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
	IL6003628	A. BUILDING: _____ B. WING _____	C 08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD HEALTHCARE & REHAB.	19330 SOUTH COTTAGE GROVE GLENWOOD, IL 60425

(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
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210d)6) 300.3240a) 300.3240f) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)
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 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:
6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.
f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility

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S9999	Continued From page 2 These requirements are not met as evidenced by: Based on record review and interview the facility failed to immediately implement measures to protect a resident from further abuse after being sexual assaulted by another resident and immediately report a crime of sexual assault to local law enforcement as required by the facility's abuse policy. The facility ' s failure to implement measures to protect a resident and call law enforcement when a crime is committed has the potential to affect 131 of 131 residents within the facility. The facility failed to provide one to one monitor for a male resident (R2) after he sexually assaulted a female resident. This failure affected 1 of 6 residents (R1) reviewed for abuse, in a sample of 15 In addition, the facility failed to have two staff member present while giving a resident incontinence care in the bed to prevent a fall. This failure applies to one of three residents (R10) reviewed for falls in a sample of 15 Findings: The facility's abuse prevention program dated 9/15/1998 and revised 8/01/2014 states: The facility shall immediately contact local law enforcement authorities (i.e. telephoning 911 where available) for sexual abuse of a resident by a staff member, another resident, or a visitor. The facility's accident/incident reported dated 7/18/15 at 2:15am documented a certified nurse aide (E5) reported that she observed a male resident (R2) on bed with the resident (R1) partially disrobed.	S9999		

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S9999	Continued From page 3	S9999		

A written statement by E5 certified nurse aide (CNA) reads: I was just coming back from off break, and was about to do my round and heard R1 screaming. So I walked into her room and saw R2 was on top of her. R2 had his pants all the way down to his feet and his shoes were off. R2 had R1's dress all the way up with her legs open and having sex with her. After that I walked back to the door and called the nurse so she could see. By the time she got down to the room he was pulling his pants up and just walked out the room. All of this happened around 2:25pm.

A written statement by E4 (nurse) reads: This writer was in the nursing station writing incident report on another resident. I did not see resident coming out of his room because the laundry cart in the hallway is blocking the two rooms involved.

On 7/20/2015 at 1:40pm E3 (social service director) reported she was the person designated to receive abuse allegation in the absence of the administrator. E3 stated on 7/18/2015 she received a call from the facility's director of nurses/ DON (E2) informing her about the incident involving R1 and R2. E3 was unable to provide the time of the call. E3 said she reported the incident to the Administrator (E1), the Regional Director and the nurse consultant. E3 stated instructions were given to put R2 on one to one monitoring. The surveyor asked E3 when this occurred. E3 replied, approximately at 3am. E3 reported she arrived to the facility later at 7:45am, in which a local police detective was at the facility. E3 stated, the facility did not report the incident to the police and the hospital called the police.

On 7/20/2015 at 5:05pm, E2 (DON) reported she

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S9999	Continued From page 4 was not on duty at the time of the incident involving R1 and R2. She was called on the phone by E4 (nurse) who was the designated night supervisor for 7/18/2015. E4 just before 3am called E2 and stated a CNA (E5) found R2 on top of R1. E4 wanted to know who was the abuse coordinator since E1 (administrator) was on vacation. E2 informed E4 it was E3 (social service director). E2 after speaking to E4 called E3 and reported the incident. E3 wanted to know what the CNA saw. E2 then called back to the facility to interview E5 (CNA) and called E3 with the details. At that point E3 took over. E2 stated, as she was arriving to the facility, she was re-routed to go to the police station sometime between 9-10am on 7/18/2015. The surveyor asked E2, what is the procedure for an allegation of rape or sexual assault? E2 stated the resident should be examined and checked for injury, the physician should be informed; an incident report generated and send the resident out for a rape kit. The surveyor asked if this was a part of the facility's abuse policy. E2 stated I don't know but that should be the procedure. E2 stated she instructed E4 to do just that (check R1 for injury) before she called E3. Next, the surveyor asked what should happen to the aggressor in this situation. E2 stated the abuse coordinator or the doctor determines what happen to the aggressor. E2 further stated, R2 was placed on every 15 minute check and a sheet was placed on his door. There is a paper log of who did the well-being checks. E2 said she would provide the surveyor with the documentation for the monitoring. On 7/21/2015 at 11:30am via phone, E4 reported she wanted to send R1 out and call the police but E2 told her not to call (the police) until the test (rape kit) comes back positive.	S9999		

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S9999	Continued From page 5 On 7/21/2015 at 11:45am via phone, E5 reported she came back from break at 2:15am and she heard R1 screaming from the room. She went to the room. R2 was on top of R1, her (R1) gown was all the way up. R2 was having sex with R1. Once R2 saw her, R2 got off R1, pulled his pants up and walked out the room. E5 also reported after the incident occurred she continued taking care of the residents. She did not do one to one monitoring for R2. E5 stated she checked on both residents (R1 & R2) during rounds. Also, she was not continuously stationed in the hallway or the resident's room. E5 stated there were two CNA assigned to unit on the third shift. On 7/21/2015 at 2:05pm via phone, E6 (second CNA working the morning 7/18/2015) reported she did not know what happened with R1 and R2. She checked on him twice during the shift. She did not sit with him and was not continuously watching him during the shift. According to a face sheet R2 is a 69 year old male resident with diagnoses of dementia with behavioral disturbance, unspecified psychosis, anxiety and personal history of traumatic brain injury. R2's progress notes documented the following: -7/18/2015 08:22 hour documented: Upon arrival resident observed standing at the nursing station. When asked to return to room or go to the dining room for breakfast while nurse to nurse report given, resident stated, "I'm not going nowhere!" Resident on 15 minute monitoring by all staff on wing. Resident in room lay in bed at this time. -7/18/2015 14:56 hour documented: resident noted to become agitated upon asking resident to	S9999		

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S9999	Continued From page 6	S9999		

go to his room resident unable to be re-directed by staff.

According to R2's minimum data set assessment (MDS) dated 6/05/2015 R2 had moderate cognitive impairment, had verbal behavioral symptoms directed toward others and needs oversight for transfer and walking. According to the minimum data set assessment dated 6/05/2015 R2 is 68 inches tall

On 7/20/2015 at 1:50pm, R2 was present in a room with a local police officer presented. The surveyor attempted to ask questions. However, every question was answered with no. R2 was noted to ambulate within the room without any problems.

According to a face sheet R1 is a 93 year old female resident. R1 diagnoses included unspecified dementia with behavioral disturbance and generalized muscle weakness.

R1's progress notes documented the following:
-7/18/2015 11:21 hour documented: At about 2:45am the CNA notified this writer that she observed a male resident on bed with a female resident. Upon writer entering the room the male resident was walking out the room with clothes on. The resident observed on the bed partially disrobed, legs opened. Assessment completed and indicated no visible bruise, no bleeding from the vagina and no signs and symptoms of pain to note at this time. DON notified, Doctor page, Family member made aware. Resident transferred to hospital via ambulance for further evaluation/ exam.
-7/18/2015 14:45 hour documented: Resident arrived from hospital via ambulance. Resident alert and oriented to self. Resident returned with

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S9999	Continued From page 7 diagnosis of sexual assault of adult -initial encounter. Awaiting return call from doctor. According to R1's minimum data set (MDS) assessment dated 7/16/2015 R1 is moderately cognitive impaired, had no activity for walking, needs extensive physical assistance for transfer and totally dependent on staff for dressing. Also R1 was 64 inches tall and weighed 110 pounds. On 7/20/2015 at 2:58pm, R1 was returned to her room transported by E7 (CNA) via wheel chair. When asked if anyone hurt her, R1 said yes and pointed a finger to her pelvic area. R1 was unable to provide specific details. R1 had two roommates R14 and R15at the time of the survey. According to a MDS assessment dated 6/30/15, R15 is moderately impaired, unable to walk and needs two people to assistance for transfer and bed mobility. According to a MDS assessment dated 6/29/15, R14 is also moderately cognitively impaired. According to the facility ' s census on 7/19/15 these two residents were present on the A-wing next door to R2, until he was transferred. The resident location monitoring log presented by E2 (DON) had dates of 7/18, 7/19 and 7/20/2015. On 7/18/2015 the time monitoring sheet is initially documented at 7:15am. The monitoring is documented in 15 minute intervals during the listed day. Surveyor noted monitoring the log sheet was not filled out completely. It lack some initials indicating checks were done, for the morning of 7/20/2015. The sheet did not indicate the location of the R2.	S9999		

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S9999	Continued From page 8 On 7/23 and 7/30/15 the surveyor watched parts of the facility ' s video tape surveillance of the resident ' s A and D units from 7/18-7/19/2015. The tape had footage of times in which R2 ambulated in the hallways or going to the nurse ' s station without staff accompanying him. On 7/21/2015 at 4:22pm via phone Z1 (detective) reported: at or about 5:10am the morning of 7/18/2015 the local police department was contacted by hospital personnel, who reported R1 was sexually assaulted by someone. Police officers viewed the facility's video tape and observed R2 entering R1's room during the 2am hour. R2 stayed in the room appropriately 9 minutes according to the time on the tape before a staff member entered the room. Z1 stated, he was initially told on 7/18/2015 by E3 (social service director) R2 was being monitored every 15 minutes. Later, Z1 received a called from E1 (administrator) stating R2 was being monitored one to one. Z1 report, the hospital doctor reported there was the present of sperm in R1's vaginal and the morning 7/20/2015 R2 was officially arrested. On 7/20/2015 between 9am-9:30am, Z1 with police officers came and arrested R2. Z1 stated because he was in under arrest an officer had to remain with R2 at all times. Incident Report Form 7/29/15 R10 rolled out of bed onto the floor while a nurse aide was providing morning care. R3 sustained a laceration to the right side of the forehead. First aid was administered to R10, R10 was assessed for pain and injuries, range of motion to all 4 extremities was within normal limits. The nurse called 911, the family and physician were notified, and R10 was transferred to the emergency room. R10 returned to the facility the same day after glue	S9999		

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S9999	Continued From page 9	S9999		

was applied to close the laceration. Investigation Follow Up 7/29/15 documents R10 rolled out of bed while nurse aide provided incontinent care. New interventions are to increase R10 to an extensive 2 person assist with bed mobility and tilting needs. The fall care plan was updated. Handwritten and signed statement by E 20 (Nurse Aide) while tucking R10's incontinent brief , R10 "spontaneous rolled out of the bed".

On 8/3/15 at 11 am, R10 propelled himself very slowly in the wheelchair down the short hall between the A-B Nurses Station and dining room using only his arms. At this time, staff assisted R10 to his room by pushing the wheelchair. R10's legs are stiff and rigid, not bending when he sits in the wheelchair. R10 cannot answer questions, engage in conversation, or follow directions.
On 8/3/15 at 11:05am, E 19 (Nurse Aide) stated R10 gets turned side to side to change the incontinent brief. E 19 stands on the open side of the bed, the other side of the bed is blocked by the wall. E 19 stated R10 cannot assist with turning or incontinent care and E 19 does not know what precautions have been put in place after the fall.
On 8/3/15 at 11:45am, by phone, E 20(Nurse Aide) stated that R10 rolled out of bed while being changed. E 20 stated R10 was turned on the side facing away from the wall, E 20 was by R10's feet and tried to pull the brief out from under R10, toward the wall. R10 rolled away from the wall, off the bed, and onto the floor. R10 had a cut on the forehead. E 20 stated she gave a statement to the police.
On 8/3/15 at 11:50am, by phone, E 21(Nurse) stated E 20 called her to the room and R10 was on the floor. E 20 tole E 21 that she pulled something out from under R10 and he rolled off the bed. E 21 assessed R10 for other injuries and

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S9999	Continued From page 10 pain, applied pressure and an ice pack to the forehead, initiated neurological checks, called 911, family, and physician, and sent R10 to the emergency room. On 8/5/15 at 12pm, E14(Wound Nurse) stated R10 is now a 2 person assist, has floor mats, and a lower bed in place after the fall. On 8/5/15 at 12:15pm, E 27(Restorative Nurse) stated as the nurse aide was pulling the incontinent brief from under R10, R10 rolled out of the bed. E 27 stated E 20 could have call for assistance because R10 cannot help turn or move, R10 cannot turn self or roll out of bed on his own. R10 is now a 2 person assist, and has a lower bed and floor mats in place. (A)	S9999		

IMPOSED PLAN OF CORRECTION

Attachment B
Imposed Plan of Correction

NAME OF FACILITY: Glenwood Healthcare & Rehab

DATE AND TYPE OF SURVEY: August 6, 2015

300.610a) 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.

300.1210a) General Requirements for Nursing and Personal Care 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 resident to meet the total nursing and personal care needs of the resident.

300.1210b) 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

300.1210d)6 All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility

This will be accomplished by:

I. A committee consisting of at a minimum, the Medical Director, Administrator and Director of Nursing (DON) will review and revise the policies and procedures for staff regarding abuse and neglect. This review will ensure that the facility's policies and procedures address at a minimum the following:

   A. Recognition of situations that could be interpreted as abusive or neglectful.
   B. Appropriate reporting of staff.

C. Appropriate and thorough investigations to prevent further potential abuse while investigation in progress.
E. The facility taking appropriate corrective action when an alleged violation is verified.

II. The facility will conduct mandatory in services for all staff within 30 days that addresses at a minimum the following:

A. Any new or revised policies and procedures, including actions needed to follow them that are developed as a result of this plan of correction.
B. All staff will be informed of their specific responsibilities and accountability for the care provided to residents.
C. Documentation of theses in-services will include the names of those attending, topics covered, location, day and time. This documentation will be maintained in the administrator's office.

III. The following action will be taken to prevent re-occurrence:

A. The above in-service education will be reviewed with all staff on a regular basis.
B. Supervisory staff will ensure that the State Regulations regarding abuse/neglect allegations (reporting and follow up) are followed.

IV. The Administrator and Director of Nursing will monitor items I through III to ensure compliance with this imposed plan of correction

COMPLETION DATE: Ten (10) days from receipt of the Imposed Plan of Correction.

LTC07202 COMPLAINT DETERMINATION FORM

FAC. NAME: GLENWOOD HEALTHCARE & REHAB COMPLAINT #: 0078871
LIC. ID #: 0032839
DATE COMPLAINT RECEIVED: 07/23/15 15:09:00

IDPH Code	Allegation Summary	Determination
104	NEGLECT	2
105	IMPROPER NURSING CARE	1
409	POLICY AND PROCEDURES	1

✓ The facility has committed violations as indicated in the attached*
___ No Violation

*Facilities participating in the Medicare and/or Medicaid programs will not receive a copy of the certification deficiencies as they have already received a copy through the certification program process.

Determination Codes

1 = VALID - A complaint allegation is considered "valid" if the Department determines that there is some credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

2 = INVALID - A complaint allegation is considered "invalid" if the Department determines that there is no credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

3 = UNDETERMINED - A complaint allegation is considered "undetermined" if the Department finds there is insufficient information reported to initiate or complete an investigation.

RESIDENT INJURY - Per the P&A v. Lumpkin consent decree, allegations of resident injury will always be "valid" if the resident who is the subject of the allegation was injured.

LTC07202 COMPLAINT DETERMINATION FORM

FAC. NAME: GLENWOOD HEALTHCARE & REHAB COMPLAINT #: 0078727
LIC. ID #: 0032839
DATE COMPLAINT RECEIVED: 07/18/15 15:00:00

IDPH Code	Allegation Summary	Determination
104	NEGLECT	2
132	SEXUAL ASSAULT RES TO RES	1
409	POLICY AND PROCEDURES	1

√ The facility has committed violations as indicated in the attached*
___ No Violation

*Facilities participating in the Medicare and/or Medicaid programs will not receive a copy of the certification deficiencies as they have already received a copy through the certification program process.

Determination Codes

1 = VALID - A complaint allegation is considered "valid" if the Department determines that there is some credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

2 = INVALID - A complaint allegation is considered "invalid" if the Department determines that there is no credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

3 = UNDETERMINED - A complaint allegation is considered "undetermined" if the Department finds there is insufficient information reported to initiate or complete an investigation.

RESIDENT INJURY - Per the P&A v. Lumpkin consent decree, allegations of resident injury will always be "valid" if the resident who is the subject of the allegation was injured.

LTC07202 COMPLAINT DETERMINATION FORM

FAC. NAME: GLENWOOD HEALTHCARE & REHAB COMPLAINT #: 0077626
LIC. ID #: 0032839
DATE COMPLAINT RECEIVED: 06/02/15 03:30:00

IDPH Code	Allegation Summary	Determination
105	IMPROPER NURSING CARE	1
409	POLICY AND PROCEDURES	2

✓ The facility has committed violations as indicated in the attached*
___ No Violation

*Facilities participating in the Medicare and/or Medicaid programs will not receive a copy of the certification deficiencies as they have already received a copy through the certification program process.

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