STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002273	A. BUILDING: _____ B. WING _____	C 08/10/2023

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

(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
S 000	Initial Comments Complaint Investigation 2396505/IL162873	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 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. Section 300.1210 General Requirements for Nursing and Personal Care 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 regulations were not met as evidence by the following:	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

Based on interview and record review, the facility failed to provide a resident (R1) with proper footwear to prevent or reduce the risk of a fall incident. This affected one of three residents (R1) reviewed for fall prevention interventions. This failure resulted in R1 falling in the hallway and sustaining a fracture to the right arm.

Findings Include:

R1 is a 59 year old with the following diagnosis: paranoid schizophrenia, alcohol abuse, and fracture of shaft of right humerus.

On 8/9/23 11:53AM, R1 was interviewed. When asked why R1's arm was in a sling R1 stated R1 fell to the floor and broke R1's arm. R1 endorsed being sent to the hospital after that. R1 was not able to give any other details what happened after the fall. R1 then endorsed that 2 other staff were present but was not able to give any names. R1 endorsed staff gave R1 a pair of shoes without any laces when R1 returned to the facility.

On 8/9/23 at 12:39PM, V2 (Nurse) stated that V3 (CNA) and V4 (Manager on Duty/Director of Housekeeping) said R1 fell down because R1's shoe laces were untied. After R1 tripped, the facility got R1 new shoes and always make sure they are now tied. The facility makes sure R1 has the appropriate footwear when R1 is up and walking. V3 endorsed that R1 doesn't wants to tie the shoes so R1 just leaves them undone.

On 8/9/23 at 12:47PM, V3 stated V3 was on the D wing doing rounds and was near the end of the hallway. V3 heard a whine and turned around. R1 was on the floor when V3 turned around. When V3 walked over to R1, R1's shoe laces were untied and V3 just assumed that R1 fell over the

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S9999	Continued From page 2 shoe laces. V3 doesn't think R1 can tie the shoes alone. R1 walks around with the shoe laces undone a lot. V3 reported staff tells R1 to tie them or ask R1 to tie them and R1 just keeps walking. On 8/9/23 at 12:57PM, V4 stated the fall was after lunch and V4 was doing rounds on the D wing. V4 endorsed being was in the middle of the hall and R1 at the doorway when you come down the hall. V4 stated it happened so fast but all of the sudden I just saw R1 go down. V4 reported another V3 and V4 walked up to R1 to see what happened and R1 was on the floor on R1's right side. V4 endorsed R1 had red gym shoes on and both of them were untied. V4 stated R1 must have tripped and fell over R1's shoes that time. V4 stated R1 always has them untied though. V4 reported R1 gets the shakes sometimes so V4 doesn't think R1 can tie them without assistance. V4 endorsed V1 asked V4 to get him a pair of shoes out of storage without any laces. The facility had some in there so I know R1 was given shoes without laces in them since R1 has a hard time tying them. On 8/9/23 at 3:09PM, V1 (Administrator) stated V1 got a call on the weekend saying that a fall occurred with R1. V1 then spoke with the nurse and was sending R1 to the hospital because R1 was having pain in the right arm. V1 endorsed staff told V1 that R1 stepped on R1's shoelace and fell. R1 had x-rays taken at the hospital that noted a fracture. V1 stated for this fall, the facility got R1 shoes that did not have any laces. V1 endorsed R1 can tie them, but it requires extra time and queuing. Sometimes R1 would tell staff that R1 does not want the shoes tied. Staff would tie them when they noticed they were undone. V1 stated R1 didn't have any issues regarding falls and R1's shoes being untied before this fall.	S9999		

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S9999	Continued From page 3 On 8/9/23 at 3:33PM, V6 (MDS Coordinator/Fall Team) stated this fall was related to R1 tripping on R1's shoes because the shoelaces weren't done. After the fall, the facility got R1 shoes without shoestrings. V6 endorsed staff try to encourage R1 to wear the shoes without laces. V6 reported R1 also had a fall in February that was due to poor coordination where he tripped. V6 stated staff gives the same amount of monitoring to everyone in the facility because no one is considered a high fall risk. V6 endorsed staff do basic interventions for everyone that hasn't had a fall like watching their gait to make sure residents are steady and making sure they have on appropriate footwear. Having appropriate footwear on can reduce your chance of falling. Like in this case, if R1 had R1's shoelaces tied, maybe R1 would not have fallen. A Nursing note dated 6/10/23 at 2:57 PM documents the manager on duty (V4) came to the nurse's station and reported R1 fell on the right side. The nurse (V2) assessed R1 and noted slight swelling in the right hand and arm. R1 complained of pain to the upper right shoulder. An x-ray was ordered to the right arm STAT. A Nursing noted at 6/11/23 documents R1 returned back to the facility after the hospital visit with a fracture to the right lower humerus. R1 is currently wearing a sling immobilizer with slight swelling. R1 is ordered to follow up with a general orthopedic physician. The Fall Report dated 6/10/23 documents R1 fell onto the right side. R1 reported pain when being assessed with slight swelling noted to the right hand. The physician was called and ordered x-rays to the right arm. It is incorrectly	S9999		

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S9999	Continued From page 4 documented that there are no predisposing situation factors. Improper footwear should have been documented as a pre-disposing situation factor to this fall. The Hospital Records were requested but were not received in time. The Final Investigation Report dated 6/10/23 documents R1 was in the hall attempting to get in line for smoke break when R1 stepped on R1's shoelace and tripped and fell to the floor. As a result of the fall, R1 sustained a fracture to the right lower humerus. R1 reported that R1 fell while walking in the hall towards the patio for smoking. The fall was witnessed by staff. Staff reported that R1 was walking towards the patio while in line and R1 was wearing shoes with shoelaces untied at the time of the fall. R1 was sent to the hospital for medical evaluation and return with a splint to the right hand in a sling. R1 had follow up orthopedic appointments scheduled. R1's shoes have been replaced with slip on style without tie up laces. The Care Plan dated 4/6/23 documents R1 is at risk for falls related to psychoactive drug use and other underlying medical conditions. On 4/13/23, R1 slid to the ground while in the dining room, but had no injuries. Interventions were placed after this fall. There is no intervention addressing R1 ambulating with shoes untied. The Care Plan dated 6/26/23 documents R 1 sustained a fall on 6/10/23 with an injury. An intervention placed on this date documents that R1 will wear appropriate footwear and shoes will be tied when ambulating. (B)	S9999		