STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055715	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD TERRACE	13301 SOUTH CENTRAL AVENUE , CRESTWOOD, Illinois, 60445

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S0000	Initial Comments Complaint Investigation: 2596049/IL195686	S0000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable	S9999		

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

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S9999	Continued from page 1 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. These regulations were not met as evidenced by: Based on interview and record review, the facility failed to follow hospital orders for a fluid restriction after a resident (R1) was hospitalized for low sodium and failed to complete additional laboratory work for a resident's (R1) low sodium levels for one out of three residents reviewed for improper nursing care in a total sample of three. This failure resulted in R1 suffering a syncopal episode twice within four days and needing to be hospitalized each episode for low sodium and bradycardia. R1 is a 69 year old with the following diagnosis: epilepsy, type 2 diabetes, schizoaffective disorder, bradycardia, and syncope/collapse. R1 no longer resides in the facility. A Nursing note dated 5/ 31/ 25 document R1 was found lying on the floor in R1's room. The fall was unwitnessed. Vital signs were within normal limits except the heart rate. The heart rate was 49 (normal heart rate is 60-100 beats per minute). R1 was not able to stand. The doctor was called and ordered to send R1 to the hospital. A call was made later to the hospital to check on R1's status. R1 was admitted with a diagnosis of low sodium. A Nursing note dated 6/2/25 documents R1 returned from the hospital with the discharge diagnosis of low sodium. R1's heart rate upon admission was 68. R1 was able to ambulate with a steady gait. The physician was made aware of R1's return and the medication that was given during the hospital including insulin. No new orders were received. The Hospital Records dated 6/2/25 document R1 was admitted with a diagnosis of low sodium. R1 was ordered a regular diet with a fluid restriction of 800 mL. Sodium levels were 124 on presentation to the emergency room and raised to 131 the next morning after receiving IV fluids overnight. This is consistent to volume depletion which is likely a component of SIDAH	S9999		

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S9999	Continued from page 2 (Syndrome of Inappropriate Antidiuretic Hormone Secretion) due to psych medications. Per the National Library of Medicine, an article titled, “Clinical management of SIADH,” dated 04/2012 documents, “Hyponatremia is the most frequent electrolyte disorder and the syndrome of inappropriate antidiuretic hormone secretion (SIADH). SIADH should be treated to cure symptoms. Therapeutic modalities include nonspecific measures and means (fluid restriction, hypertonic saline, urea, demeclocycline), with fluid restriction and hypertonic saline commonly used.” (https://pmc.ncbi.nlm.nih.gov/articles/PMC3474650/) A Laboratory note dated 6/13/25 documents the sodium level was 134. All lab levels were reviewed by the physician and no new orders were received. The Laboratory Report dated 6/13/25 documents a sodium level of 134 mEq/L. The reference range for a normal level is 138-147 mEq/L. No other laboratory levels were tested again after this. A Transfer to Hospital note dated 6/25/25 documents R1 was observed having a near syncopal episode in the dining room. R1 was taken back to R1’s room and assessed. R1's pulse was 58. The physician ordered to send R1 to the hospital. A Nursing note dated 6/25/ 25 at 8:37 PM documents arrived back to the facility. Vital signs are within normal limits. Diagnosis from the hospital was low sodium and slow heart rate. R1’s discharge instructions include wearing a cardiac monitor for seven days continuously then returning it back to the hospital. The physician was called several times and the nurse was not able to get a hold of the physician for any new orders. This will be endorsed to the next shift. A Nursing note dated 6/26/25 documents the physician ordered an electrolyte panel for R1 to follow up on the hyponatremia diagnosis. A Nursing note dated 6/29/25 documents R1 fell in the dining room. Vital signs were within normal limits except heart rate was 38. R1 was picked up off the floor and assisted to a private room to be monitored. The physician was notified in order to send R1 to the hospital. The pulse was rechecked while waiting for the ambulance and R1 was still bradycardic. R1 was admitted to the hospital with a diagnosis of syncope and bradycardia. R1 was admitted for monitoring.	S9999		

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S9999	Continued from page 3 There is no documentation that the psychiatrist or primary physician adjusted any medications to address the low sodium levels or that a fluid restriction was ordered. Vital signs from 5/31/25-6/29/25 were reviewed. A heart rate of 46 beats per minute was documented on 5/31/25 and a heart rate of 30 on 6/29/25. Vitals signs are not documented each shift every day per the care plan intervention. The Physician Order Summary was reviewed. There is no order for a fluid restriction, a cardiac monitor for one week, or a medication adjustment in the psychiatric medication. R1 has an order for carbamazepine 100mg three tablets twice a day and one 200mg tablet once a day, phenytoin 100mg two capsules three times a day, invega sustenna 11mg injection once a month, seroquel 300 mg two tablets twice a day, and metformin 500mg tablet once a day. All these medication especially when used in combination can cause SIADH. None of these medications have had dosages lowered within the last six months. On 7/18/25 at 12:37PM, V1 (Nurse) stated V1 received notification that the labs were abnormal so V1 notified the physician. V1 reported the facility uses the reference numbers in the laboratory report to tell if a laboratory level is low, high, or normal. V1 stated all abnormal lab levels must be reported to the physician by a phone call and faxing the numbers over to the physician. V1 stated if no new orders are given by the physician that it must be documented. V1 reported the physician was looking for hyponatremia in this lab draw, and it was a previous issue R1 kept having. V1 stated no new orders were put in for this lab level per the physician's request. V1 reported R1 had a near syncopal episode on 6/25/25 where R1 was dizzy when R1 tried to stand. V1 stated R1 was sent to the hospital by the physician and came back with a cardiac monitor. V1 reported R1 fell again on 6/29/25 after having another syncopal episode. V1 reported R1 did have a low heart rate in the 30s at the time of this fall. V1 stated hospital paperwork is reviewed by the nurses and a medication review as well as any other changes in orders have to be reviewed with the physician when the resident is readmitted. V1 reported all new orders have to be reviewed with the physician so any changes can be made to the current orders at the facility. V1 stated a nurse documents in the computer system that a physician was notified of any new orders or changes from current orders after returning from the hospital. V1 reported if it is not documented, it means it didn't happen. V1 stated a fluid restriction needs to be documented in	S9999		

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S9999	Continued from page 4 the computer system as well as an order be put in. V1 was not able to show the surveyor in the computer system where the fluid restriction documentation for R1 was. V1 denied being aware that R1 was on a fluid restriction. On 7/18/25 at 1:07PM, V2 (CNA) stated staff was monitoring R1 due to recent episodes dizziness and falls. V2 denied R1 having a fluid restriction while R1 was at the facility. V2 reported if a resident is on a fluid restriction then it is charted in the computer system. On 7/18/25 at 1:38PM, V3 (ADON/Restorative Nurse) stated it is the admitting nurse's responsibility to review the hospital paperwork and inform the physician of any changes. V3 reported the DON should also be made aware of any changes to the plan of care. V3 stated r1 was having low heart rate and low sodium but was unaware of what was causing it. V3 reported the nurses have to document any conversation with a doctor to let the oncoming staff what is going on with the resident. V3 stated if a resident is on a fluid restriction, staff have to monitor them and document the amount of fluids. V3 reported the CNAs will document in the computer under the meals tab which allow staff to watch how much the resident is drinking. V3 was not sure not if R1 was supposed to be on a fluid restriction. V3 stated if a resident was on a fluid restriction from the hospital then it needs to be continue at the facility. V3 reported the doctor will be called for an order, the dietitian will come to evaluate the resident, and the dietary department will be notified. On 7/18/24 at 2:34PM, V4 (Former Nurse) stated V4 took care of R1 the day of the first fall on 5/31/25. V4 reported R1 was too weak to stand and R1's pulse being low at the time of the fall. V4 stated that R1 was diagnosed with low heart rate and low sodium while at the hospital, but was unaware of the cause. V4 reported when a resident is readmitted from the hospital, orders must be reviewed, and the physician must be called to carry out any new orders. V4 confirmed a fluid restriction must be ordered so everyone knows that a fluid restriction is in place for that resident. V4 stated a fliud restriction must be documented in the computer system so continuing shifts know how much fluid a resident is having throughout the day. V4 denied ever seeing an order for a fliud restriction. V4 reported a physician must be notified of any new orders from the hospital or any changes while the resident was in the hospital so the doctor is aware of the plan of care. V4 denied remembering a fluid restriction was ordered after R1 returned from the first	S9999		

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S9999	Continued from page 5 hospitalization. On 7/18/25 at 2:45PM, V5 (Nurse) stated V5 readmitted R1 back to the facility after the second admission to the hospital. V5 confirmed R1 was diagnosed at the hospital with low heart rate and low sodium levels. V5 reported the physician (V7) was called to get orders after R1 arrived, but the physician did not return a call, so this task was endorsed to the next nurse. V5 reported an administrator or DON should notified if the nurses cannot get in contact with the physician. V5 admitted that V5 was busy and “probably forgot” to notify the administrator or DON that V5 could not get in contact with the physician for any new orders. V5 denied R1 ever being on a fluid restriction. V5 was unaware why R1 would need a fluid restriction. V5 denied being aware that the last sodium level drawn was trending low. On 7/18/25 at 3:13PM, V6 (DON) stated R1 was admitted to the hospital after a fall due to a syncopal episode where R1 was diagnosed with bradycardia as well as low sodium. V6 reported after a resident is readmitted from the hospital, the physician must be notified of their return and makes the physician aware of any new orders from the hospital. V6 stated the nurse must document this conversation and if any orders have changed. V6 reported the nurse is responsible for letting the physician know of any diet change orders. V6 stated R1 did have a redraw of labs to check the sodium level. V6 stated V6 knows the sodium level was low but close within normal range so no additional orders were put in. V6 denied the sodium level was monitored again or any additional orders put in place until R1 went to the hospital on 6/25/25. On 7/18/25 at 7:00PM, V7 (Primary Physician) stated R1 is a diabetic and also takes psych medication and this combination can cause low sodium. V7 reported it is caused by a disturbance in electrolytes due to the hormones being imbalanced. V7 stated a blood test was completed about one week later after the first hospitalization and the sodium level was “normal.” V7 stated the sodium level was only one point out of normal range at 134. V7 reported V7 did not feel like it needed to be checked again because it was near normal. V7 stated V7 was aware that R1 went out to the hospital a second time for bradycardia and low sodium and was readmitted to the facility with a cardiac monitor. V7 stated V7 told the admitting nurse to continue all treatments from the hospital after each readmission. V7 reported V7 cannot adjust the psychiatric medications so the nurses were informed to get in contact with psych to adjust R1’s medication to	S9999		

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S9999	Continued from page 6 help with low sodium levels. V7 was unaware why a fluid restriction was done and was unable to explain how a fluid restriction would increase a sodium level. V7 said, “Whatever maneuver they used in the hospital to get normal sodium is what they did.” V7 stated it is the nurse’s responsibility to speak with the psych physician about changing medication. V7 reported V7 was not aware of a third admission for bradycardia and low sodium. On 7/22/25 at 10:26AM, V8 (Psych Nurse Practitioner) stated V8 saw R1 in May and June of this year. V8 reported R1 was not having any new delusions or behaviors so no medication adjustments were needed. V8 stated V8 did not know about R1’s low sodium. V8 confirmed psych meds can cause low sodium from SIADH. V8 denied being aware that R1 was ever treated for that condition while at the hospital. V8 stated that low sodium is a medical condition and the medical doctor (V7) would’ve handled that. V8 reported the medical doctor would’ve handled this because the medical doctor has access to the laboratory levels. V8 stated low sodium levels can cause generalized weakness and if the sodium gets low enough, it can cause a person to have seizures. V8 reported that condition is usually managed with a fluid restriction before adjusting any medications because adjusting the medications can have a negative effect on behaviors. V8 stated if V8 were told about the low sodium, then it would have been documented in the progress notes in June. The surveyor asked if V8 was aware about the low sodium, what changes to the medication would V8 have made? V8 reported that V8 would have had to have a discussion with the medical physician before making any changes to any medications. On 7/22/25 at 11:14AM, V6 stated if the primary physician and psych physician need to discuss a resident’s plan of care then they will communicate with each other. V6 stated that V7 is a medical doctor so V6 was under the impression that V7 was managing the low sodium level. V6 denied V7 ever asking the facility to get psych involved for R1’s medication adjustments. V7 denied being aware why a fluid restriction wasn’t re-ordered after R1 was readmitted. V6 reported if the facility does not agree with the doctor’s orders or feel a resident needs additional orders than another physician can be contacted that sees that resident. V6 denied any other physicians being contacted for R1’s low sodium level. The Fall Report dated 5/31/25 documents R1 was found lying on the floor in R1’s room. Vital signs were within normal limits except heart rate was low at 49.	S9999		

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S9999	Continued from page 7 R1 reported hitting R1's head. R1 was not able to stand on R1's own. An order was received to send R1 to the hospital. There are no predisposing environmental or physiological factors that caused the fall. The Fall Report dated 6/29/25 documents R1 fell in the dining room. R21 reported R1's legs gave out while R1 was going to the bathroom. The physician ordered R1 go to the hospital. R1 was bradycardic. There are no predisposing environmental or physiological factors except change in condition that caused the fall. The Care Plan dated 6/3/25 documents R1 is at risk for falls after sustaining a fall on 5/31/25. An intervention includes to endure R2 drinks water throughout the day. The Care Plan dated 6/26/25 documents R1 present with decreased cardiac output related to a diagnosis of bradycardia as evidenced by near fainting episodes. An intervention includes that R1 will wear a cardiac monitor as ordered by the physician and vital signs will be documented every shift. The Minimum Data Set (MDS) dated 5/30/25 documents a Brief Interview for Mental Status score as a 12 (Moderate cognitive impairment). There were no hospital records available from the hospitalization on 6/25/25 or 6/29/25. Intake and output or fluid restriction documentation was requested during this survey but none was provided. The policy titled, "Admission Process," dated 03/2021 documents, "…2. When a resident arrives at the facility…utilize accompanying hospital records for detailed information." The policy titled, "Change in Condition," dated 03/2021 documents, "Guideline: To keep the physician or extender, who is in charge of medical care, responsible party, responsible for health care decisions, informed of the resident's medical condition so they may direct the plan of care as needed. Standard: Notification of the physician, legal representative, or responsible party, should occur when there is a change in the resident's condition. Change in condition is defined as (notify parties immediately in the event of death): an incident or accident that involved the resident which results in injury and requires physician intervention; a change in the resident's physical, mental or psychosocial status; a need to alter treatment; and/ or a decision to transfer or discharge the resident from the facility." The policy titled, "Physician Orders – Verbal and Fax,"	S9999		

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S9999	Continued from page 8 dated 03/2021 documents, "…Procedure: 1. Verbal Orders: Verbal orders are those given to the nurse by the physician or extender in person or by telephone, however are not written in the medical record. Follow this process: a) Write the orders verbally given by the prescriber in the medical record…d) The prescriber should sign the according order according two state guidelines. e) Follow through with the orders as required. If the orders are unable to be followed the provider should be made aware and then additional orders received…3. Outside Appointment Orders:…b) If the resident returns with orders from the consulting physician, the orders must be verified with the attending physician before they can be carried out…d) If the attending position is not in agreement with the orders, the consulting physician must be notified by the nurse. e) It is the responsibility of the physicians to come to agreement on which orders are to be followed." (A)	S9999		