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 03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD REHABILITATION CTR	14255 SOUTH CICERO AVENUE CRESTWOOD, IL 60445

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S 000	Initial Comments Complaint Investigation 2491411/ IL170011	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)5) 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 care and personal care shall be provided to each	S9999		

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S9999	Continued From page 1	S9999		

resident to meet the total nursing and personal care needs of the resident.

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:

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to identify, assess, and treat a change in skin condition until it was an unstageable, necrotic pressure ulcer for 1 of 5 residents (R1) reviewed for wounds in the sample of 13. This failure resulted in R1's wound deteriorating, showing signs of possible infection, and requiring hospitalization.

The findings include:

R1's Admission Record (printed 3/15/24) shows he was admitted to the facility on 9/1/23. R1's Minimum Data Set (MDS) dated 12/6/23 shows R1 is dependent on staff for toileting hygiene and required maximal assistance to roll from lying on

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his back to left and right side, and return to lying on his back when in bed. The same MDS shows R1 has no rejection of care behaviors, R1 is always incontinent of bowel and bladder, and R1 has one unstageable pressure ulcer which was not present upon admission to the facility.

R1's Braden skin risk assessment dated 9/2/23 shows he is at risk for developing pressure ulcers. R1's Progress Notes dated 12/6/23 at 12:22 PM shows that the wound doctor wants R1 sent to the hospital for an evaluation related to a wound on his backside. R1's Progress Notes dated 12/6/23 at 11:07 PM show R1 was admitted to the hospital with a diagnosis of unstageable pressure injury. R1's Care Plan initiated on 9/5/23 shows R1 has potential for impairment to his skin integrity and he should be monitored for any skin injury.

R1's Wound Assessment and Plan shows V4, Wound Physician, saw R1 on 11/22/23. V4 documented an initial assessment of an unstageable (depth obscured) pressure injury of R1's sacrum measuring 9 cm (centimeters) length by 9.5 cm width with a wound onset date of 11/22/23. There was moderate exudate, 20% (percent) slough and 80% eschar with no signs or symptoms of infection.

V4's Wound Assessment and Plan of R1's sacral pressure ulcer shows R1 was not seen on 11/29/23 as he was out of the facility for an appointment. On 12/6/23, V4's Wound Assessment and Plan shows R1's sacral pressure ulcer has declined and measures 11 cm length by 9 cm width with 100% eschar and signs and symptoms of infection include odor. V4's comments show R1 "needs surgical debridement and recommends he be sent to the hospital for

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S9999	Continued From page 3 further evaluation and treatment." On 3/15/24 at 11:54 AM, V3, Wound Care Nurse/Coordinator, said if everyone is doing everything they should be doing, a wound should be identified before it becomes necrotic. V3 said R1 had wounds to his left and right heels and sacrum which were all acquired in the facility. V3 said R1's sacral pressure ulcer was first identified on 11/22/23 when it was a 9 cm by 9.5 cm unstageable pressure ulcer. V3 said unstageable means the skin on top of the wound was necrotic, so you could not see what was going on underneath. V3 said wounds should be identified long before becoming necrotic. V3 said it is important to identify wounds as soon as possible so they can put treatment measures in place and prevent the site from declining further. V3 said R1 was sent to the hospital on 12/6/23 and was admitted with a diagnosis including, but not limited to, unstageable pressure injury. On 3/15/24 at 3:18 PM, V4, Wound Care Physician, said she remembers sending R1 to the hospital the last time she saw him in the facility because his sacral wound looked worse and possibly looked infected. V4 said the phrase "Healing Status Declined" means the wound did not get better, but in fact, got worse, in comparison to the previous exam. V4 said odor can lead one to think of a possible wound infection, and R1's (sacral) wound odor triggered her to believe the wound was possibly infected V4 said because there was worsening of the sacral wound with 100% eschar, she felt R1 needed further evaluation to see if debridement was necessary as she is limited on what treatment she can do at the bedside. V4 said a wound would not become necrotic overnight. V4 said she did not see R1 again and does not know his	S9999		

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S9999	Continued From page 4 outcome. On 3/15/24 at 2:28 PM, V8, Registered Nurse (RN), said the CNAs (certified nursing assistants) will report any redness or skin changes to the floor nurse and the nurse will assess the resident's skin and do a risk management report and send it to the wound care nurses so they can assess the area and implement wound care treatments right away. V8 said it is important to identify skin changes right away so it does not worsen and progress to a pressure ulcer. V8 said it is important to catch skin changes early to start the healing. V8 said if a pressure ulcer worsens, it gets more difficult and complicated to manage. If skin changes are found early, treatment can be more successful. On 3/15/24 at 2:29 PM, V9, CNA, said she knows to report any skin changes to the nurse right away. V9 said it is important so the resident can get treatment as soon as possible. V9 said a change in skin condition would go through so many stages before becoming black that finding a black wound which was not previously identified would be very unlikely. V9 said any skin changes should begin with documentation right from when redness is first noted. (A)	S9999		