STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145220	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Crest Health Care	3300 West 175th Street Hazel Crest, IL 60429

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45316 Based on observation interview, record review the facility failed to follow their policy in ensuring that ceiling tiles in the residents are free from watermarks or spots, and that vents in the residents' room are free from dust build up. This deficiency affects all four rooms (Rooms 205, 211, 2316, and 2210) reviewed for clean, comfortable, and homelike environment. Findings include: On 9/17/2024 between 10:30 AM and 11:30 AM, rooms 205, 211, 2210, and room [ROOM NUMBER] were observed to have brown sports on the ceiling, and vents have dust build up. On 9/18/2024 at 12:41 PM, V11 (Maintenance Director) said that the brown sports on room [ROOM NUMBER] ceiling is from water leakage from the air conditioner. At 12:49 PM, V11 said that the brown spots on the ceiling above a 211-1 bed is from a water leakage from the toilet from the room above 211-1's room, and that the brown sports on 205 ceiling is from water leakage. On 9/19/2024 at 01:00 PM, V11 said that the brown sports on room [ROOM NUMBER] ceiling is also from water leakage. V11 said that the vents should be free of dust, and the ceilings should not have brown sports and should be replace. On 9/18/2024 at 12:55 PM, V2 said that the ceilings should be free of brown sports and the vents free of dust build up. Facility Policy: Preventative Maintenance Program Purpose: To conduct regular environmental tours/safety audits to identify areas of concern within the facility. Protocol: To conduct environmental tours/safety audits of the facility, using the following criteria: (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145220	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Crest Health Care	3300 West 175th Street Hazel Crest, IL 60429

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Preventive Maintenance Program will review the following areas during random rounds: 14. Ceiling tiles are free from watermarks or spots.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145220	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Crest Health Care	3300 West 175th Street Hazel Crest, IL 60429

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781 Based on observation, interview, and record review the facility failed to implement written policies and procedures that prohibit and prevent abuse. This deficiency affects one (R19) of three residents in the sample of 29 reviewed for Abuse prevention program. Finding includes: On 9/17/24 at 11:10AM, Observed R19 up in wheelchair and able to propel himself. He is alert, oriented and response appropriately. On 9/18/24 at 9:40AM, V1 Administrator said that he is the abuse coordinator. V1 said that resident abuse screening is done upon admission. V1 said that V2 Assistant Administrator and V5 Social Service Director are responsible for screening residents for identified offender. V5 is responsible for developing abuse prevention and identified offender care plan. On 9/18/24 at 1:37PM, V5 Social Service Director (SSD) said that she is responsible for developing abuse prevention and identified offender care plan. Reviewed R19's medical records with V5 SSD. Informed V5 that R19 does not have care plan for abuse prevention and identified offender. V5 said that R19 should have abuse prevention care plan because his admission assessment indicated that he is at high risk for abuse. V5 said that R19 should have identified offender care plan upon admission. R19 is admitted on [DATE] with diagnosis listed din part but not limited to Paranoid Schizophrenia, Mild Dementia, recurrent Depressive disorders. Admission screening on 4/24/24 and quarterly assessment on 7/30/24 indicated that he is at high risk for abuse. There are no abuse prevention care plan and identified offender care plan was formulated. Facility's policy on Abuse Prevention Program Facility Procedures indicates: Procedures for prevention: IV. Establishing a Resident Sensitive Environment This facility desires to prevent abuse, neglect, or misappropriation of property by establishing a resident sensitive and resident secure environment. This will be accomplished by a comprehensive quality management approach involving the following: Resident Assessment: As part of the resident social history evaluation and MDS assessments, staff will identify residents with increased vulnerability for abuse, neglect, mistreatment or who have needs and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goal, and approaches, which would reduce the chances of abuse, neglect, or mistreatment for these residents. Staff will continue to monitor goals and approaches on a regular basis. Facility's policy on Identified Offender indicates: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145220	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Crest Health Care	3300 West 175th Street Hazel Crest, IL 60429

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy statement: it is the policy of this facility to establish a resident sensitive and resident secure environment. In accordance with the provision of the Nursing Home Care Act, this facility shall check the criminal history background on any resident seeking admission to the facility in order to identify previous criminal convictions. Care Planning: Upon admission of an identified offender or the decision to retain an identified offender, the facility, in consultation with the medical director and law enforcement, shall specifically address the resident's needs in an individualized plan of care. *The facility shall in corporate the identified offender report and recommendations. Report into the identified offender's plan of care including the security measures listed. *The facility shall evaluate the care plans at least quarterly for identified offenders to make sure the areas related to the identified offence are still appropriate and effective. This review shall be documented, and care modified as needed. *The facility shall remain responsible for continuously evaluating the identified offender and for making any changes in the care plan that are necessary to ensure the safety or reside

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145220	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Crest Health Care	3300 West 175th Street Hazel Crest, IL 60429

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781 Based on observation, interview, and record review the facility failed to provide nail care to resident who is dependent with Activity of Daily Livings (ADL). This deficiency affects one (R103) of three residents in the sample of 29 reviewed for providing ADL care. Findings include: On 9/17/24 at 12:30PM, While observing R103 for wound care observed bilateral hand with long and dirty fingernails. Noted black/dark colored dirt under the fingernails. Showed both observation to both V9 Wound Care Nurse (WCN) and V14 CNA (Certified Nurse Assistant). Both said that CNA should provide nail during personal hygiene/shower. V9 said that R103 refused nail care but when V9 WCN asked her if they can trim her fingernails and clean it R103 agreed. Requested for policy. On 9/18/24 at 1:30PM, Follow up policy with V2 Assistant Administrator. On 9/20/24 at 11:13Am, V3 Director of Nursing said that they don't have policy on nail care. R103 is admitted on [DATE] with diagnosis listed din part but not limited to Cerebral Infarction, Encephalopathy, Dementia, Gastrostomy, Mild protein calorie malnutrition and Methicillin resistant of staphylococcus aureus infection. Comprehensive care plan indicates that she has self-care deficit and requires assistance with ADLs to maintain highest possible level of functioning as evidenced by following limitations and potential contributing factors, poor coming to sit and stand balance, weakness, impaired cognitive status related to Dementia, hypertension, chronic obstructive pulmonary disease and altered mental status. Intervention: Provide assistance with all ADLs as required per the resident needs' dependence: eating, transferring, bed mobility, bathing, dressing, personal hygiene, ambulation, and personal hygiene. Facility's policy on Activity of Daily Living (ADLs) indicates: Purpose: To preserve ADL function, promote independence and increase self-esteem and dignity. Facility unable to provide policy on nail care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145220	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Crest Health Care	3300 West 175th Street Hazel Crest, IL 60429

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781 Based on observation, interview, and record review the facility failed to identify early signs of skin impairment and provide treatment in timely manner. The facility failed to develop care plan and implement interventions to prevention skin impairment to resident who is at high risk. The facility also failed to follow manufacturer recommendation when using low air loss mattress. This deficiency affects two (R88 and R103) of three residents in the sample of 29 reviewed for providing Quality of care. Findings include: R103 On 9/17/24 at 10:25AM, V22 Family member said R103 developed a sore on her foot that is now gangrene. R103 is not diabetic. R103 may require amputation. R103 was sent to the hospital after V22 complained to the facility. V22 said that she informed unknown CNA (Certified Nurse Assistant) about the sore couple months ago. V22 said that she has not spoken to R103's PCP (Primary Care Physician) but has spoken to wound care nurse, head nurse and administrator. On 9/17/24 at 12:30PM, Observed V9 WCN and V14 CNA provided wound treatment to R103's left lateral foot arterial ulcer. V9 WCN said that R103 has 95% necrotic tissue and 5% open reddish tissue/open skin. R103 is totally dependent with ADLs (Activity of daily living) and transfers. On 9/19/24 at 10:26AM, Review R103's medical records with V9 WCN. V9 said that R103 is admitted with skin intact and at high risk for skin impairment. V9 said that on 8/29/24, she was called by CNA, which she cannot recall the name, and notified her that R103 has skin impairment and discoloration on left lateral foot/toes. R103's physician and family member were notified. Arterial ultrasound as done at the facility with abnormal results and R103 was sent to hospital for evaluation and was admitted . R103 was not seen by podiatrist in the facility. Review R103 progress notes and shower/bath record for August 2024. No documentation of skin impairment prior to 8/29/24. R103 returned to the facility on [DATE] with betadine dressing wound treatment and podiatry recommendation. No surgical intervention. Informed V9 that R103's arterial full thickness left 5th toe extent to lateral foot measures 12cm x 5cm with 100% deep purple discoloration and left 4th toe arterial full thickness measures 2cm x 1cm with 100% deep purple discoloration are very visible to be missed during daily or every shift routine care. V9 WCN said that CNA should report any early signs of skin impairment to the nurse. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145220	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Crest Health Care	3300 West 175th Street Hazel Crest, IL 60429

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R103 is admitted on [DATE] with diagnosis listed din part but not limited to Cerebral Infarction, Encephalopathy, Dementia, Gastrostomy, Mild protein calorie malnutrition, Methicillin resistant of staphylococcus aureus infection. Physician order sheet indicates Skin assessment weekly on shower or bath every Tuesday and Friday. Betadine external solution (Povidone-iodine) Apply to left 4th and left 5th toe extent to lateral foot topically every other day and as needed for wound care. Cleanse with NSS (normal saline solution). Admission Braden scale/Skin assessment indicated that she is at high risk for skin impairment. Comprehensive care plan indicates she has an alteration in skin integrity and is at risk for additional and or worsening of skin integrity issues. Interventions: Skin will be checked during routine care on a daily basis and during the weekly/bi-weekly bath/shower schedule. Any skin integrity issues/concerns will be conveyed to the Charge Nurse for further evaluation and or treatment changes/new interventions and the physician will be called as needed. R103's wound assessment dated [DATE] indicated left lateral full thickness measures 12cm x5cm, 100% deep purple discoloration, facility acquired. Left 4th toe full thickness, measures 2cm x 1cm, facility acquired, 100% deep purple discoloration. Bilateral lower extremity arterial duplex ultrasound dated 8/29/24 indicated moderately severe bilateral peripheral vascular/arterial disease. Recommend CT (computed tomography)/MRA (magnetic resonance angiography) runoff would be confirmatory. Most recent wound report dated 9/12/24 indicates left 4th toe, full thickness arterial, measures 2.6cm x 1.0cm, 100% deep purple discoloration. Left 5th toe extending to lateral foot, full thickness, arterial, measures 13cm x 5.5cm. R103's hospital discharged record dated 9/4/24 indicated that she was admitted to hospital on 8/29/24 with left foot wound. Infectious disease treated her with antibiotics and podiatry recommendation wound care only and no surgical intervention. Left foot/toes cellulitis and possible osteomyelitis, CT foot with no signs of cellulitis. Seen by podiatry- continue local wound care. No plans for surgical intervention at this time. Patient is not a good candidate for intervention as she is contracted at baseline. R88 On 9/18/24 at 10:13AM, Observed R88 lying in bed with Low air loss mattress (LAL). V10 Infection Preventionist removed the top linen of R88 to check the LAL mattress. Noted flat sheet, folded bath blanket in quarters and cloth pad underneath R88. V10 said that R88 should only have 1 pad or 1 sheet over the LAL mattress. On 9/18/24 at 10:22AM, V24 CNA (Certified Nurse Assistant) said that she is the assigned CNA for R88. The hospice CNA came around 9:30am and provided care to R88. V24 said that the Hospice CNA was the one who placed the multilayer of linens over the LAL mattress of R88. V24 has not seen R88. She is aware that resident on LAL mattress should be only on 1 pad or 1 flat sheet over the mattress. On 9/18/24 at 1:58PM, Informed V9 WCN (Wound Care Nurse) of above observation. V9 said that R88 should either have 1 pad or 1 flat sheet underneath her. Review R88 medical records with V9. V9 WCN said that R88 is at high risk for skin impairment. Noted that R88 does not have care plan for prevention of pressure ulcer/injury. V9 said that R88 should have care plan developed for pressure ulcer/injury /skin impairment prevention. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145220	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Crest Health Care	3300 West 175th Street Hazel Crest, IL 60429

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R88 is admitted on [DATE] with diagnosis listed in part but not limited to Benign neoplasm of left breast, Intraductal carcinoma of left breast, Psychosis, Dementia. Active physician order sheet indicates pressure reduction mattress. Braden scale /Skin assessment indicated that she is at risk for skin impairment. Comprehensive care plan does not have care plan developed for prevention of pressure ulcer/injury. Facility's policy on Low air Loss Mattress indicates: Purpose: Provide support and pressure relief to pressure ulcers/injuries when in bed, reduce the incidence of pressure ulcers/injuries while optimizing resident comfort, as well as pain management. Procedure: Note: Low air loss mattress may be used for residents who are high risk for pressure ulcer/injury development, multiple stage 2, stage 3 and above to trunk of the body. May apply either one pad/one sheet underneath residents. Facility's policy on Pressure injury and skin condition assessment indicates: Policy: It is the policy of this facility that pressure injury and other ulcers, (diabetic, arterial, venous) will be assessed and measured at least every 7 days by licensed nurse and recorded on the facility approved wound assessment form. Purpose: To establish guidelines for assessing, monitoring, and documenting the presence of skin breakdown, pressure and other ulcers and assuring interventions are implemented. Standards: 4. Each resident will be observed for skin breakdown daily during care and on the assigned bath day by the CNA. Changes shall be promptly reported to the change nurse who will perform the initial assessment. 7. At the earliest sign of a pressure injury or other skin problem, the resident, legal representative and attending physician will be notified. The Director of Nursing will be notified on daily basis by the use of 24-hour report and skin assessment form will be initiated. The initial observation of the injury/ulcer or skin breakdown will be also described in the clinical record. 21. The resident's care plan will be revised as appropriate, to reflect alteration of skin integrity, approaches, and goals for care. Facility's policy on Pressure ulcer prevention indicates: Purpose: To prevent and treat pressure ulcer Note: Daily skin checks will be done by CNAs during routine care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145220	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Crest Health Care	3300 West 175th Street Hazel Crest, IL 60429

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781 Based on observation, interview, and record review the facility failed to implement fall preventive measures and updates fall care plan after each fall occurrence. This deficiency affects all three residents (R13, R88 and R146) in the sample of 29 reviewed for Fall Prevention Program. Findings include: On 9/18/24 at 10:13AM, Observed R88 lying in bed not in the lowest position. On 9/18/24 at 11:58AM, Review R88's medical record with V8 Restorative Nurse/Fall Coordinator. V8 said that R88 is at high risk for falls due to multiple fall incidents. Review R88's fall incidents report for 2024 dated: 1/22, 7/18, 7/26, 7/30 and 8/26/24. All fall incidents were unwitnessed fall and rolled out from bed. All fall incidents did not have fall investigation/root cause analysis. Interventions are not changed after each fall occurrence. On 9/18/24 at 12:28PM, Rounds made to R88 with V8 Restorative Nurse. Observed R88 lying in bed not in the lowest position. V8 said that the bed should be in the lowest position for safety. V8 took the bed control placed at the foot part of the bed and adjusted the bed to the lowest position. R88 is admitted on [DATE] with diagnosis listed in part but not limited to Benign neoplasm of left breast, Intraductal carcinoma of left breast, Psychosis, Dementia. Most recent fall assessment dated [DATE] indicated that she is at high risk for falls. Comprehensive care plan indicated that she is risk for fall as evidenced by incontinence, poor coming to sit and stand balance, poor vision, gait/balance problems, use of Geri chair, BP and psych meds related to Diabetic, hypertension, weakness, and Dementia. Intervention: Ensure bed in the lowest position with all safety devices. R146 On 9/18/24 at 10:19AM, Observed R146 ambulatory in his room. He is not wearing soft Velcro safety helmet (red cap). R146 said that he does not wear helmet or cap. On 9/18/24 at 12:10PM, Review R146's medical records with V8 Restorative Nurse. V8 said that R146 is at high risk for falls due to multiple falls. Review R146's fall incident report for 2024 dated: 5/21, 6/10,7/25 and 9/16/24. All fall incidents were unwitnessed fall. R146 is ambulatory. All fall incidents did not have fall investigation/root cause analysis. Interventions are not changed after each fall occurrence. Informed V8 that R146 is not wearing is protective helmet or cap this morning when surveyor made rounds. On 9/18/24 at 12:45PM, Rounds made to R146's room with V8 Restorative Nurse. V8 searched R146's drawers and closet but no protective helmet/cap was found. Observed R146 in the dining room without protective helmet/cap. V8 said that R146 should have his protective helmet/cap on as indicated in care plan. V8 said that he did not see R146 not until surveyor made rounds with him. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145220	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Crest Health Care	3300 West 175th Street Hazel Crest, IL 60429

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R146 is admitted on [DATE] with diagnosis listed in part but not limited to Vascular Dementia, altered mental status (AMS), Aphasia following Cerebral infarction, Mild neurocognitive disorder, Syncope, and collapse. Most recent fall assessment dated [DATE] indicated that he is at high risk for falls. Comprehensive care plan indicated that he is at risk for falls as evidenced by pacing, confusion, gait/balance problem, psychoactive drug use related to AMS, Hypertension, Diabetes Mellitus, Myocardial infarction, and history of Cerebrovascular accident. Intervention: Soft Velcro safety helmet (red cap). Facility's policy on Fall Prevention Program indicates: Policy: It is the policy of this facility to have a fall prevention program to assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. The Fall prevention program includes the following components: 4. Use and implementation of professional standards of practice 5. Changes in the interventions that were not unsuccessful 10. Care plan incorporates: b. Interventions are changed with each fall as appropriate c. Preventive measures. Standards: 3. Safety interventions will be implemented for each resident identified at risk using a standard protocol. Standard fall/safety precautions for all residents: 16. All nursing personnel will be informed of residents who are at risk for falling. 22. Monitor gait, balance, and fatigue with ambulation. 40001 On 9/18/2024 at 11:30am R13 was observed sitting by the shower room door attempting to go into the shower room alone. On 9/18/2024 at 1:30pm V8 (Restorative/Falls Nurse) said R13 is a high fall risk and last fall was in the common shower room on the unit he should have assistance into the shower room and out, R13 care plan also should be updated I will do that now. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145220	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Crest Health Care	3300 West 175th Street Hazel Crest, IL 60429

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/19/2024 at 10:30am V3(Director of Nursing-DON) said R13 is a high fall risk and has had multiple falls. I expect the restorative nurse to update the care-plan after every fall and make staff aware of the interventions. An admission record indicates R13 has a diagnosis of gas gangrene dated on 8/21/2024, osteomyelitis of the right ankle and foot 7/26/2024, a fall on the same level from slipping, tripping, and stumbling without subsequent striking against object on 4/21/2023. A fall risk review dated 10/31/2012 indicated that R13 is a low risk for falls. A fall risk review dated 9/11/2024 indicates that R13 is high risk for falls. A fall report dated 11/25/2023 R13 had a fall and sustained a laceration on right eyebrow. A fall report dated 7/3/2024 indicates R13 fell to buttocks no injury. A fall report dated 7/11/2024, R13 fell out chair no injury. All care plans updated for each fall. On 8/23/2024 R13 had a fall in the shower room no injury and no care plan update. A care plan last dated revision on 8/11/2024 for at risk for falls due to comorbidities and possible side effects of medication that may cause dizziness sitting in chairs too small, overreaching for items at lower level of wheelchair.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145220	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Crest Health Care	3300 West 175th Street Hazel Crest, IL 60429

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 40001 Based on observation, interview and record review, the facility failed to ensure food was held at a safe and proper temperature before serving. This failure effect 143 residents out of 146 residents in the facility observed for food temperatures. Findings include: On 9/17/2024 at 11:50am V27 (Dietary Cook) was observed for food temperatures, the ground turkey for upstairs was at 128.6 degrees, and then reheated and temperature was at 131.0 degrees. The turkey patties temperature was at 131.2 degrees, the whipped potatoes was at 128.0 degrees, and the pasta temperature was at 126.5 degrees. On 9/17/2024 at 12:00 noon V27 said the food temperature should be holding at 160-170 degrees, I will reheat the food and take all the temperatures over. On 9/17/2024 at 12:30pm V27 (Dietary Supervisor) said all food should be held at 135 degrees before serving, I will make sure all the food is at the correct temperature before serving. Facility Policy: Policy: To ensure food safety, hot food is cooked to a minimum safe temperature and is held no lower than 135 degrees Fahrenheit. Cold food is held a T 41 degrees Fahrenheit or lower. Procedure: Hot food temperatures are taken and recorded on the log at the time the food is taken from the oven. Correct final cooking temperatures are minimum for holding temperature. Ground chicken, turkey patties 135 degrees Fahrenheit. Starches (Rice, Potatoes, Pasta, Beans) at 135 degrees Fahrenheit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145220	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Crest Health Care	3300 West 175th Street Hazel Crest, IL 60429

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781 Based on observation, interview, and record review the facility failed to collaborate and coordinate care by failure to ensure that resident's updated medical records are available and accessible to all interdisciplinary team (IDT) in the facility. This deficiency affects two (R88 and R113) of three residents in the sample of 29 reviewed for Hospice Services Program. Findings include: On 9/17/24 at 10:0AM, Observed R88 lying in bed. She is awake but verbally unresponsive. She is totally dependent with activity of daily living (ADL). On 9/17/24 at 12:04PM, Observed R113 lying in bed. He is awake and response to simple questions. He is totally dependent with ADLs. On 9/17/24 at 12:10PM, Review R88 and R133 hospice records in individual binders with V3 Director of Nursing and V9 Wound Care Coordinator. R88 is admitted on [DATE] with diagnosis listed in part but not limited to Benign neoplasm of the left breast, Intraductal carcinoma of left breast, Dementia. Psychosis. Active physician order sheet indicates admitted to hospice care on 6/18/21. Comprehensive care plan indicates that she has terminal prognosis related to cancer and is on hospice care. Hospice records indicated admission orders/hospice certification dated 6/18/21. No updated hospice certification and plan of care. Hospice interdisciplinary (IDT) one (1) page visit log indicated 9/9/24 (RN), 9/11/24 (Aide) and 9/16/24 (Aide). Most recent progress notes dates indicated 6/3, 6/5 and 6/10/24. R88's hospice contract agreement with hospice vendor indicated: 7. Communications concerning hospice patient. The parties will communicate pertinent information with each other either verbally or in hospice patient's record at least weekly and or at each hospice patient visit to ensure that the needs of each hospice patient are addressed and met 24 hours per day. Documentation of such communication shall be included in the hospice patient's medical record. 11. Clinical records. Hospice provider and facility shall each prepare and maintain complete and detailed clinical records concerning the hospice patient receiving facility. Each clinical record shall completely, promptly, and accurately document all services provided to and events concerning hospice patient. R113 is admitted on [DATE] with diagnosis listed in part but not limited to Vascular dementia, Multiple sclerosis, adult failure to thrive, Gastrostomy, Dysphagia, Transient ischemic attack, and cerebral infarction. Physician order sheet indicates she is admitted to hospice care on 8/20/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145220	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Crest Health Care	3300 West 175th Street Hazel Crest, IL 60429

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Comprehensive care plan indicates that he is on hospice care. Intervention: Collaborate with the hospice team to integrate services provided by the facility and hospice. Hospice records indicated No hospice admission orders/certification. No updated hospice certification and plan of care. Hospice provider agreement contract dated 12/21/22 was different from hospice provider indicated in his chart and hospice IDT notes. IDT one (1) page visit log from June 22 to [DATE]. Most recent CNA 1 page progress notes indicated 8/20 and 8/22/24. Most recent RN 1 page progress notes indicated 8/14, 8/23 and 9/7/24. R113's hospice contract agreement with hospice provider indicated: 7. Communications concerning hospice patient. The parties will communicate pertinent information with each other either verbally or in hospice patient's record at least weekly and or at each hospice patient visit to ensure that the needs of each hospice patient are addressed and met 24 hours per day. Documentation of such communication shall be included in the hospice patient's medical record. 11. Clinical records. Hospice provider and facility shall each prepare and maintain complete and detailed clinical records concerning the hospice patient receiving facility. Each clinical record shall completely, promptly, and accurately document all services provided to and events concerning hospice patient. On 9/17/24 at 12:38PM, V2 DON said that R88 and R113 should have updated hospice medical documentations that are accessible and available for the IDT in the facility. V2 said that social services coordinates services to the hospice provider and making sure that pertinent hospice documentations are available in resident's hospice binder. On 9/18/24 at 1:37PM, Informed V5 Social Service Director of above concerns. V5 said that nursing staff is also coordinating with hospice staff and making sure that hospice pertinent documentation are available in resident's hospice binder. Informed V5 of R113's hospice provider/vendor in the agreement contract is inconsistent with hospice vendor ordered by physician. Surveyor was referred to V1 Administrator. On 9/19/24 at 1:30PM, V1 Administrator unable to provide R113's hospice agreement contract with the vendor ordered by the physician. R113 is currently using different hospice vendor not indicated in the physician order. Facility's policy on Hospice Services Policy indicates: Purpose: To ensure that appropriate hospice care is available to the residents and families and to outline the responsibilities of hospice service providers as well as facility staff. 1. Residents will be provided hospice care upon physician's order indicating need and related terminal illness diagnosis has been documented. The physician will confirm the need for hospice services at least every 60 days by signing the re-cap physician orders indicating same. 6. All hospice service staff will write a progress note for each resident visit indicating treatment provided and pertinent information related to the resident's condition which is available in the medical record for all IDT staff to access. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145220	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Crest Health Care	3300 West 175th Street Hazel Crest, IL 60429

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8. Hospice staff involved in direct care will be responsible for reviewing the care plan, CNA assignment sheets and physician's orders as applicable to assure care is provided in accordance with the resident's individual needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145220	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Crest Health Care	3300 West 175th Street Hazel Crest, IL 60429

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 39781 Based on observation, interview, and record review the facility failed ensure cleanliness of washing machines and to keep the clean linens covered. The facility also failed to conduct annual test to prevent the growth of Legionella and other opportunistic waterborne pathogen in the building water system. This deficiency could affect the entire 146 residents who are using linens that are being washed in the facility and water that being used in the facility. Findings include: On 9/17/24 at 10:30AM, V10 Infection Preventionist provided copy of facility's annual Legionella test done on 5/18/23. Surveyor was referred to V1 Administrator and V11 Maintenance Director for the annual test for 2024. On 9/17/24 at 12:04PM, V11 Maintenance Director said that annual legionella test is not yet done for this year. They are only doing daily water temperature in the facility. They ordered it and waiting for the kit. Presented copy of email dated 9/17/24 indicating V1 Administrator ordering CDC Elite lab culture legionella test kit with analysis from vendor. Requested for policy. On 9/18/24 at 1:06PM, Rounds made with V10 Infection Preventionist to Laundry room. Observed 3 washing machine are all dirty. 1 was out of order and 2 were functional. There were residues from the detergents on top of the washing machine and accumulated dirt inside and outside including the rim of the door. Noted missing and broken floor times in front of the washing machine. The eye wash sink was dirty. Noted overflowing of unfolded linen/clothes from the containers without cover. V21 Laundry Aide said that all those linens/clothes were clean. V21 said that they don't have daily cleaning log for the washing machine after using it. On 9/18/24 at 1:15PM, Showed observation with V6 Laundry Supervisor. V6 said that they do not have daily cleaning log of the washer and dryer machine. V6 said that the washer and dryer machine should be clean daily after each use. On 9/20/24 at 11:03AM, Surveyor follow up with V1 Administrator regarding policy on water testing for Legionella and other opportunistic water pathogen in the building water system. V1 said that they don't have policy. They should do the testing for legionella annually and daily water temperature testing in the facility. Facility's policy on laundry service indicates: Policy: It is the policy of this facility that all linen is handled in a manner to prevent the spread of infection. 1. Clean linen b. All clean linen will be stored covered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145220	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Crest Health Care	3300 West 175th Street Hazel Crest, IL 60429

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Notes: it is the responsibility of the Laundry Staff to maintain cleanliness of the laundry room and its equipment. Machines should be cleaned and disinfected minimal daily. Spills are to be cleaned immediately. Facility unable to provide policy on water testing for Legionella and other opportunistic water pathogen in the building water system.