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 03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD REHABILITATION CTR	14255 SOUTH CICERO 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: 2391798/IL157080	S 000		
S9999	Final Observations Statement of Licensue Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 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 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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 03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD REHABILITATION CTR	14255 SOUTH CICERO 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
S9999	Continued From page 1 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. 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 as evidenced by: Based on observation, interview, and record review the facility failed to follow its policy for fall prevention program by failure to implement fall prevention interventions to resident (R40) on high risk for fall and has history of multiple falls. This failure caused R40 to have an unwitnessed fall after being re-admitted within 4 hours from the hospital, sustaining a cut/laceration on right eyebrow which required a visit to hospital to control bleeding and suturing at the right eyebrow area. The facility failed to update resident's fall care plan after each fall occurrence. The facility failed to complete fall assessment after each fall incident. This deficiency affects all six (R19, R40, R63, R121, R128, and 154) residents in the sample of 34 reviewed for Fall prevention	S9999		

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 03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD REHABILITATION CTR	14255 SOUTH CICERO 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
S9999	Continued From page 2 program. Findings include: R40 is re-admitted on 3/8/23 after hospitalization last 2/25/23 due to fall evaluation and foot infection. R40 has diagnosis listed in part but not limited to Complete traumatic amputation of right lower leg, orthopedic aftercare following surgical amputation, Acute cystitis, Diabetes mellitus with foot ulcer, Polyneuropathy, Acquired absence of left great toe and right toe, Dementia, Urinary retention. Fall assessment indicated at high risk for falls. Care plan indicated at high risk for falls and fall injuries. R40's Facility reported incident initial dated 3/8/23 indicated R40 was observed laying on floor next to his bed. Upon assessment nurse noted open area to right eyebrow. Nurse cleaned and bandaged area. Physician made aware with order send to R40 to hospital for evaluation and treatment. R40's progress note indicated: 3/8/23 at 6:45pm, R40 re-admitted from hospital. 3/8/23 at 10:50pm, incoming nurse reported that R40 observed on the floor at the bedside. R40 bleeding from the back of the head and above the eyebrow. R40 was sent out to hospital 3/9/23 at 4:14am, Returned from hospital. Sutures noted to the right side near eyebrow. 3/9/23 at 1:15pm, transferred to hospital for evaluation due to control bleeding at right eyebrow suture site. On 3/9/23 at 11:10am, Observed R40 lying in bed in slanted position, with half side rail up on the right side of the bed and no side rail on the left side of the bed. His head had a loose bandage	S9999		

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 03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD REHABILITATION CTR	14255 SOUTH CICERO 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
S9999	Continued From page 3 soaked with blood positioned at the left corner of the headboard. The bed was not in the lowest position, its approximately 27 inches from the floor. R40 is lethargic but restless. Called V12 Agency nurse and V41 CNA to R40's room and showed observation. Both said that R40's bed cannot be lowered down. Observed also that the bed is not locked. V12 said that R40 was re-admitted last night around 7pm and had an unwitnessed fall incident around 11pm. R40 was sent out to the hospital for suturing of the laceration on right eyebrow area. At 11:20am, V40 Nurse Practitioner (NP) came to the room with V42 NP to examine R40. Showed observation to both NPs. At 11:22am, V13 Restorative Nurse/Fall coordinator came and showed observation. Both NPs said that R40 should be on the low bed and have frequent monitoring. On 3/9/23 at 6:38pm, Telephone interview with V45 Agency Nurse . She said that she works on 11-7 shift on 3/8/23. She was just coming in, when she heard R40 calling for help and observed him lying on the floor on his back with blood coming from his head. She called the nurse and CNA. R40 was confused and unable to give details of what happened. His bed was not in the lowest position. (She said the bed height is above her knee and she is 5'7). No floor mats. She was not sure the location of his call light. His bed was locked. He is incontinent with feces and needed to be changed. He had indwelling catheter. R40 was sent out to the hospital to control bleeding and for suturing. He came back at 4am with 15 sutures covered with dressing. He returned to the same room. He was sleepy, lethargic. Floor mat was provided but the bed cannot be adjusted to lowest position.	S9999		

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 03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD REHABILITATION CTR	14255 SOUTH CICERO 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
S9999	Continued From page 4 On 3/7/23 at 9:58am, V13 Restorative Nurse /Fall coordinator said that V3 DON does the root cause analysis after each fall and both of them update the fall care plan. She said that fall assessment done upon admission, quarterly, annual and after each fall incident. Review R40 's medical record with V13. R40 is initially admitted on 11/13/20. V13 she does not have access of the record before 1/3/22 due to transition to PCC (electronic medical record). Observed V13 changed and updated that fall care plan while reviewing with the surveyor. Surveyor informed V13 that she cannot update the care plan while being interviewed. V13 said that she just wants to reflect the most recent status of the resident care plan. R40 had fall incidents on 2/25/23, 2/4/23, 1/26/23, 1/23/23, 7/15/21, 11/20/20. Fall care plan was not updated after fall incident dated 1/26/23 and 2/4/23. No fall assessment after fall incident on 2/4/21. On 3/8/23 at 10:08am, V3 DON provided post investigation for fall incidents of 1/26/23, 2/4/23 and 2/25/23 in paper form. Informed V3 that post fall investigation for R40's fall incident for 2022 was documented in computer generated fall incident report form and asked V3 why she is providing paper post investigation forms. No copies of the fall incident report provided dated 2/25/23, 2/4/23, 1/26/23 and 1/23/23. No copy of post fall investigation provided for 1/23/23. She said, "that's all I have". On 3/9/23 at 11:42am, V3 DON said that fall care plan should be updated after each fall incident and fall assessment should be completed after each fall. Fall intervention should be followed. Facility's policy on Managing falls and fall risk indicates: Based on previous evaluation and	S9999		

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 03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD REHABILITATION CTR	14255 SOUTH CICERO 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
S9999	Continued From page 5 current data, the staff will identify interventions related to the resident's specific risk and causes to try to prevent the resident from falling and to try to minimize complications from falling. 4. If falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains relevant. Facility's policy on Clinical Fall protocol indicates: Monitoring and follow up: 2. The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling. 4. If the individual continues to fall, the staff and physician will re-evaluate the situation and consider other possible reasons for the resident's falling (besides those that have already been identified) and will re-evaluate the continued relevance of current interventions. R19 is re-admitted on 1/11/23 with diagnosis listed in part but not limited to Congenital hydrocephalus, Chronic Kidney disease, Cerebrovascular disease, Muscle atrophy, Muscle weakness, Dementia. Admission fall assessment dated 1/12/23 indicated high risk for fall. Care plan indicated at high risk for falls and fall injuries. Intervention: Fall mat when in bed. On 3/7/23 at 11:58am, Observed R19 with V15 Restorative aide and V16 CNA in her room eating lunch, no floor mat on the right side of her bed. Her bed is not in the lowest position. V15 said that she should have both floor mats on the sides of her bed. On 3/7/23 at 12:25pm, Reviewed R19's medical record with V13 Restorative nurse/Fall	S9999		

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 03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD REHABILITATION CTR	14255 SOUTH CICERO 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
S9999	Continued From page 6 coordinator. R19 had following fall incidents: 5/8/21 and 9/23/21. Fall intervention indicated use of floor mats. Informed V13 that floor mat is not in place on the right side of her bed when I made rounds this morning. R63 is admitted on 2/10/23 with diagnosis listed in part but not limited to Acquired absence of bilateral leg below knee, Phantom limb pain, Acute respiratory failure, Diabetes Mellitus type 2. Admission fall assessment and fall care plan indicated he is at high risk for falls. Progress notes dated 3/2/23 indicated: R63 was observed on the floor by the patio door on the 1st floor face down. There is a cut to upper right face with bleeding. R63 explained that his envelope fell on the floor and he tried to pick it up and fell. R63 was sent to hospital for evaluation. On 3/7/23 at 9:38am, V5 LPN said that R63 has recently fallen on 3/2/23. Rounds made with V5 to R63's room. At 9:45am, Observed R63 lying in bed, he has bilateral below the knee amputation. His call light was on the floor, unable for him to reach. V5 pick up the call light and placed it within reach. V5 said that resident's call light should be within reach. R63 said that he has fallen recently, hit his head and cause abrasion on his right forehead. Both lower leg prosthesis on the floor. His wheelchair at his bedside, no Dycem (non-slid material) placed on wheelchair seat. On 3/7/23 at 9:58am, Review R63's medical record with V13 Restorative nurse/Fall coordinator. V13 said she is not aware that R63 had fall incident on 3/2/23. She said that the floor nurse should place the incident report in the risk management report for them to see and do the root cause analysis. The floor nurse should notify her and the DON if any resident has fallen. R63 is	S9999		

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 03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD REHABILITATION CTR	14255 SOUTH CICERO 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
S9999	Continued From page 7	S9999		

high risk for fall. R63 had the following fall incidents: 3/2/23,12/15/22, 1/15/22, 12/21/21, 9/9/21, 8/5/21 and 6/12/21. Informed V13 that R63 does not have dycem in his wheelchair seat.

R121 is admitted on 12/20/21 with diagnosis listed in part but not limited to Dementia, History of falling, Alzheimer, Weakness, Malaise, Lack of coordination.

On 3/7/23 at 12:11pm, Observed R121 with V15 Restorative aide and V16 CNA in her room with no floor mats on both sides of her bed. V32 CNA said that she is the assigned for R121 and she is not aware that she needs to have floor mats. V15 RA said that she should have floor mats.

On 3/7/23 at 12:25pm, Review R121's medical record with V13 Restorative nurse/Fall coordinator. She said that R121's fall assessment indicated that she is at high risk for fall. V13 said fall care plan indicated that she is at high risk for falls and fall injuries with intervention: Floor mats. Informed V13 that no floor mats are in place around her bed when I made rounds this morning.

R128 is admitted on 3/17/22 with diagnosis listed in part but not limited to Hemiplegia and hemiparesis following traumatic intracerebral hemorrhage affecting left non-dominant side, Morbid obesity, Weakness, History of falling, Altered mental status. Fall assessment indicated she is at high risk for fall. Care plan indicated she is at high risk for falls and fall injuries.

On 3/7/23 at 12:14pm, Observed R128 sitting on her bed. She said she had fallen three times in the facility. No floor mats and dycem (non-slid material) on her wheelchair seat. V17 CNA said

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 03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD REHABILITATION CTR	14255 SOUTH CICERO 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
S9999	Continued From page 8 that she is assigned to R128, but she is not aware not she needs to have floor mats and dycem on her wheelchair seat. On 3/7/23 at 12:25pm, Reviewed R128's medical record with V13 Restorative nurse/Fall coordinator. V13 said that a fall admission assessment was done on 3/17/22 indicating at high risk for falls. R128 had the following fall incidents: 4/11/22, 6/7/22, 7/13/22, 7/31/22 and 12/8/22. V13 said Fall interventions indicated use of floor mats and dycem. Informed V13 that floor mats and dycem are not in place when I made rounds this morning. A fall report indicates that R154 had an unwitnessed fall on 2/13/2023 resulting in a fractured clavicle, and an unwitnessed fall on 2/22/2023 resulting in neuro checks and resident refusing hospital visit. On 3/10/2023 at 11:00am V2 (Director of Nursing-DON) said a fall assessment should be completed after every fall a resident has with new care plan interventions. An Order Summary Report documents that R154 has a history of Displaced fracture of shaft of left clavicle, initial encounter for closed fracture, and a history of falling. R154 has an order to wear sling as ordered. A morse fall scale was done on 12/23/2022 with a score of 50 which indicates a high risk for falls. There was no fall assessment on 2/13/2023. A fall risk assessment on 2/22/2023 with a score of 19 indicates moderate risk for fall. (B)	S9999		