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
	IL6002273	A. BUILDING: ______ B. WING ______	C 02/05/2021

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

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S 000	Initial Comments Complaint Investigation: 2190389/IL130300-F689, F684	S 000		
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS 300.610a) 300.1210b) 300.1210d)3)6) 300.3240a) 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	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	S9999		

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:
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.
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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met evidenced by:

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S9999	Continued From page 2	S9999		

Based on interview and record review, the facility failed to monitor a resident after a fall incident, complaints of dizziness and abnormal vital signs for 1 of 3 (R1) residents reviewed for monitoring a change in condition. This failure resulted in R1 having another un-witnessed fall incident and being found unresponsive requiring CPR and subsequently expiring at the facility.

Findings include:

R1 was admitted to the facility on 1/29/2017 with diagnosis of schizophrenia, major depressive disorder, anemia, psychoactive substance abuse, asthma with acute exacerbation, hypothyroidism, epilepsy, insomnia and forms of tremors.

R1's fall report dated 12/31/20 at 13:43 documents under incident description: It was reported to V3 (nurse) that R1 fell in A wing hallway. R1 stated she fell after feeling dizzy. Under immediate action documents: Upon arrival writer noted resident seating on the floor alert and oriented x3. Denies any complaints of pain at this time. Assessment done from head to toe all extremities are equal. R1 assisted up from the floor and back to her room. No injuries.

V9 (Nurse), V5 (nurse) and V13 (unit manager) all said on 12/31/20 around 11pm, they were made aware that R1 was not feeling well. On 1/28/21 at 4:14PM, V9 (nurse) said he was unable to get R1's blood pressure due to machine malfunctioning. V9 said R1 reported she did not want to blood pressure checked again. On 1/29/21 at 223PM, V13 (unit manager) said around 11pm she assisted staff with assessing R1. R1's hands were cold and staff took all vitals

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within normal limits and no further concerns. On 1/29/21 at V5 (nurse) said she saw R1 shaking like she was cold. V9 was trying to get blood pressure but it was not working. V5 (nurse) reported R1 said she was fine and went back to her room.

R1's medical record did not have documentation of event on 12/31/20 at 1100pm.

R1's progress notes dated 1/1/21 at 300AM document: Nurse was informed that R1 had complaints of shortness of breath, writer (V4 (nurse)) immediately assessed R1. Vital signs Respirations 22, Temperature 96, Heart rate 135 beats per minute, blood pressure 70/60, oxygen saturation was 92 % on room air. V4 gave breathing treatment, oxygen 2liters/minutes via nasal cannula. Resident was stabilized. R1 progress note dated 1/1/21 at 315 document: Staff continue to monitor R1. Oxygen saturation 94% with oxygen treatment. Doctor notified of R1's change in condition order to send R1 to the hospital for evaluation. Writer (V4) called elite ambulance for pick up within 20 minutes. Nurse notified R1 about her status going to the hospital.

On 1/28/21 at 203PM, V4 (nurse) said V6 (CNA) reported R1 was complaining of shortness of breath. R1 was in the dining room. R1's respirations were elevated and oxygen saturations were in the low 90's. R1 was given albuterol inhaler and oxygen. R1 did not want to use oxygen. R1 said she was feeling better. V4 (nurse) said she left R1 with V6(CNA) and went to call doctor and send to hospital. V4 said CNA's are supposed to stay with residents but unsure if staff took the R1 to her room to rest. V4 (Nurse) said she called private ambulance who stated a 20 minute estimated time of arrival. V4 said she

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S9999	Continued From page 4 went to R1's room and notified R1 that ambulance would at the facility in 20 minutes to transfer her to hospital. On 2/2/21 at 419PM, V15 (MD) said normal blood pressure is 110/70, normal pulse would be less than 100 and respirations 18-20. R1's documented vital signs (Respirations 22, Temperature 96, Heart rate 135 beats per minute, blood pressure 70/60) would indicate a change in condition requiring immediate intervention and 911 would be the best option unless private ambulance would there within same time frame. R1 should have been monitored by staff while waiting for ambulance due to possibility of experiencing a further change in condition. R1 would be at higher risk for falls due to low blood pressure. On 2/3/21 at 937AM, V2 (DON) said normal vital signs for blood pressure would be 120/70. Systolic below 100 and diastolic under 60 would be considered low. Normal pulse 60-100. V2 said R1 should have been sent out 911 with documented vital signs because 911 is faster and able to deliver care faster for resident. R1 would be at higher risk for falls or further change in condition and should have been monitored by staff while waiting for ambulance. On 1/28/21 at 301pm, V6 (CNA) said no one instructed her to stay with R1. V6 said she went on her break after informing nurses about R1's concern around 300AM. R1's medication administration record for December 2020 and January 2021 do not document any as needed inhalers or medications given.	S9999		

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S9999	Continued From page 5 R1 progress note dated 1/1/21 at 325AM by V4 (nurse) document: While Nurse and CNA was on the way to R1's room, saw roommate in the hallway and stated R1 was in the floor in the bathroom. Nurse immediately ran into R1's room noted R1 was unresponsive CPR was initiated immediately. Code was called. 911 was called. On 1/28/21 at 1130am, R2 (R1's roommate) said around 1030 pm she heard R1 breathing funny and told her to go to the nurse but was unsure if she did. R2 does not recall hearing or seeing anything until around 340am she heard staff tell R1 the ambulance would be here in 20 minutes. R1 was in her bed sleeping at that time. She heard R1 get up and go to the bathroom turn on the water. Shortly after she heard a loud noise and saw R1 on the ground in the bathroom. R2 said she went to get the nurse and saw staff in dining room and reported R1 was on the floor and staff came to assist R1. Private ambulance run sheet documents received call on 1/1/21 at 3:22AM, enroute 3:27AM at patient at 352AM. Call was received by dispatch while 10 minutes away from scene reporting the facility called sounding frantic and wondering how much longer until crew arrived. Crew notified dispatch it would be 10 minutes till arrival and dispatch notified facility. The facility acknowledged the ETA. When crew arrived to the scene local police department was on the scene, but no local fire department. Ems went to the back of the ambulance to get stretcher, a staff member from the facility came to the door and tried to rush crew into the facility stating this is an emergency. When crew asked why local police on scene, they responded the patient is not doing well. Upon arrival to patient room, staff observed in hallway and when the nurse saw crew coming	S9999		

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S9999	Continued From page 6 went into the crash cart, got ambu bag and went into the patient's room. When crew entered room, local police officer was performing CPR on the patient in bathroom. Crew asked the police officer how long he had been performing CPR and he stated 10- 15 minutes. The nurse was getting the ambu bag and started ventilations for the patient. Patient downtime unknown per the nurse because they did not find the patient themselves but the roommate found the patient. Local police report documents dated 1/1/21 at 342AM dispatched to facility for unresponsive female. Police officer documented he took over CPR and local Emergency service arrived but unable to revive R1 and pronounced deceased at 411AM. Report documents report given by V4 (nurse) to local police as follows: R1 was not feeling well around 130AM and 200AM on 1/1/21. V4 said she took her vital and they were "low." V4 contacted local ambulance to transport to hospital. After speaking to Ambulance Company she told R1 to get a bag ready to go to the hospital. V4 then left R1 in her room to gather her belongings. V4 said a short time later R2 told the nursing staff at front desk that R1 had fallen in the bathroom. R1 progress note dated 1/1/21 at 411 document: staff continued CPR on R1 while paramedics arrived and took over the compression from the nurses. R1 was pronounced dead at 411 AM. Doctor and family notified. On 2/4/21 at 430 PM, V1 (Administrator) said there was no incident report for R1 for 1/1/21. Facility fall policy dated 4/2020 documents if 911 emergency intervention is indicated: call ambulance, notify family, have staff member stay	S9999		

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S9999	Continued From page 7 with resident and continue to monitor condition; complete transfer documents. Facility change of condition policy dated 4/2020 documents under guideline to keep the physician who is in charge of medical care, responsible party, responsible for health care decisions, informed of the residents medical condition so they may direct the plan of care as needed. Under procedure documents determining when to call, evaluate situation and determine it is an emergency, medical situation or non-emergency situation. If death or emergency is a trigger event; send resident to the hospital, then contact the physician. (A)	S9999		