STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E177	A. BUILDING _____ B. WING _____	09/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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.

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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** Based on interview and record review, the facility failed to follow their abuse policy by not preventing the physical assault of one of four residents (R1) reviewed for physical abuse. This failure resulted in R1 being physically assaulted by R2. R1 was transferred to the local hospital and treated for [REDACTED]. Findings include: R1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R1 reported she was pushed by R2. R1 sustained a cut to back of her head and sent to local hospital. R2 was taken by local police. Based on the investigation conducted review of medical records and interview of staff and residents involved, it can be concluded that R2 pushed R1. R1 fell as a result of the push. It can be concluded that R2 did not have any willful intent of causing harm or physical abuse to R1. R2 appeared to be exhibiting behaviors related to his diagnosis. V12 (CNA) statement documents she saw R2 go straight to R1 in the dining room and started beating her and pushed her on the floor and hit her head on the floor then there was blood all over the floor. V5 (social service aide/security) statement documents R1 was on the floor and said R2 pushed her. R2 was coming out of (A) wing and said he didn't know what happened. Then he came back and kicked R1 and he kept kicking and punching R1. V8 (nurse) statement documents R1 was attacked, beaten and pushed down by another pacing /agitated Resident. R1 sustained an injury to back of her head and blood was noted gushing out from injured area. R1's care plan dated 1/13/07 documents R1 is at risk for abuse and neglect based on comprehensive assessment. R1 has behavior or using racial slurs, verbally aggressive, making demeaning and offensive comments. Interventions in place initiated 1/13/07 are as followed assure R1 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. Counsel R1 on the importance of appropriate behaviors and encourage to utilize appropriate coping techniques; establish guidelines regarding visiting if persons interested in visiting have a history of inappropriate and maladaptive behavior towards R1. Provide supervision during visits, as necessary. Local police incident report dated 9/17/20 documents call related to a battery complaint. R2 said he kicked R1. R2 related he did not know R1 and R1 did nothing to upset him. R2 was detained. V12 (CNA) reported she was in the C wing when she heard a man screaming. V12 said she exited the room and observed R2 running and screaming down the hallway. V12 said she followed behind R2 and observed him enter the dayroom at which time he ran up to R1 pushed her to the ground and began kicking and punching her while she was on the ground. V5 (social service aide/security) said he entered the day room and observed R2 kicking R1. V5 was able to get R2 to walk away from R1 and then R2 spun away from him and ran back to R1 and began kicking R1 again. Unable to speak to R1 due to hysterical condition. On 9/25/20 at 9:47AM, R1 said she was going to get something from vending machine that night and said that R2 just attacked her. R1 said R2 threw her to the ground and she had to get stitches to back of her head, five or six broken ribs and one punctured her lungs. R1 reports being in pain a lot. R1 said she was scared and afraid of getting hit again. R1 said she was afraid for her life if she went back to nursing home. R1's local hospital records dated 9/17/20 document R1 from local nursing home after being pushed by another resident. R1 fell and hit her head and has laceration to the back of her head. Laceration length of 3 cm with depth of 6mm that required 6 staples. CT of chest on 9/17/20 documents acute fractures involving the right third rib, right posterolateral fourth, fifth and sixth rib. Acute right posterior tenth and eleventh rib fracture. Right sided pneumothorax. Facility abuse prevention program policy dated 2/7/2017 documents, the facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. Abuse means any physical or mental injury inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury. The term willful in the definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Physical abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. Physical abuse includes hitting, slapping, pinching, kicking and controlling behaviors.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their abuse policy by not reporting a final abuse investigation within 5 working days to the Regulatory agency for 1 of 3 residents (R1) reviewed for physical abuse. Findings include: On 9/29/20 at 1:40Pm, V1 (administrator) said final abuse [MEDICATION NAME] should be sent within 5 days to department of health. Facility initial abuse reportable for R1 and R2 dated 9/17/20 at 1:27AM was emailed to regional office. Facility final abuse report for R1 and R2 dated 9/25/20 at 1:53PM was emailed to regional office. Facility abuse prevention program policy dated 2/7/2017 documents, under five day final investigation documents within five working days after the report of the occurrence, a complete written report of the conclusion of the investigation including the steps the facility has taken in response to the allegation, will be sent to the department of public health
F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** Based on interview and record review the facility failed to provide documentation or evidence of notification of transfer in writing to a residents representative and failed to notify the ombudsman of facilites discharge and transfer for 1 of 3 residents (R3) reviewed for discharge. Findings include: R3's progress note dated 8/17/20 documents ADDENDUM: Resident was presented with an emergency notice of Involuntary discharge and not a 30-day notice of Involuntary discharge as earlier documented. R3's progress note dated 8/14/20 documents resident transferred out via Vital ambulance plus two attendants, in stable condition, and transferred without further incident. Unable to reach family at the listed number. On 9/25/20 at 353Pm, V1 (administrator) said unable to recall who informed R3's representative but claims to have spoken to R3's representative that evening but failed to document conversation. V1 said she did not have any copies of letter sent to R3's family. On 9/25/20 at 1:15 PM, V4 (social service director) said he did not communicate with R3's family on 8/14/20. On 9/29/20 at 1:38Pm, V4 (social service director) said they should report to ombudsman monthly any transfer or discharges. The facility had log but did not fax July or August resident transfer information until today. Facility fax transmittal

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

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.

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F 0623 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) dated 8/14/20 document 6 pages were sent to ombudsman. There is no mention of R3's name or any other information on fax. R3's medical record does not document any evidence that written notice was sent to R3's representative. Facility emergency transfers log for July and August were faxed to ombudsman's office on 9/29/20. Facility's policy on involuntary transfer revised 7/20/18 documents the facility is responsible for: notifying the physician. The physician should order emergency transfer and enter note explaining the situation; completing transform form; completing discharge summary; notifying resident and /or representative the reason for transfer and notification must be in writing.
F 0626 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.** Based on interview and record review the facility failed to follow facility's policy on involuntary transfer to reevaluate a resident after hospital stay for readmission, failed to clearly document in the resident medical record the reason for discharge for 1 of 3 resident (R3) reviewed for readmission. Findings include: R3's progress note dated 8/14/20 documents Resident presented with mental status change characterized by being impulsive, anxious, angry and set peer's clothes (in the peer's dresser) on fire with a cigarette lighter. A review of R5's progress note dated 9/10/20 document Resident noted smoking in her room by her oxygen tank and making delusional statement. R5 sent to hospital. R5's progress note document R5 returned to facility on 9/15/20. On 9/25/20 at 3:53Pm, V1 said no one went to evaluate R3 during hospital stay or prior to discharge from hospital. R5 was allowed to return because she had clear understanding of right and wrong. R5 was able to be redirected and R3 was not able to be redirected based on their brief interview scores. On 9/25/20 at 1:15 pm, V4 (social service director) said she was not aware of anyone evaluating R3 after hospital stay. V4 said R5 was able to return because she was already planning a discharge from the facility. On 9/29/20 at 10:12AM, V36 (physician) said he did not document in R3's medical record about the reason for discharge or need that could not be meet at facility. V36 said he would have documented that in R3's hospital record after incident. V36 said all progress notes would be in electronic record and not on paper. R3's medical record does not indicate any communication with hospital following discharge on 8/14/20. R3's medical record does not document the needs the facility could not meet for readmission. R5's brief interview for mental status dated 9/23/20 indicates score of 14 indicating cognitive intact. R3's brief interview for mental status dated 6/10/20 indicates score of 15 indicating cognitive intact. Facility's policy on involuntary transfer revised 7/20/18 documents the facility is responsible for: notifying the physician. The physician should order emergency transfer and enter note explaining the situation; completing transform form; completing discharge summary; notifying resident and /or representative the reason for transfer and notification must be in writing.
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** Based on interview and record review the facility failed to develop a plan of care with effective interventions to monitor/supervise a resident with a history of aggressive behaviors to reduce the risk of peer to peer physical assault affecting 2 of 5 residents (R2/R1) reviewed for supervising aggressive behavior. This failure resulted in R2 physically assaulting R1 causing R1 a right sided pneumothorax, broken ribs and a laceration requiring (6) staples at the local hospital. The facility also failed to develop a plan with interventions to prevent or reduce the risk of fire setting for a resident with known history of setting fire for 1 of 3 residents (R3) reviewed for supervision. This failure resulted in R3 setting a pile of clothing in R3's room on fire. Based on interview and record review the facility failed to develop a plan to prevent a resident with history of poly substance abuse from obtaining unknown prescription medication from outside of the facility. This failure affected 1 of 3 residents (R5) reviewed for supervison. Findings include: R2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R2 started throwing punches and hit one staff to left side of her head. R2's progress notes document on 2/23/20 R2 hit another resident in the arm and sent to local hospital. R2's progress note dated 3/13/20 document R2 becoming aggressive with another peer (R11) and sent to local hospital. Facility abuse reportable dated 3/20/20 document R11 said R2 pushed her. Staff reported R2 becoming agitated and standing up out of his chair and pushing R11. R2's progress note dated 6/15/20 document R2 was physically aggressive toward staff and damaging facility property. R2's progress note dated 9/17/20 document R2 was running in dining room and agitated. R1 was on the floor attacked, pushed down and beaten. R2's care plan focus documents: The resident has history of aggressive behavior and has exhibited verbally/physically abusive behavior related/manifested by: Being challenged by mental illness, ineffective coping mechanisms, physically abusive behavior when agitated, poor verbal skills and inability to express self in more appropriate language. Resident was physically aggressive towards staff and peers on 2/10/2020. R2 attempted physical aggression towards staff on 02/19/2020. Resident was physically aggressive towards a peer on 2/23/2020. Resident was physically aggressive to female peer on 9/18/20. The following intervention all initiated 1/27/20 document the following: Assist in identifying coping skills for anger control; Avoid getting in power struggle with resident; Encourage verbalization of concern and make clarifications if needed; Explain the rules of Conduct to the resident and importance to treat others with respect; Intervene by speaking in a calm and professional soft tone of voice; Utilize the use of behavior contract if needed; Utilize the use of Non Violent Crisis Intervention as a last resort. On 9/25/20 at 1:15 PM, V4 (social service director) said R2 care plans should be updated after each behavioral incident. R2 required monitoring but unable to locate interventions related to monitoring in plan of care. V4 unable to locate any updates to R2's care plan or able to explain how interventions listed were effective. Facility final investigation dated 9/25/20 documents a resident to resident altercation on 9/17/20 at 1200 am in dining room. R1 reported she was pushed by R2. R1 sustained a cut to back of her head and sent to local hospital. R2 was taken by local police. Based on the investigation conducted review of medical records and interview of staff and residents involved, it can be concluded that R2 pushed R1. R1 fell as a result of the push. It can be concluded that R2 did not have any willful intent of causing harm or physical abuse to R1. R2 appeared to be exhibiting behaviors related to his diagnosis. V12 (CNA) statement documents she saw R2 go straight to R1 in the dining room and started beating her and pushed her on the floor and hit her head on the floor then there was blood all over the floor. V5 (social service aide/security) statement documents R1 was on the floor and said R2 pushed her. R2 was coming out of A wing and said he didn't know what happened. Then he came back and kicked R1 and he kept kicking and punching R1. V8 (nurse) statement documents R1 was attacked, beaten and pushed down by another pacing /agitated Resident. R1 sustained an injury to back of her head and blood was noted gushing out from injured area. R3 was admitted to facility on 6/3/2020 with a [DIAGNOSES REDACTED]. R3's Preadmission screening and Resident review Passar dated 6/15/20 documents under behavior type fire setting and arson; behavior level- high; 6/2019 burned bible under a porch. R3's Pre admission paperwork dated 5/28/20 documents, In regards to one to one constant supervision: patient stated I don't need anyone to watch me all day. If I am about to hurt myself or anyone, I'll let the nurse know right away. Monitor patient closely every 15 minutes. Facility reportable dated 8/14/20 documents R3 was upset with co-peer because she would not let her use her phone, so she reportedly took a lighter during smoking time, then went into the room and set some clothes on fire. Resident reported that her roommate was not in the room at that time. Code initiated. Resident was placed on one to one monitoring until ambulance arrived. R3 was given an emergency discharge upon leaving the facility. On 9/25/20 at 1:15 PM, V4 (social service director) said he was not aware of R3's history with fire and there should have been a plan of care in place to ensure we are able to meet the needs and ensure they are monitored. V4 said he was not made aware of R3's PASARR was in medical record. V4 said residents rooms are searched weekly if not daily by staff. If resident has history of unsafe smoking or behaviors we would do more room searches. On 9/25/20 at 3:53Pm, V1 (administrator) said she was not aware of R3's PASARR or preadmission paper work prior to admission. R3's plan of care does not document any interventions related to fire/smoking safety. R3's smoking safety risk assessment signed 6/5/20 documents a score of one indicating may be independent with smoking. Facility smoking safety policy revised 12-2018 documents, it is against facility policy to carry a lighter. Facility is match free facility. staff are available to light cigarettes for residents during designated smoking times. R5 was admitted with the [DIAGNOSES REDACTED]. R5's brief interview for mental status dated 7/2/2020 document a fifteen which indicates cognitive intact. On 9/23/2020 at 1:50pm, R5 said, I went to an outside substance abuse group. My drug of

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) choice is opioids. I asked V35 (Housekeeper) to get my medication from an outside pharmacy. I gave him my information and it was free to pick up. On 9/24/2020 at 12:21pm, V1 (Administrator) said, V34 (Activity Director) found a bag of medication in the activity room. She brought the bag to me. The medication was inside of a burger king bag. The V35 (Housekeeper) had the bag. V35 went to lunch an sat the bag down in the activity room. It was a clear bag, with a burger king bag and inside of the burger king bag were prescription bags with medication inside. V1 reported that V35 said, R5 asked him to pick up the medication as a favor. V1 said, V35 said, I thought it was ok to help the resident. I went to the pharmacy, gave them the residents name, got the medication and then got my lunch. I put the medication in my food bag. V35 left the building before I could complete the investigation. V35 was terminated for failing to return to work. On 9/24/2020 at 1:19pm, V4 (Social Service Director) said, staff was bringing R5 medication from an outside pharmacy. Staff brought the medication in the building inside a burger king bag. The facility doctors did not prescribe the medication. We did a room search and found some pills in R5's room. We discharged R5 to the hospital for a psychiatric evaluation. On 9/24/2020 at 2:22pm, V2 (Director of Nursing) said, we do not prescribe medication to treat opioid drug addiction. We don't have a license. The nurse practitioner at an outside group prescribed R5 the medication to treat opioid addiction. R5 should have not had the script. On 9/25/2020 at 3:03pm, V31 (Restorative Adie) said, we did a room search for R5. We found white loose pills in a bag in a sandwich bag. The bag was half full. On 9/25/2020 at 3:30pm, V32 (Psychiatrist) said, the facility was concerned that R5 was getting a medication to treat opioid drug addiction from an outside source. R5 had a prescription from a doctor that did not work with the facility. R5 had three or four brown bags full of different medication. The medication to treat opioid drug addiction was included in those bags, it was a controlled substance. The medication was confiscated. On 9/28/2020 at 10:31am, V33 (Medical Doctor) said, R5 has a psychiatrist. R5 was discharged to the hospital for a drug overdose. R5 had medication that was old. I don't know where she got the medication from. I did not prescribe the medication for opioid addiction nor was I aware of it. R5's Petition for Involuntary/Judicial admitted d 9/10/2020 documents: R5 has a lot of medication in room while a room sweep was being performed. Facility Inventory for Control Drugs date 9/11/2020 documents: R5 had one hundred and ten pills of medication for depression.
F 0925 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.** Based on observation, interview and record review the facility failed to have an effective pest control program with the present of roaches in the kitchen and gnats in the common areas. This failure affected 4 of 4 residents (R5, R6, R7, R13) reviewed for pest control. Finding includes: On 9/22/2020 at 2:59pm and 3:39pm two small bugs were crawling on the floor just past the entrance way. V3 (Dietary Manager) said, those are baby roaches. Dried food was observed stuck to the outside wall under the kitchen window. A cluster of gnats were seen attached to the wall under the kitchen window and flying around. V1 (Administrator) was shown the gnats. V1 said, do you want me to count them. On 9/23/2020 at 1:50pm, R5 who was alert and oriented said, I have seen roaches by the kitchen window. On 9/24/2020 at 10:30am, R6 who was alert and oriented said, I have had roaches on my tray when it came from the kitchen. On 9/24/2020 at 2:07pm, R13 who was alert and oriented said, I have seen plenty of gnats in my room and in the dining room when we are trying to eat. I saw some yesterday. On 9/25/2020 at 11:25am, R7 who was alert and oriented said, I saw gnats yesterday and today flying around my drink. On 9/25/2020 at 4:14pm, V1 (Administrator) said, the roaches have decreased considerably. Pest control Invoice dated: 9/1/2020 documents: Activity: German Roaches Location: Kitchen Pest control Policy dated 2014: Procedure: Keep pest out by prevention.