Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002265	A. BUILDING: _____ B. WING _____	C 11/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD REHABILITATION CTR	14255 SOUTH CICERO AVENUE CRESTWOOD, IL 60445

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S 000	Initial Comments Complaint Investigations: 2299174/IL153413 -- No deficiency cited 2298716/IL152847 -- F689, F695 cited. 2298613/IL152715 -- F689 cited 2298358/IL152419 -- No deficiency cited. 2299715/IL151877--No deficiency cited.	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2) 300.1210b) 300.1210c) 300.1210d)6) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S9999	Continued From page 1 d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These Requirements were not met evidenced by: Based on interviews and record reviews, the facility failed to prevent an avoidable fall incident and failed to develop a plan to prevent or reduce the risk of falling. These failures affected 2 of 3 residents (R1, R2) reviewed for fall prevention. These failures resulted in R1 having a unwitnessed fall after R1 was observed with a low oxygen saturation level of less than 90% this fall resulted in R1 sustaining bilateral femur fractures, and R2 had 2 fall incidents within 2 days, R2 sustained a brain bleed after the second fall. Findings include: 1. On 11/18/22 at 10:45 am, V6 RT (respiratory therapist) stated that V6 does not recall R1. V6 stated that she sees all new admissions with diagnosis of heart failure. V6 stated that these residents are only followed for 30 days unless the resident's physician requests further visits from RT. V6 stated that she comes to this facility twice a week to see residents. This surveyor reviewed R1's notes with V6. V6 stated that she will double	S9999		

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S9999	Continued From page 2 check pulse oximetry results with a different machine if results are low. V6 stated that she contacts the nurse and the NP (nurse practitioner), if NP available, and alerts them to her findings and recommendations. V6 stated that oxygen saturation levels in the low 80s could cause a resident to exhibit confusion. There is no documentation found in R1's medical record noting the nurse or nurse practitioner/physician were notified of V6's low oxygen levels. On 11/18/22 at 12:15 pm, V7 (nurse) stated that if RT (respiratory therapist) has any new orders/recommendations, she will let the nurse know. V7 stated that V7 does not recall being informed by V6 RT of R1 having low oxygen levels. V7 stated that R1's vital signs are assessed every shift. V7 stated that V7 checked R1's oxygen saturation level while R1 was receiving oxygen. V7 stated that V7 would have known if R1's oxygen saturation level was in the 80s during her shift. When questioned how V7 would know if R1's oxygen level was low on room air if V7 only checked oxygen level while on oxygen, V7 did not respond. On 11/22/22 at 10:40 am, V13 NP (nurse practitioner) denied being aware of R1's oxygen saturation level 81% - 88% on room air. V13 stated that nobody communicated to him what was going on with R1: elevated BNP (b-type natriuretic peptide-blood test that provides how the heart is working, high level is a sign the heart is not working as it should be) and the need for oxygen use. V13 stated that V13 did not see R1 using any oxygen during his visits. V13 stated that there had to be something going on medically with R1 for her oxygen levels to be in	S9999		

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S9999	Continued From page 3 the 80's on room air. V13 stated that if V13 had been made aware, V13 would have come to facility to assess R1. Review of V6 RT's documentation notes the following: On 9/21/22, upon entering room, R1 was sitting in high fowler's position (upright position to help with breathing) in bed. R1's oxygen saturation level was 85% on room air, checked with two different pulse oximeters. R1 denies shortness of breath at this time, breath sounds are diminished bilaterally. R1 does have a non-productive cough. R1 was placed on 3 liters of oxygen via nasal cannula; oxygen saturation level gradually increased to 95% with oxygen. On 9/26/22, upon entering room, R1 was sitting in high Fowler ' s position in bed. R1 is slightly confused and will occasionally mumble her words. R1 was found off the oxygen. Oxygen saturation level on room air, checked with two different pulse oximeters, was 83-88%. R1 was placed back on 3 liters of oxygen via nasal cannula. R1's oxygen saturation level increased to 94%. On 9/28/22, upon entering room, R1 was sitting in high fowler's position in bed eating breakfast. R1 took her oxygen off to eat breakfast. Oxygen saturation level was 83% on room air. R1's breath sounds are diminished bilaterally. On 10/3/22, upon entering room, R1 was sitting in high fowler's position in bed. R1 was found off the oxygen. Oxygen saturation level was 81% on room air, checked by two different pulse oximeters. R1 was placed on 4 liters of oxygen via nasal cannula. R1's breath sounds are diminished bilaterally. Review of this facility's fall investigation report, dated 10/4/22, notes R1 was observed on her	S9999		

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S9999	Continued From page 4 knees beside bed. R1 stated that R1 was trying to go to the bathroom unassisted but knees got wobbly and R1 fell to floor. R1 complained of moderate pain to both knees. X-rays were completed at facility noting bilateral distal femur fractures. Review of R1's hospital record, dated 10/4/22, notes R1 presented to the hospital after having an unwitnessed fall in the bathroom. R1 stated she is unsure if she hit her head. R1 complained of constant, moderate pain to both knees, headache, and posterior head tenderness. Chest x-ray noted right lung airspace disease consistent with pneumonia or edema. X-ray of R1's left femur noted a displaced oblique (bone breaks diagonally) fracture of the distal femur. X-ray of R1's right femur noted a displaced comminuted oblique fracture of the distal femur. 2. On 11/22/22 at 10:00 am, V12 NP (nurse practitioner) stated that in her opinion, urgent x-rays should be completed within 4 hours. V12 stated that if not done within 4 hours, V12 would send the resident to the hospital for evaluation and treatment. V12 denied being informed of R2's first fall. This facility's fall investigation report reviewed with V12. V12 stated that it is unclear how R2 hurt both knees if he rolled out of bed. V12 acknowledged that a resident that has an unwitnessed fall and is receiving anticoagulation medication, V12 would err on the side of caution and send resident to the hospital for evaluation. On 11/22/22 at 10:15 am. V2 DON (Director of Nursing) stated that this facility does not have a policy related to unwitnessed falls. V2	S9999		

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S9999	Continued From page 5 acknowledged that a resident should be sent to the hospital if he/she has an unwitnessed fall, cannot explain what happened, and is receiving blood thinning medication. V2 stated that R2 denied hitting his head when he fell on 10/13. When asked how could R2 be certain he did not hit his head; after the fall R2 was disoriented x 3 per the neurological flowsheet and R2 did not know what happened, V2 did not respond. On 11/22/22 at 1:55 pm, V8 (nurse) stated that V8 did charting on R2's fall later in the evening on 10/13/22. V8 stated that x-ray was ordered at 3:29 pm, believes R2 fell just before shift change at 3:00 pm. V8 stated that she did neurological checks on R2, but could have gotten mixed up with the times when she documented on the neurological flowsheet. V8 stated that R2 complained of bilateral knee pain after fall and denied hitting his head. V8 stated that V8 initiated the fall documentation on 10/13/22. The fall investigation report reviewed with V8. When questioned how R2 hurt both knees rolling off bed, V8 did not respond. V8 stated that when V8 assessed R2 after fall, V8 does not believe she was able to determine R2's orientation status as R2 only shook head. There is no documentation on the fall investigation report, dated 10/13/22, noting R2 denied hitting his head. Review of the medical record notes R2 was admitted to this facility on 10/12/22 with diagnoses including: dementia, difficulty walking, weakness, and atrial fibrillation. Review of R2's POS (physician order sheet), dated 10/12/22, notes an order for Rivaroxaban (blood thinner) 20mg (milligrams) oral in the	S9999		

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S9999	Continued From page 6 evening for atrial fibrillation. Review of R2's neurological flowsheet, dated 10/13/22 starting at 4:30 pm, notes R2 disoriented x 3 (disoriented to person, place, and time). There is no documentation found in R2's medical record noting neurological checks were initiated at 3:00 pm, the time of R2's fall. There also were no neurological assessments documented from 10/13/22 at 9:15 pm until R2 had a second unwitnessed fall on 10/15/22 at 1:15 am. Review of R2's medical record, dated 10/12/22, V12 NP noted R2 is alert and oriented x 1. R2 is a high fall risk. On 10/13 at 10:59 pm, V8 (nurse) noted: R2's family member informed nurse that R2 was on the floor. V8 went to assess R2. R2 was face down in prone position on his floor/fall mat next to his bed. Neurological check performed. Head to toe assessment performed. R2 is confused and could not recount what happened. R2 had complaints of pain to bilateral knees. Physician notified. Orders for urgent x-ray of bilateral knees in place. 10/14/22 at 12:48 pm, V19 (nurse) noted: R2 observed walking toward the nursing station, staff were called to re-direct R2 back to his room, R2 was noted with confusion. R2's bed in lowest position for resident comfort, floor mat on both side of the bed due to recent fall, call light within resident reach even though R2 wasn't cognitive to use it. On 10/15/22 at 00:51 am, V16 (nurse) noted: V16 was called to the R2's room. R2 was observed lying on the floor on his right side in his bedroom. R2 was observed with a hematoma on his right side of his head with active bleeding. R2's head was cleaned, and the bleeding was stopped. R2	S9999		

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S9999	Continued From page 7 was unable to express events leading to fall. Review of R2's urgent bilateral knee x-rays were ordered on 10/13/22 at 3:23pm and were not completed until 10/14/22 at 6:40 am. Review of R2's hospital record, dated 10/15/22, notes R2 presented to the hospital at 1:36 am after an unwitnessed fall. R2's hospital diagnosis: traumatic subarachnoid bleed with loss of consciousness. CT (computerized tomography) scan of R2's head noted: right frontal subarachnoid hemorrhage (bleeding within the subarachnoid space, which is the area between the brain and the tissue covering the brain. It causes sudden, severe headache, nausea, vomiting and loss of consciousness.) with adjacent cortical petechial bleed (A petechial hemorrhage in the brain occurs as result of a brain contusion, which is a form of traumatic brain injury that leads to the bruising of the brain tissues), and a prominent right scalp hematoma. Review of this facility's fall investigation report, dated 10/13/22 approximately 3:00 pm, notes R2 was observed on the floor lying face down in front of R2's bed. R2 was unable to state what happened due to cognitive status. Neurological checks were not initiated until 4:30 pm. On 10/15/22 at 1:15 am, R2 had second unwitnessed fall and hit head on wood room divider on 10/15/22 at 1:15 am. This report notes R2 experiences periods of confusion and not consistent with calling for assistance. R2 sustained bleeding on brain and was hospitalized. (A) Statement of Licensure Violations (2 of 2)	S9999		

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S9999	Continued From page 8 300.1010h) 300.1210b) 300.1210d)3) Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour,	S9999		

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S9999	Continued From page 9 seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. These Requirements were not met evidenced by: Based on interviews and record reviews, the facility failed to adequately monitor and treat an oxygen saturation level of less than 90% for one resident (R1) out of three reviewed for change in respiratory status. This failure resulted in R1 having a oxygen saturation level between 81 and 88% for 13 days. R1 had a fall incident and was sent to the local hospital. R1 sustained bilateral femur fractures and was treated for respiratory acidosis and required use of BIPAP (Bilevel positive airway pressure) machine. Findings include: On 11/18/22 at 10:45 am, V6 RT (respiratory therapist) stated that V6 does not recall R1. V6 stated that she sees all new admissions with diagnosis of heart failure. V6 stated that these residents are only followed for 30 days unless the resident's physician requests further visits from RT. V6 stated that she comes to this facility twice a week to see residents. This surveyor reviewed R1's notes with V6. V6 stated that she will double check pulse oximetry results with a different machine if results are low. V6 stated that she contacts the nurse and the NP (nurse	S9999		

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S9999	Continued From page 10 practitioner), if NP available, and alerts them to her findings and recommendations. V6 stated that oxygen saturation levels in the low 80's could cause a resident to exhibit confusion. There is no documentation found in R1's medical record noting the nurse or nurse practitioner/physician were notified of V6's low oxygen levels. On 11/18/22 at 12:15 pm, V7 (nurse) stated that if RT (respiratory therapist) has any new orders/recommendations, she will let the nurse know. V7 stated that V7 does not recall being informed by V6 (RT) of R1 having low oxygen levels. V7 stated that R1's vital signs are assessed every shift. V7 stated that V7 checked R1's oxygen saturation level while R1 was receiving oxygen. V7 stated that V7 would have known if R1's oxygen saturation level was in the 80's during her shift. When questioned how V7 would know if R1's oxygen level was low on room air if V7 only checked oxygen level while on oxygen, V7 did not respond. On 11/22/22 at 10:40 am, V13 NP (nurse practitioner) denied being aware of R1's oxygen saturation level 81% - 88% on room air. V13 stated that nobody communicated to him what was going on with R1: elevated BNP (b-type natriuretic peptide-blood test that provides how the heart is working, high level is a sign the heart is not working as it should be) and the need for oxygen use. V13 stated that V13 did not see R1 using any oxygen during his visits. V13 stated that there had to be something going on medically with R1 for her oxygen levels to be in the 80's on room air. V13 stated that if V13 had been made aware, V13 would have come to facility to assess R1.	S9999		

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S9999	Continued From page 11 Review of V6 RT's documentation notes the following: On 9/21/22, upon entering room, R1 was sitting in high fowler's position (upright position to help with breathing) in bed. R1's oxygen saturation level was 85% on room air, checked with two different pulse oximeters. R1 denies shortness of breath at this time, breath sounds are diminished bilaterally. R1 does have a non-productive cough. R1 was placed on 3 liters of oxygen via nasal cannula; oxygen saturation level gradually increased to 95% with oxygen. On 9/26/22, upon entering room, R1 was sitting in high Fowler ' s position in bed. R1 is slightly confused and will occasionally mumble her words. R1 was found off the oxygen. Oxygen saturation level on room air, checked with two different pulse oximeters, was 83-88%. R1 was placed back on 3 liters of oxygen via nasal cannula. R1's oxygen saturation level increased to 94%. On 9/28/22, upon entering room, R1 was sitting in high fowler's position in bed eating breakfast. R1 took her oxygen off to eat breakfast. Oxygen saturation level was 83% on room air. R1's breath sounds are diminished bilaterally. On 10/3/22, upon entering room, R1 was sitting in high fowler's position in bed. R1 was found off the oxygen. Oxygen saturation level was 81% on room air, checked by two different pulse oximeters. R1 was placed on 4 liters of oxygen via nasal cannula. R1's breath sounds are diminished bilaterally. Review of R1's medical record notes R1 was admitted to this facility without the need for	S9999		

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S9999	Continued From page 12 oxygen use. Review of R1's hospital record, dated 10/4/22, notes R1 presented to the hospital after having an unwitnessed fall at this facility. Chest x-ray noted right lung airspace disease consistent with pneumonia or edema. R1 was placed on BIPAP machine due to somnolence (excessive sleepiness) and respiratory acidosis with elevated carbon dioxide level. (no violation)	S9999		