STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		IL6002273	B. WING			C <b>15/2024</b>
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CRESTW	OOD TERRACE		OUTH CENTRA			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
S 000	Initial Comments		S 000			
	Complaint Survey:	2491959/IL170738				
S9999	Final Observations		S9999			
	Statement of Licer	sure Violations				
	300.1210b) 300.1210c) 300.1210d)2					
	Section 300.1210 Nursing and Perso	General Requirements for nal Care				
	and services to atta practicable physica well-being of the re each resident's cor plan. Adequate and care and personal	Il provide the necessary care ain or maintain the highest al, mental, and psychological esident, in accordance with mprehensive resident care d properly supervised nursing care shall be provided to each e total nursing and personal resident.				
		e-giving staff shall review and about his or her residents' care plan.				
	d) Pursuant to sul care shall include, and shall be practic seven-day-a-week					
		nts and procedures shall be dered by the physician.				

Illinois Department of Public Health

evidenced by:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

These Requirements were NOT MET as

**Electronically Signed** 

TITLE

(X6) DATE

04/05/24

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLANTON CONNECTION		IDENTIFICATION NO.	A. BUILDING:			
	*	IL6002273	B. WING		C 03/15/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CRESTV	VOOD TERRACE		OOD, IL 604			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	
S9999	Continued From pa	age 1	S9999			
	failed to ensure a la medication was cor residents (R1, R2) physician orders in failure resulted in R	and record review, the facility ab draw for an antiseizure impleted as ordered for two out of three reviewed for a total sample of five. This is suffering a seizure and ospital where the antiseizure as low.				
	Findings Include:					
	R2 is a 54 year old with the following diagnosis: idiopathic epilepsy and paranoid schizophrenia.					
	remember when R2 reported it was due the facility. R2 state and R2 has to take R2 was not aware does not remember	DPM, R2 was unable to 2 went to the hospital last, but to having a seizure while at ed R2 was born with seizures medications to control them. of any missed blood draws. R2 r the last time R2's blood was a R2 was unaware if any levels were low.				
	to remember a date not responding and dining room. V10 re having a seizure lor denied being aware work for R2. V10 whad laboratory work V10 stated a physic what date the laboratory to the outside know what to draw V10 reported the outcomes to the facility	AM, V10 (Nurse) was not able but stated one day R2 was staring off while sitting in the eported 911 was called for R2 nger than one minute. V10 of any missed laboratory as not aware the last time R2 completed for Dilantin levels. Sian will put in an order for atory work should be a requisition should be sent laboratory company so they when they come to the facility. It is a residents that are on the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER.		A. BUILDING:				
		IL6002273	B. WING		03/1	; 5/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
CRESTW	VOOD TERRACE		UTH CENTRA			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORREC PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)		LD BE COMPLET	
S9999	Continued From pa	age 2	S9999			
	collection list. V10 stated if the physician ordered the laboratory work then the order must be followed.					
	On 3/14/24 at V11 (Dilantin level is usu V11 reported Dilant medication that mu normal limits. V11 smust be completed seizures. V11 stated the facility and was Dilantin level should reported it is the reskeep track of orders them. V11 stated if as ordered and low the abnormal value.  The Physician Ordeorder for Dilantin (a laboratory blood wo Both of these order.  The Laboratory Regional documents the Dilantin document after the A Daily note dated.	er Summary documents an anti-seizure medication) ork on 10/20/23 and 1/20/24. rs were placed on 10/19/23. port dated 10/20/23 antin level was 14.8 ug/mL 0 ug/mL).				
	wheelchair. R2 was placed on the left si about five minutes. transported to the h					
	The Hospital Disch	arge Summary dated 1/21/24				

PRINTED: 05/07/2024 FORM APPROVED

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		IL6002273	B. WING	<u> </u>	03/15	/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
CRESTV	VOOD TERRACE		UTH CENTRA OOD, IL 6044			
(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) COMPLETE DATE
S9999	Continued From page 3		S9999			
	reevaluation and the Dilantin level was mand is documented	son for visit was a seizure ediagnosis was seizure. The easured while in the hospital as 2.6 ug/mL. This level is in injection of Dilantin and ility.				
	seizures/an epilepsy complications. An in documented to obta	d 8/23/23 documents R2 has a disorder and is it risk for a latervention for this care plan is in and monitor lab/diagnostic aport results to MD and follow				
	R1 is a 47 year old with the following diagnosis: schizophrenia disorder, bipolar disease, and epilepsy with seizures.					
	antiseizure medicati seizures. R1 reporte was taken and the E did not know what th hospital gave Dilanti the facility. R1 was to Dilantin levels need	AM, R1 reported R1 takes an on (Dilantin) to manage the ed at the hospital R1's blood Dilantin level was low but R1 ne level was. R1 stated the n via IV and sent R1 back to unaware how frequently the to be tested. R1 does not was last tested before being				
	was not aware how to be checked. V5 reponeed to follow are in Summary) and will to drawn when. V5 state outside laboratory comust be sent to the chave the lab draw comedication level must	PM, V5 (Nurse) stated V5 often a Dilantin level should orted all the orders the nurses the POS (Physician Order ell you what labs need to be ed the facility uses an ompany and a requisition company so the resident will ompleted. V5 reported this st be checked to make sure it ated a resident could have a				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	, a	IL6002273	B. WING		C 03/15/2024	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
CRESTV	VOOD TERRACE		UTH CENTRA DOD, IL 6044			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	
\$9999	seizure if the medicion on 3/13/24 at 12:52 R1's antiseizure methrough laboratory vV2 reported Dilantir three months. V2 st drawn in 10/2023 at did not have a result nurses are respons out all the orders in aware why these lated on 3/13/24 at 1:35F orders must be contrequires. V7 denied laboratory works for of checking the laboratory works for of checking the laboratory with a result on 3/13/24 at 1:49F on Dilantin for seizuthis medication must be controlled to the controlled	ation is not within range.  2PM, V2 (Interim DON) stated edication levels are monitored work ordered by the physician. In levels are measured every stated R1 had Dilantin levels and other labs were ordered but it for 01/2024. V2 reported V2 ible for checking and carrying the system. V2 denied being be were not collected.  PM, V7 (Nurse) stated all inpleted as the physician order being aware of any missing r R1. V7 stated the importance oratory work is to "see what is	S9999			
	check the order she new orders were pladenied being aware work for R1. V8 star missed on the date physician should be On 3/13/24 at 4:37F stated R1 has a his Dilantin. V9 reported to be collected ever depending on what V9 stated the levels checked so make stherapeutic range to	eet every day to ensure no acced on any residents. V8 of any missed laboratory ted if any laboratory work is it is to be collected then the				

(X3) DATE SURVEY

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  IL6002273		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		B. WING	C 03/15/2024			
	PROVIDER OR SUPPLIER	13301 SO	DRESS, CITY, S' UTH CENTRA	AL AVENUE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	DN (X5) D BE COMPLET PRIATE DATE	ΓE	
S9999	the lab that was ord means it was not co aware that R1's Dila was in the hospital.  The Physician Order order for laboratory 10/20/23 and 1/20/2 placed on 10/19/23.  A Physician note dawas assessed on the blood test was order day.  The Laboratory Reproduction of the surveyor during was drawn on 1/20/2 A Nursing note date ambulance was call The ambulance atteration of 9:45 AM to 1 denied any complainor symptoms of dist.  The Hospital Record The Hospital Record 1 present of the elevaluation of possible level drawn while at level was 8.1 ug/mL was given Dilantin valued to normal and the surveyor during was drawn on 1/20/2 A Nursing note date ambulance was call the ambulance atteration of 9:45 AM to 1 denied any complainor symptoms of dist.	ered in 01/2024 then that empleted. V9 denied being antin levels were low while R1 er Summary documents an work to be collected on 24. Both of these orders were ated 10/20/23 documents R1 his day by the physician. A red for a Dilantin level on this ented at 7.8 ug/mL which is smal is 10-20 ug/mL).  Entation the facility provided to this survey that any lab work 24 as ordered.  End 3/9/24 documents an eled per request of R1's family, endants arrived to the facility transfer R1 to the hospital. R1 ints of pain and had no signs	\$9999			

(X2) MULTIPLE CONSTRUCTION

FORM APPROVED Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: IL6002273 B. WING 03/15/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 13301 SOUTH CENTRAL AVENUE CRESTWOOD TERRACE CRESTWOOD, IL 60445 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S9999 Continued From page 6 S9999 seizure disorder related to disease process and is at risk for complications. In intervention documents to obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. The policy, titled, "Laboratory and Diagnostic Testing," dated 04/2020 documents, "Guideline: To accurately report and monitor laboratory and diagnostic testing. Standard: Laboratory and diagnostic testing are performed according to the order; Testing is based upon the resident condition and/or to monitor therapeutic blood levels for medication management. Oversight in coordination is completed by the Director of Nursing or designee ... Procedure: 1. The nurse receives the order for laboratory or diagnostic testing, and; c) Completes requisitions according to the date the test is to be completed. Laboratory requisitions are filed in designated accordion folder ... 2. Laboratory and diagnostic results are received and reviewed by the licensed nurse. 3. The nurse receiving the laboratory or diagnostic results a) The nurse documents in the medical record communication with the physician and/or extender regarding results." (B)

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