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
	IL6002265	A. BUILDING: ______ B. WING ______	C 02/18/2024

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 23910054/IL167366	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	S9999		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/05/24

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care and personal care shall be provided to each 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 follow their pressure ulcer prevention protocol for one of three residents (R263) reviewed for pressure ulcers in a sample of 36. This failure resulted in R263 developing a left hip skin tear and a right buttocks skin tear, a right and left heel deep tissue injury with eschar, and a stage three pressure ulcer to the right inferior buttocks.

Findings include:

On 2/2/2023 at 9:30am V35 (Wound care Manager) said that R263 was alert to name and could follow some commands, he was bed bound

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and incontinent of bowel and bladder and had no open skin areas. Record review documents that on 10/31/2023 R263 developed a skin tear to the right buttocks, on 11/1/2023 R263 developed a skin tear to left hip, on 11/10/2023 R263 developed a pressure ulcer with a deep tissue injury to his left and right heel, on 11/15/2023 R263 developed a pressure ulcer to the right inferior buttocks stage three with granulating tissue to the wound bed. V35 said the wound care team should have applied a pressure ulcer relieving low air loss mattress to R263's bed when he developed the skin tear to the left hip and the Braden score dropped to 14 indicating R263 was no longer at very limited risk, but had become a moderate risk for the development of pressure ulcers.

On 2/2/2023 at 10:00am V36 (Wound care Nurse) said that R263 was alert and oriented to self only and that he was bed bound and was unsure of his ambulation status and that R263 did not have any skin issues upon admission. R263 developed wounds in the facility and the wound care manager is the one who makes the decision to place residents on pressure ulcer relieving mattresses. The Braden score did indicate that R263 was declining and had open wounds that required pressure ulcer prevention measures and a low air loss mattress should have been put in place.

On 2/1/2023 at 3:30pm V2 (Director of Nursing-DON) said that R263 was admitted to the facility alert and oriented times one to two and was on the memory care unit, R263 was a fall risk and did not have any open areas on his skin. R263 started declining and developing skin issues, I expect my wound care team to know when to apply pressure ulcer prevention tools as

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needed. R263 had a stage three and he should've had a pressure ulcer relieving mattress in place.

Record review documents that R263 was admitted to the facility on 9/12/2023 alert to self, incontinent of bowel and bladder, chairbound and unable to ambulate but with skin intact. On 9/13/2023 a Braden score of 22 indicating R263 was a very limited risk for pressure ulcer development. On 10/3/2023 R263's Braden score was a 14 which indicates R263 was at moderate risk, on 10/31/2023 R263 developed a skin tear to the right buttocks measuring a 1.60 cm x 5.80 cm. On 11/1/2023 R263 developed a left hip skin tear measuring 2.40 cm x 1.70 cm. On 11/10/2023 R263 developed a left heel pressure ulcer deep tissue injury measuring 6.30 cm x 6.50 and a right heel pressure ulcer deep tissue injury measuring 5.80 cm x 7.00 cm. On 11/15/2023 R263 developed a right inferior buttocks pressure ulcer stage three measuring 0.70 cm x 1.50 cm x 0.10 cm. On 11/16/2023 R263 scored a 13 on the pressure ulcer Braden score which indicates Moderate risk for pressure ulcer development. A care plan dated 11/16/2023 indicates R263 had a pressure prevention intervention for a pressure relieving/reducing mattress device on the bed.

Facility Policy: Pressure/Skin Breakdown-Clinical Protocol
Effective date: January 2017
Policy Specifications.
Document an individual significant risk factors for developing pressure ulcers sores, immobility, history of pressure wounds and recent weight loss.
3. Examine skin on new admission.
5. Identify factors contributing to skin breakdown.

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S9999	Continued From page 4 7. The physician will authorize pertinent orders related to wound treatments, including pressure redistribution surfaces. Prevention of Pressure Wounds: January 2017 Purpose: The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. General Guidelines: 2. The most common site of a pressure injury is where the bones are near the surface of the body including back of the head, around the ears, elbows shoulder blades, backbone, hips, knees, heels, ankles, and toes. Interventions and Preventive Measures: 2. for a person in bed, c. If a special mattress is needed, use one that contains foam, air, as indicated. The following equipment and supplies will be necessary when providing preventive skin care. 1. Tool for assessing skin and pressure injury risk. a. Braden Risk Assessment Form b. Intervention Preventive Measures (B)	S9999		