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S 000	Initial Comments Complaint Investigation 2590200/IL183960	S 000		
S9999	Final Observations Statement of Licensure Violations: Section 300.1010h) Section 300.1210d)3) Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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.	S9999		

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Based on interview and record review, facility lacked an effective system to prevent fluid volume overload, assess and monitor fluid volume status, and notify the nephrologist of treatment refusals and abnormal radiology results for one (R8) out of three residents reviewed for dialysis in a total sample of ten. This failure resulted in staff failing to recognize R8's change in condition as fluid volume overload after R8 complained of shortness of breath, and R8 expired in the facility after being found unresponsive.

Findings Include:

R8 is a 48 year old with the following diagnosis: chronic respiratory failure with hypoxia and hypercapnia, morbid obesity, congestive heart failure, cardiomegaly, lymphedema, end stage renal disease with dependence on renal dialysis, and encounter for tracheostomy and gastrostomy.

A Nursing note dated 1/3/25 at 4:30 PM documents R8 refused to go to dialysis. The nurse explained the importance of dialysis and risks for not receiving treatment. The dialysis nurse spoke with the nephrologist who made an order to send R8 to the hospital for an evaluation.

A Nursing note dated 1/3/25 at 7:12 PM documents the ambulance arrived for transportation to the hospital, but R8 refused to go. The primary physician was notified. There is no documentation of the nephrologist being notified of R8's refusal to go to the hospital for an evaluation.

A Nurse Practitioner note dated 1/4/25 documents R8 was seen today for the initial visit. R8 refused hemodialysis on Friday and discussed

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concerns. R8 is to resume hemodialysis on Monday. No further orders were put in place to monitor R8 before the next dialysis session.

A Nursing note dated 1/5/25 at 4:19 PM documents R8 is receiving continuous oxygen at 3 L via nasal cannula. Vital signs are within normal limits but R8 complains of shortness of breath. R8 continuously requested to go to the hospital. The nurse and management educated R8 on breathing techniques and that vital signs are normal. A chest x-ray was ordered to rule out pneumonia. R8 was also counseled on refusing dialysis treatment and the adverse effects to overall health. R8's family member was notified and reported understanding. There is no documentation that an assessment was completed to listen to R8's lungs or that any vital signs were taken after this point to assess R8 for any further changes in condition or changes in vital signs.

A Nursing note dated 1/5/25 at 5:10 PM documents R8 refused to go to the hospital. The nurse educated R8 that R8 should go to the hospital due to refusing dialysis treatments and missing two sessions. R8 voiced understanding after education was provided. A STAT order for labs were put in place. This note was not charted until 10:22PM which is after the time R8 expired.

The x-ray company's Portable Service Requisition Sheet dated 1/5/25 documents the tech was performing the exam at 6:36PM. R8 was morbidly obese and bedbound. R8 was nonresponsive and physically unable to maintain the lateral position during the exam.

A Nursing note dated 1/5/25 at 7:45 PM documents upon rounds, R8 was found without

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vital signs and was unresponsive. A code blue was called and CPR was initiated. 911 was called. EMS arrived at the bedside but was unable to resuscitate R8. Time of death was called at 8:23 PM.

The Emergency Code Documentation dated 1/5/25 documents R8 was found around 7:45 PM by the nurse and had absent respirations, pulse, and blood pressure. CPR was started at this time. EMS arrived at 7:53 PM and took over. R8 expired in the facility at 8:23 PM.

The Fire Department Record dated 1/5/25 documents the crew was dispatched to the facility for a full arrest. Upon entering our R8's room, staff from the nursing home were performing CPR and ventilating R8 with a bag valve mask. Staff also stated that R8 missed two dialysis treatments this week. Once placed on the cardiac monitor, it showed asystole for R8's heart rhythm. R8 was given three rounds of medications and CPR with no signs of improvement. The crew called medical control and relayed report. The crew was instructed by the physician to terminate resuscitation efforts with a time of death at 8:23 PM.

On 1/14/25 at 1:52PM, V16 (Nurse) stated V16 was the nurse for R8 at the time R8 refused dialysis. V16 reported telling the dialysis company that R8 refused and an order was placed by the dialysis company to send R8 out to the hospital. V16 stated the nephrologist (V22) gave the order to send R8 to the hospital. V16 reported once the ambulance arrive to the facility R8 refused to go to the hospital. V16 reported telling V24 (Primary Physician) that R8 refused to go to the hospital but did not tell V22 (nephrologist). V16 stated V16 worked with R8 on 1/5/25 on the 3 PM to 11 PM

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shift. V16 reported the previous nurse told V16 a chest x-ray needed to be completed on R8 but V16 was not sure why the chest x-ray was ordered. V16 stated the chest x-ray was completed around 7:30 PM and about 15 minutes later, V16 went to go check on R8. V16 reported at this time R8 was unresponsive, did not have a pulse, and was not breathing. V16 stated a cold blue was called and CPR was started. V16 reported last seeing R8 around 5:30 PM and R8 was using R8's phone. V16 stated checking R8's vital signs around 4:30 PM when V16 arrived to the facility. V16 was unaware of what the x-ray results showed. V16 denied checking the x-ray report and stated it is the responsibility of the doctor.

On 1/14/25 at 3:33PM, V18 (CNA) stated V18 came on at 3 PM on 1/5/25. V18 reported this was the first time working with R8. V18 stated the only complaint R8 made was that R8 had a stomach ache and did not want to eat. V18 reported last seeing R8 around 6:30 or 7 PM (This is the time the x-ray was being completed and R8 was noted to be lethargic and unresponsive by V26 (Radiology Technician)) before V18 went on break. V18 stated the V18 was aware R8 skipped dialysis. V18 team reported as V18 was coming back from break, the paramedics were trying to resuscitate R8. V18 denied being aware R8 complained of shortness of breath earlier in the day.

On 1/14/25 at 5:20PM, V19 (Nurse) stated V19 took care of R8 during the morning shift on 1/5. V19 reported shortly after breakfast, R8 kept requesting to go to the hospital. V19 stated R8 appeared fine and had normal vitals. V19 denied remembering if R8 reported being short of breath. V19 reported being aware that R8 missed at least

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one dialysis session. V19 stated V19 did an assessment on R8 and listened to R8's lungs, which were clear. V19 reported V19 did not chart that part of the assessment. V19 stated if you don't chart what a nurse does then it is considered that it wasn't done. V19 reported last seeing R8 between 1:30 and 2:30 PM. V19 stated R8 was sleeping during this last set of rounds and V19 did not wake R8. V19 denied remembering why a chest x-ray was ordered. V19 reported R8 stated that R8 felt panicked and was getting anxious so V19 talked R8 through some breathing exercises to calm down. V19 stated a chest x-ray was put in STAT but does not know why the x-ray was not completed on V19's shift. V19 reported fluid builds up in the body when dialysis is missed.

On 1/15/25 at 10:38AM, V20 (Dialysis Nurse) stated V20 was aware that R8 refused dialysis on 1/3. V20 reported calling the nephrologist (V22) to notify of the refusal. V20 reported that V22 ordered to send R8 to the hospital for an evaluation. V20 stated it is the facilities responsibility to send R8 to the hospital. V20 denied being aware that R8 did not go to the hospital. V20 reported if V20 was made aware then V20 would have called the nephrologist to update V22 and get any further orders. V20 stated if a resident skips dialysis then they can become fluid overloaded. V20 reported fluid overload can begin anywhere from one day to three days after missing a treatment.

On 1/15/25 at 11:43AM, V21 (Nurse Practitioner) stated V21 was aware that R8 refused dialysis on 1/3. V21 reported telling R8 that if R8 became short of breath that R8 would need to go to the hospital to be dialyzed. V21 stated V21 did not follow up with R8 on 1/5 because when V21 saw

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R8 the day before, R8 was stable. V21 reported vital signs were being done each shift on R8 so no other orders needed to be put in. V21 stated V21 did not put in any further orders to monitor for fluid overload because R8 was stable the last time R8 was assessed by V21.

On 1/15/25 at 12:03PM, V22 (Nephrologist) stated V22 had a very good rapport with R8 and followed R8 since R8 began dialysis at the hospital. V22 reported being aware that R8 refused dialysis on 1/3. V22 stated that an order was put in to send R8 out to the hospital for an evaluation. V22 denied that any staff made the dialysis center or V22 aware that R8 refused to go to the hospital. V22 stated V22 was under the impression that R8 went to the hospital and got dialysis there. V22 reported R8 does not have a healthy heart or lungs to be skipping treatments without issues. V22 stated if a dialysis patient tells you they are short of breath then they need emergent dialysis. V22 reported V22 wanted to be involved if R8 was continuing to refuse care due to having a close relationship with R8. V22 stated V22 would have continued to speak with R8 or even come in to talk to R8 until R8 agreed to go to the hospital. V22 reported V22 would have gotten to the root of why R8 was refusing to go to dialysis. V22 stated that if V22 was aware that R8 did not go to the hospital that at a minimum labs and chest x-rays would have been ordered daily over the weekend.

On 1/15/25 at 12:21PM, V23 (Nurse Manager) stated V23 was aware that R8 refused dialysis on 1/3. V23 reported V23 began looking through orders and realize the facility had "nothing going on for him." V23 suggested getting labs and a chest x-ray to get a baseline. V23 denied R8 received any dialysis since R8 was admitted on

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12/31. V23 reported vital signs were completed once a shift to monitor R8. V23 stated the facility staff communicate with a primary physician and dialysis staff communicates with the nephrologist. V23 reported if R8 was symptomatic then R8 would've been sent out to the hospital immediately. V23 stated all orders were put in STAT due to it being a weekend and it would have been a long wait if put in as a standard order. V23 reported they needed to be updated on R8's status on that day. V23 denied being aware that R8 complained of being short of breath.

On 1/15/25 at 12:45PM, V1 (Asst. Administrator) stated V1 was at the facility but stepped out of the building at the time R8 was found unresponsive. V1 reported upon returning to the facility, V1 saw the paramedics and learned R8 expired. V1 stated V1 was made aware that R8 skipped dialysis on 1/3/25 and refused to go to the hospital. V1 reported the plan was to have a conversation with R8 on 1/6/25 to see if R8 wanted to continue dialysis or be put on hospice. V1 stated R8 had a chest x-ray and labs ordered on 1/5 because R8 refused dialysis. V1 reported V24 (Primary Physician) was made aware every time R8 refused dialysis or to go to the hospital. V1 stated only the dialysis nurses communicate with the nephrologist (V22). V1 reported it was portrayed that V22 put in the order for R8 to go to the hospital. V1 was not aware if V22 was called after R8 refused to go to the hospital. V1 reported the results to the x-rays are automatically uploaded to the computer system. V1 stated the nurse is responsible to read the results and notify the physician if there's any abnormalities. V1 reported if R8 was having any symptoms of fluid overload, R8 would have needed to go to the hospital and would not have had a choice at that

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point. V1 stated vital signs and head to toe assessments were performed each shift to monitor R8 for fluid overload.

On 1/15/25 at 1:56PM, V24 (Primary Physician) stated R8 refused dialysis and refused to go to the hospital on 1/3. V24 reported R8 asked to go to the hospital again on 1/5 due to a change in condition. V24 was unable to remember what the change of condition was. V24 stated if dialysis is refused or sessions are missed that the body can fill up with fluid. V24 reported the results of R8's chest x-ray indicate R8 would've had some kind of pneumonia and that the pleural fluid was meaning that R8's heart was filling up from fluid due to the kidneys, not working.

On 1/16/25 at 12:40PM, V25 (Radiology Director of Operations) stated once the facility puts in order for an image to be taken, it gets electronically sent over to the radiology company. V25 reported the x-ray was ordered for R8 and assigned to a technician at 11:39 AM. V25 reported STAT orders are normally taken between 4 to 6 hours. V25 could not answer why the x-ray was not completed within 4 to 6 hours but reported the facilities are aware that if the STAT x-ray is not completed within this timeframe, they can decide what to do by calling the physician for notification. V25 stated the facility has bidirectional access which allows them to see results once they are uploaded into the computer system after being reviewed by radiologist. V25 reported the results to the chest x-ray for R8 were uploaded into the system at 6:52 PM.

On 1/17/25 at 10:05AM, V1 stated STAT x-rays are usually done with in 4 to 6 hours. V1 reported sometimes the x-rays aren't taken in that time

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frame. V1 stated if a resident declines any further or shows symptoms of anything then they are sent out to the hospital immediately.

On 1/18/25 at 11:10AM, V26 (Radiology Technician) stated V26 got to the facility and took the ordered chest x-ray around 6:30PM. V26 reported R8 was lethargic and would not respond to any questioning. V26 stated V26 exited the room before doing the exam to ask an unknown CNA if this was R8's normal state. V26 reported the CNA told V26 that it was normal for R8 to act unresponsive and did not go into the room to check on R8. V26 stated since R8 was not able to follow directions or move, V26 was only able to get a one view chest x-ray when a two view was ordered. V26 denied R8 being able to roll onto R8's side. V26 reported out of the 17 images, 11 of them were scheduled to be STAT that day. V26 denied the facility calling and checking on the status of when the x-ray would be taken. V26 reported normally if a resident cannot move staff will come in and assist, but no staff was available to help during the time of this x-ray.

On 1/21/25 at 1:17PM, V19 stated V19 received an order to send R8 to the hospital on 1/5 but R8 changed R8's mind. V19 again denied remembering if R8 complained of being short of breath V19 was shown the note that was written by V19 on /5/25. V19 said, "Apparently he was complaining of shortness of breath after I read my note." V19 denied remembering what time R8 complained of shortness of breath. V19 reported checking R8's vital signs one time during that shift. V19 reported getting an order for a chest x-ray from V27 (Nurse Practitioner). V19 stated V24 (Primary Physician) gave the order to send R8 to the hospital. V19 reported an order should be put into the computer system as soon as they

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are received V19 denied remembering why the orders were put into the computer system by V19 after 10 PM.

On 1/21/25 at 1:39PM, V27 (Nurse Practitioner) stated V27 was not called or notified about R8's change in condition. V27 reported at the time of R8's change in condition another physician's group covers for needs of the residents. V27 denied having any involvement in R8's care.

On 1/21/25 at 2:13PM, V24 stated staff needs to call V24 to verify all orders before putting them in the computer system. V24 stated the order should be put into the computer system as soon as V24 agrees to it so it can be completed as soon as possible. V24 denied remembering what orders staff suggested for R8 on 1/5. V24 denied remembering why the chest x-ray was ordered for R8 on 1/5. V24 said, "If the order says congestion, then I guess he was having some congestion. We have to put in a reason for every x-ray so the radiologist knows what they're looking for." V24 denied that staff ever called V24 to report a change in condition where R8 needed to be sent out via 911. V24 stated if a resident has a change then V24 must be notified, but if it is serious, then staff must send out the resident via 911 as soon as possible.

The Admission Hospital Records dated 12/31/24 document R8 originally came to the hospital on 10/31/24 after being found hypoxic due to pneumonia. R8 suffered sepsis and multi organ failure. R8 began hemodialysis for acute renal failure, experienced cardiomegaly with congestive heart failure, respiratory failure, and needed a tracheostomy as well as gastrotomy tube placed. R8 received hemodialysis on Tuesdays, Thursdays, and Saturdays at the hospital. R8

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received dialysis on 12/30/24 and had 3 L of fluid removed. R8 received dialysis again on 12/31/24 and had 3.4 L of fluid removed. R8 was given an extra session of dialysis before discharge and anticipation of being admitted to a new facility. Upon discharge, R8 had no significant volume overload.

The Admission Evaluation dated 12/31/24 documents R8 is only able to urinate small amounts. Breath sounds upon admission are documented as clear bilaterally.

The Physician Order Summary documents a STAT chest x-ray was ordered on 1/5/25 at 11:38 AM. An order was placed on 12/31/24 for R8 to receive hemodialysis on Mondays, Wednesdays, and Fridays. More orders were placed to send R8 to the hospital and or STAT CBC and CMP (laboratory work) on 1/5/25. After reviewing the order details, the orders for the transfer to the hospital and laboratory work was put in on 1/5/25 at 10:10PM. These orders were placed almost 2.5 hours after R8 was found unresponsive.

The Radiology Report dated 1/5/25 documents the results of the chest x-ray showed bilateral lung infiltrates, pericardial effusion, and pulmonary vascular congestion.

The Order Information Sheet from the x-ray company documents the company was notified of the chest x-ray order at 11:39 AM on 1/5/25. The order priority did come in as STAT. The technician arrived to the facility at 6:36 PM and completed the exam at 6:38 PM. The reason documented for ordering the exam is congestion. The results of the chest x-ray were read by the radiologist at 6:49 PM and uploaded into the computer system the facility could access at 6:52

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	IL6002265	A. BUILDING: _____ B. WING _____	C 01/31/2025

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
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PM. The chest x-ray did have a positive critical finding.

The Care Plan dated 1/3/25 documents R8 is resistant to care related to anxiety and adjusting to the nursing home. R8 is currently on hemodialysis however R8 still eats food not listed on the renal diet and is resistant to care including dialysis and other care. There are no interventions or protocols on what to do when R8 refuses a dialysis treatment.

The policy titled Refusal of Treatment," dated 08/2008 documents, "Policy Interpretation and Implementation: ...3. If a resident/resident's clinical representative refuses treatment, the unit manager, charge nurse, director of nursing services, or designee will interview the resident to determine what and why the resident is not adherent to the plan of care in order to try to address the resident's concerns and explain the consequences. 4. The care plan team will assess the resident's needs and offer the resident alternative treatments, if available, while continuing to provide other services outlined in the care plan. 5. If the resident's refusal brings about a significant change, a reassessment will be made, and such information will be incorporated into the resident's care plan. 6. The attending physician must be notified of such refusal, consistent with facilities policy and accepted standard of practice."

The policy titled, "Notification of Change," dated 7/1/24 documents, "Purpose: It is the practice of this facility that changes in a resident's condition or treatment are immediately shared with the resident and/or resident representative, according to their authority, and are reported to and consulted with the attending physician. The

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resident and/or the resident representative will be educated about treatment options and supported to make informed decision ... Objective of the Notification of Change Guideline: The objective of the notification guideline is to ensure facilities staff make appropriate notification to the physician or delegated non-physician practitioner in immediate notification to the resident and/or the resident representative when there is a changing condition. Requirements for Notification of Resident, the Resident Representative, and their Physician: A significant change in the resident's physical, mental, or psychosocial status - A significant change includes deterioration and health, mental, or psychosocial status in either life-threatening conditions or clinical complications and/or a need to alter treatment significantly ... Physician Notification and Consultation: Notification is provided to the physician to facilitate continuity of care and obtain guidance from the physician about changes or additions to or discontinuation of treatments ... Procedure: 1. Obtain orders for appropriate treatment in monitoring and promote the residents right to make choices about treatment and care preferences 2. Document the notification and record any new orders in the resident's medical record. 3. Educate the resident and/or representative about the proposed plan to treat, manage, or monitor the resident's change in condition 4. Educate the resident and/or resident representative about the risks and benefits of the proposed treatment change and provide an opportunity for the resident to make an informed choice of treatment 5. Update the resident's care plan, transcribe, and implement the providers orders 6. Communicate the changes to the care team and pharmacy."

The Facility Agreement with the x-ray company

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S9999	Continued From page 14 dated 9/12/24 documents, " ...Duties and Obligations of the Facility: ...f. Facility agrees to provide a clinician/staff member to be present and assist when a service is performed." The facility in-services were reviewed. The In-service on 10/15/24 and 10/23/24 document the in-service was provided to nursing staff (CNAs and nurses) about changes in condition. Topics covered include: a change in condition must be reported to the RN or MD when first noted, STAT orders must be completed within 4 hours and if not then the MD must be notified, and nurses are expected to know abnormal lab values and diagnostic results - if the MD does not provide orders for the abnormal result then it must be questioned why. AA	S9999		