STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145939	A. BUILDING _____ B. WING _____	C 04/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERFRONT TERRACE	**7750 SOUTH SHORE DRIVE CHICAGO, IL 60649**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint Investigation 1681974/IL84746 - F223, F323 1682004/IL84783 - No Deficiency	F 000		
F 223 SS=D	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to avoid a resident from being exposed to the vebal abusive behavor of another resident (R1). This has the potential to affect two of five residents (R4, R3) reviewed for abuse in a sample of five residents. Findings Include: 4/20/2016 at 2:15pm, R4 was interviewed. R4 was R1's roommate from 3/21/2016 to 4/4/2016. R4 said R1 used profanity everyday when speaking to her and yelling out profanity at night. R1 called her 'Bs and MFs' when addressing her. "I couldn't watch television in my room without R1 saying 'turn that MF off'. I couldn't use the phone without R1 cursing at me." R4 was asked how she felt about R1 using profanity toward her. "I	F 223		

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

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felt bad. I'm not use to being called a 'B' every time someone talks to me. I complained to staff 7 days straight."

4/20/2016 at 2:35pm, E6 (Activity Aide) was interviewed. E6 was asked about R1's behavior during activities with other residents. E6 said she would pass R1 in the 1st floor hallway. R1 was in a recliner. R1 would ask to go to activities. "I would push R1 to activities in the day room. R1 would start cursing at everyone. This would happen every time R1 was in a group activity." E6 was asked if any of the residents got up set with R1 using profanity. "R3 would become agitated. Some residents just left the activity."

4/20/2016 at 2:45pm, R3 was interviewed. R3 said R1 cursed at all the activities. "R1 cursed when we had church services. It was upsetting. You couldn't enjoy anything because of her foul mouth."

4/19/2016 at 4:30pm, E4 (Social Service Director) was interviewed. E4 said that she was aware of R1 being verbally and physically abusive from admission. R1 was care planned for verbal and physical abuse 3/21/2016, R1's admission date. E4 presented a care plan dated 3/21/2016.

Social Service note dated 3/25/2016 documents R1 verbal and physical aggression. R1 threw a pop can at a visitor.

E4 was asked if she was aware of R4 complaining about R1's abusive language and R1 disrupting group activities on the first floor. "Yes, I confronted R1 about her behavior. R1 told me that she was not going to change. The plan was to move R1 to the 3rd floor with the Dementia

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residents. They would be less aware of her behavior." R1's current roommate is R5. R5 is diagnosed with Dementia, Altered Mental Status, Confusion, Dementia with Auditory Hallucinations, Major Depression and Cerebral Vascular Accident (CVA).

4/25/2016 at 12:50pm, E2 (Director of Nursing/DON) and E4 were interviewed concerning R4 having to live with R1's abusive behavior for 14 days. E2 said when R1 was admitted she was 'total care' and had to wear a 'Bi-PAP' at night. "R1 was yelling about the 'Bi-PAP'. I spoke to R4 about R1's behavior when R1 was first admitted to the facility. I told R4 that I did not have a bed to move R1 to at the time. R4 was okay with that. R4 said she understood R1 was crazy. E2 was asked if she went back and talked to R4 when R4 started complaining again about R1's behavior on a daily basis. E2 did not answer the question.

E2 was asked if she had followed the facility's "Grievance/Complaint" policy or initiated an abuse investigation concerning R1's abusive behavior towards R4. A "Concern/Compliment" form dated 4/4/2016 was produced. E4 signed the form as the person taking the report. E4 confirmed that she wrote the report, 4/4/2016. R1 was moved to the 3rd floor 4/4/2016. R4 had been complaining for 7 days prior to that.

The facility's procedure for filing "Grievances/Complaints" was reviewed. The policy stipulates that upon receipt of a grievance/complaint an investigation will take place and be concluded within 5 workings days. R4 complained for 7 days about R1 behavior, but the complaint form was never filed out until the

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facility had another bed available for R1 in order to meet the 5 working days guideline for investigating and resolving a complaint.

Z1 and R1 were interviewed. Z1 said R1 pointed to E5 and told her what he said. "I confronted E5 and told him what my sister said. E5 asked me if I believe what my 'crazy' sister said. I said 'Yes'." Z1 admitted to using profanity and going towards the housekeeping cart. Z1 said she did call another family member to come up to the facility to see what was going on. "That was my husband. He was checking to see if I was okay. They had me down stairs talking while he was up here on the 3rd floor."

During the entire interview, R1 was in her wheelchair using profanity to describe the staff and residents. R1 said she liked the residents on the 3rd floor. "They're just crazy. The staff and those other residents think they're better than me." Z1 kept yelling at her to "shut-up". R1 told Z1, "I can speak for myself."

Z1 was told about R1 threatening residents and staff that she will call Z1 or another family member to come into the facility and 'beat their ass'. Z1 said that she does not believe R1 all the time, but she does believe what R1 says a lot of the time. "That's why I went after E5. E5 told R1 to 'SUCK HIS DICK'. I know the staff was not going to do anything about it." Z1 was told about shaking R1's wheelchair in the hallway, Z1 said. "You call that being abusive. You call telling R1 to shut-up abusive." R1 said this about herself and her family, "This is how we 'roll'. This is how we are. We ain't changing."

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F 323	Continued From page 4	F 323		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the volatile behavior of a visitor (Z1) does not create a possible incident which could cause a resident harm. This failure applies to one of five residents (R1) reviewed for abuse and has the potential to affect 33 of 101 residents in the facility, who resides on the facility's third floor resident unit. Findings Include: On 4/20/2016 at 12:45pm, Z1 (family of R1) was observed in the hallway of the 3rd floor next to the nurse's station with R1. Z1 was forcefully shaking R1's wheelchair and telling R1 to 'shut-up'. R1 was using profanity. A third floor nurse was at the medication cart which was within 5 feet of Z1 and R1. Other staff members were within visual range. No one stopped Z1. On 4/20/16 the surveyor interviewed Z1 and R1. Z1 was questioned about shaking R1's wheelchair in the hallway, Z1 said, "You call that	F 323		

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being abusive. You call telling R1 to shut-up abusive." R1 said, this about herself and her family, this is how we roll. This is how we are. We ain't changing."

Next, a Preliminary 24-hour Incident Investigation Report dated 4/13/2016 at 10:30am contained the following information:
A verbal altercation occurred between E5 (Housekeeper) and Z1 (family of R1) when Z1 accused E5 of telling R1 to perform oral sex on him. Z1 took a broom from the E5's cart and tried repeatedly to hit E5.

This incident occurred in the 3rd floor hallway. According to the surveyor's observation, the 3rd floor is a secure unit that houses cognitively impaired residents.

4/19/2016 at 3:20pm, E3 (nurse on the third floor) was interviewed. E3 said she was passing medications on the 3rd floor when she heard E5 and Z1 in the hallway. Z1 accused E5 of telling R1 to perform a oral sexual act on him. E5 said, "Do you believe what that crazy woman says?" Z1 said, "Yes!" E3 said she got between E5 and Z1 trying hold Z1 back. Z1 started talking about E5's "Mother". "Z1 grabbed the broom off the cart. I was holding her back from hitting E5. E5 was being held back." At the time of the incident (10:30am), the 3rd floor hallway was filled with residents walking, in wheelchairs and sitting in the hallway. E3 said R1 constantly used profanity toward staff and other resident. R1 was always threatening to call a family member to beat somebody butt. Z1 would threaten to sue the facility and call another family member to take care of us. Z1 used profanity when speaking to us."

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F 323	Continued From page 6 4/20/2016 at 11am, E7 (Director of Environmental Services) was interviewed. E7 was asked when is staff are trained to call the police? The facility does not have security guards or staff trained in Crisis Prevention Intervention (CPI). E7 did not know. 4/19/2016 at 3:45pm, E2 (Director of Nurses) was interviewed. E2 was asked if the Police was called 4/12/2016. E2 said, after everything calmed down she brought Z1 down to her office and asked if she wanted her to call the Police? E5 was also asked if he wanted to call the Police. E2 was asked why staff did not call the Police to the 3rd floor when Z1 picked up the broom and attacked E5. E2 did not answer the question. E2 was asked after this incident was any restrictions put on Z1. "No. I will do that now. I will restrict Z1 from coming into the building. Z1 will have to visit R1 in the Lobby." 4/20/2016, Z1 was observed on the 3rd floor of the facility with R1 in the hallway with other residents.	F 323		