed to supervise a resident who was diagnosed with bilateral eye blindness, used a white cane and required supervision and touching assistance with ambulation to prevent an avoidable accident and altercation. This affected two of three residents (R1, R2) reviewed for supervision. This resulted in R1 tripping over R2's wheelchair and the resident engaging in a resident-to-resident altercateion.Findings Include:R1 was diagnosis with category five blindness to the right eye, category four blindness to the left eye, atrophy of globe of right eye. Minimal Data Set Section B (vision) document severely impaired. Section C (cognitive pattern) dated 12/29/25 documents: brief interview for mental status summary score of fifteen which indicate cognitively intact. Section GG (functional abilities) documents mobility device: cane/crutch. Walk ten (10) feet: Once standing, the ability to walk at least 10 feet in a room, corridor or similar space documents a score of (04) four. 04 indicates: supervision or touching assistance- helper provides verbal cues and or touching/steading and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. R1' s care plan initiated 12/5/2024 documents: R1 has an activities of daily living (ADL) Self Care Performance Deficit related to diagnosis of legal blindness. R1 uses a white cane for ambulation. Intervention: Assist R1 with ambulation, transfer, etc as necessary. Ensure R1 uses his white can when up and about.Incident note dated 1/7/25 documents: Writer was alerted by staff that resident (R1) was punched in the abdomen by a co-resident. R1 states that he was going to put his coffee back at the kitchen window, he accidently bumped into another resident (R2) which caused his co-resident to become agitated and punched him in the abdomen. Resident (R1) stated he retaliated and hit co-resident (R2) with his ambulating device.Physical Aggression Received report dated 1/7/26 documents: Writer was alert by staff that resident (R1) was punched in the abdomen by another resident. Was this incident witnessed: N (which indicates no.)Facility Initial reportable incident dated 1/7/26 documents: Residents (R1/R2) were involved in an altercation.On 1/8/26 at 1:43pm, R1 who was assessed to be alert and oriented, said, he went to put his coffee cup up in the window. R1 said, he bumped into something and almost fell. R1 said, he can see shadows. R1 said, he asked the resident (R2) he bumped into why was he sitting there. R1 said, he did not see R2. R1 said, R2 punch him in the chest with his fist. R1 said, he hit R2 two or three times with his cane.R1's witness statement dated 1/8/26 documents: I was putting my cup in the window, that guy was there in his wheelchair. I can't see that good, I bumped into the chair. I tried to say that I was sorry but he (R2) started yelling f**k you, f**k you. The he (R2) hit me, so I hit him back. Social service note dated 1/7/26 documents: The resident (R1) was seen trying to get past another peer, in which he lost his step and hit the peer with his cane.On 1/8/26 at 1:48pm, R2 who was assessed to be alert and oriented to person, place and time said, he was getting ready to put his coffee cup away and R1 hit him in the mouth with his cane. R2 said, R1 busted my lips. R2 showed surveyor the inside of his upper top lip. R2's upper lip was observed (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with a redden raised area the size of a dime with a white soft tissue middle that was consistent with a busted lip. R2 said, he did not hit R1.R2's witness statement dated 1/8/26 documents: He (R1) bumped into my chair and got mad and hit me.Daily note dated 1/7/26 documents: Resident (R2) was involved in a physical altercation with another resident (R1) where he was hit. A superficial scratch was observed on the right upper lip.On 1/8/26 at 2:13pm, V6 (medical records) said, she saw R1 hit R2 on the head with his stick. V6 said, R2 was sitting in his wheelchair covering his head. V6 said, V3 (social service aide) was the first staff member to intervene. V6 (medical record) witness statement dated1/8/26 documents: I was doing big bank. I heard an uproar with resident and staff. I saw that R1 was striking R2 with his walking stick. V3 came and intervened and separated them.On 1/8/26 at 2:18pm, V4 (activity aide) said, she was wrapping up from making coffee. V4 said, she looked up after hearing residents arguing. V4 said, she heard R1 who is legally blind ask R2 what are you sitting here. R2 got upset and replied f**k your mom, f**k you. R1 was taking his coffee cup to the window. Normally we take, R1's coffee cup up to the window. V4 said, she saw R1 hit R2 a few times with his cane. V4 said, R1 hit R2 in the mouth with his cane.V4 (activity aide) witness statement dated1/8/26 documents: I was making fresh coffee for the resident. I hear verbal communication between R1 and R2. I placed the coffee on the cart while yelling to get the residents attention as well as staff. R1 was swinging his stick. By the time, I got over there, hits were being thrown. I continue to get louder so other people can hear me from afar.On 1/8/26 at 2:27pm, V3 (social service aide) said, he was monitoring the smoking break. V3 said, he was in the doorway between the outside patio and the main dining room. V3 said, he heard a commotion. V3 said, he heard cursing. V3 said, he saw R1 having a physical altercation with R2. R1 hit R2 the face. R2 had blood coming from his mouth.On 1/8/26 at 4:04pm, V2 (PRSD) said, the incident between R1 and R2 could have been prevent had the resident's been supervised.On 1/9/26 at 10:12am, V1 (administrator) said, she does not have access the video footage from 1/7/26 involving R1/R2's incident. V1 said, it's an IT issue.On 1/9/26 at 11:20am, R3 who was assessed to be alert and oriented to person, place and time, said R1 was returning his coffee cup. R3 said, the facility wants residents to pick up after themselves. R3 said, R1 fell into R2's wheelchair. R3 said, R1 got tangled in R1's wheelchair. R3 said, he saw R2 hit R1. R3 said, R1 had his cane folded up in his pocket. R3 said, R1 keep his cane folded in his pocket when it's not in use so he won't loss it. R3 said, he saw R1 take his cane out of his pocket and hit R2 with the leather piece on his cane. R3 said, R1 stumbles over residents and walks into their wheelchairs daily. R3 said, whenever R1 gets entangled or bumps into someone, R1 will walk forward verses backing up.On 1/9//26 at 1:03pm, V5 (nurse) said, she did not witness the incident between R1 and R2. V5 said, it was at the change of the shift. V5 said, she heard staff calling nursing. V5 said, she cannot say which staff called her. V5 said, staff was yelling staff/nurse. V5 said, when she reached R1 and R2 the incident had happened and was over.On 1/9/26 at 2:43pm, V1 said, she does not have a supervision policy, but her staff has been educated on supervising and monitoring the resident that included a post test.On 1/9/26 at 3:00pm, V2 (DON) said, R1 is legally blind and ambulates with a cane (mobility tool) to detect obstacles or objects. V2 said, R1 does not need anyone to walk with him. V2 said, if a resident requires supervision with ambulation staff needs to be within arm's reach of the resident. V2 said, if a resident requires touching assistance with ambulation, then the staff needs to physically touch the resident to assist. On 1/9/26 at 3:34pm, R1 said, he was walking without his cane. R1 said, on the day of the incident, no staff was helping him returned his coffee cup. R1 said, staff helped today. R1 said, he cannot see until he gets right up on a person/resident or object. The top portion/ handle of R1's assistive ambulation device (cane) was observed with leather wrapping.On 1/9/26 (continued on next page)

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