STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145718	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestwood Rehabilitation Ctr	14255 South Cicero Avenue Crestwood, IL 60445

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 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34072 Based on interviews and record reviews, the facility failed to follow its change in resident's condition policy and its urgent laboratory testing protocol and notify the attending physician/nurse practitioner the urgent laboratory tests ordered were not done within the 4-6-hour time frame. This affects one of three residents (R1) reviewed for notification of physician of changes in condition. This failure resulted in over a nine-hour delay of labs being obtained. R1 was subsequently sent to the local hospital. R1 was admitted and treated for the diagnosis of dehydration, pneumonia, and urinary tract infection. Findings include: On 2/27/25 at 10:07AM, V5 RN (registered nurse) stated that V5 is familiar with R1. V5 stated that V5 sent R1 to the hospital on 1/19 for pneumonia. Stated that R1's family member took R1 home for a couple of days. V5 stated that shortly thereafter R1 got sick. V5 stated that urgent laboratory tests should be done within 4-6 hours, if not done within that time, the nurse is expected to call the primary physician/primary nurse practitioner and ask want he/she wants to do; wait or send resident out to hospital. V5 stated that the nurse is expected to document in the resident's progress notes urgent orders and if not done within time frame document physician notification and any follow up orders. V5 stated that the nurse also documents on 24 report sheet that laboratory tests are pending. V5 stated that R1's eating had decreased and R1 was weak. V5 stated that V5 would assist R1 with eating. On 2/27/25 at 12:20PM, V6 CNA (certified nurse aide) stated that V6 is familiar with R1. V6 stated that R1 started eating and drinking less mid January when R1 became sick. V6 stated that the CNAs are expected to document the amount eaten and fluids in POC (point of care) charting. V6 stated that the CNAs are expected to report if the resident has decreased intake or refusal to eat to the nurse. V6 stated that when R1 started to get sick, R1 stopped getting out of bed. V6 stated that R1 was more tired and weak, coughing and looked dehydrated; R1 just looked sick. V6 stated that R1 started becoming incontinent of bowel and bladder, staff had to feed him. The facility's staffing assignment sheets note V6 provided care for R1 on the day shift on 1/12, 1/14, 1/16, and 1/17. On 1/17 V6 also provided care for R1 on the evening shift. (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
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F 0580 Level of Harm - Actual harm Residents Affected - Few	On 2/27/25 at 2:05PM, V8 (primary NP) stated that when V8 orders testing to be done, V8 expects it to be done. V8 stated that when V8 was informed of R1's BMP results, R1 was really dehydrated. V8 stated that V8 ordered intravenous fluids for R1. V8 stated that when V8 was notified that V5 nor the outside midline catheter insertion nurse could not access a vein, V8 knew R1 was severely dehydrated. V8 stated that at a critical time V8 did not know what was going on with R1 because the nurses were calling any NP and not V8 or V9 (primary physician). V8 stated that V8 and V9 are responsible for managing R1's care and this can't be done if V8 and V9 are not kept informed of R1's changes in condition. On 2/28/25 at 1:50PM, V8 NP stated that R1 was not eating or drinking which would be a factor in R1's dehydration. V8 stated that V8 can only implement interventions as soon as V8 knows the test results. R1's dietary assessment, dated 1/5/25, notes R1's fluid needs are 1330-1600ml (milliliters) of fluids/day. R1's POS (physician order sheet), dated 10/19/24, notes to encourage R1 to increase fluid intake to 8 cups of water per day every shift for chemical imbalance. R1's POS, dated 1/17/25 at 1:03PM, notes orders for UA/C&S (urinalysis/culture and sensitivity), urgent BMP (basic metabolic panel) and CBC (complete blood count). R1's POC (point of care) charting notes document fluid intake - amount of milliliters R1 drank each shift. The facility is unable to provide any POC documentation of R1's fluid intake since 10/19/24. R1's urgent laboratory test results, dated 1/19/25 at 11:14AM, R1's creatinine was 4.42 (normal range is 0.67 - 1.17) and BUN was 103 (normal range is 5 -20) and WBC (white blood cell count) was 18.3 (normal range is 4.2 - 11). R1's last dehydration risk assessment was completed on 6/15/2023. On 1/17/25 at 12:45PM, V5 RN noted R1 received in bed, alert and oriented x 1-2 with confusion. R1 noted to be lethargic and fatigued while in bed. Appetite poor for breakfast. R1 able to respond to name and verbal stimuli. V8 NP notified with new orders for UA/C&S, chest x-ray, and BMP. Orders rendered and carried out. At 1:38PM, V5 called and spoke with staff from the outside laboratory company for urgent CBC/BMP. ETA 4-6 hours. On 1/18/25 at 10:13AM, V5 RN noted R1 able to tolerate 30% of breakfast. On 1/18/25 at 11:27AM, urgent chest x-ray completed. On 1/18/25 at 6:46PM, V8 NP noted R1 with generalized muscle weakness ,unsteady gait, using wheelchair. Chest x-ray positive for pneumonia. 1/18/25 at 7:00PM, V5 RN noted R1 able to consume 30% of dinner. R1 has been resting in bed during shift. R1 noted to have congestion while trying to communicate. As needed albuterol sulfate inhaler administered and tolerated well. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	There is no documentation in R1's MAR (medication administration record) noting R1 received albuterol inhaler. 1/18/25 at 9:55PM, V5 RN noted Still awaiting urgent laboratory testing. V5 called the outside laboratory company. New order placed urgent CBC/BMP. No ETA given. 1/18/25 at 10:24PM, urgent laboratory testing done. 1/19/25 at 9:24AM, V5 RN noted R1 received resting in bed, alert, responsive to verbal stimuli. Fluids encouraged and given. R1 able to tolerate 1 cup of water. R1 appetite poor for breakfast. V5 able to feed R1 20%. On 1/19/25 at 12:34PM, V5 RN noted abnormal laboratory results relayed to V8 NP. Per NP, new orders to give sodium chloride solution 0.9% 3 liters intravenously at 100ml/hour; repeat BMP after infusion. Orders carried out. On 1/19 at 1:21PM, V8 attempted x2 to insert peripheral intravenous line without success. Outside company was called for urgent peripheral intravenous line insertion. 1/19 at 2pm, the outside company in facility for peripheral intravenous line insertion. Unsuccessful in establishing intravenous access. On 1/19/25 at 3:27PM, R1's family member requested for R1 to be sent to the hospital. On 1/19/25 at 5:09PM, an outside ambulance service transported R1 to the hospital. R1's bladder incontinence care plan, dated 7/3/24, notes monitor R1's fluid intake. Monitor/document for signs/symptoms of UTI (urinary tract infection) no urine output, altered mental status, change in behavior, change in eating pattern. There is no documentation found in R1's medical record noting the number of bladder continence episodes or the number and quantity of urine with each incontinent episode. There is no documentation found in R1's medical record noting urine was collected for urinalysis prior to hospitalization on [DATE]. The hospital record provided to the facility, dated 1/19/25, notes R1's urinalysis was positive for nitrites, white blood cells, and ketones; confirming R1 had a UTI. Chest x-ray showed pneumonia. Laboratory confirmed dehydration.