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
	IL6003594	A. BUILDING: ______ B. WING ______	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENCREST HEALTHCR & REHAB CTR	**2451 WEST TOUHY AVENUE CHICAGO, IL 60645**

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S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures	S9999	Attachment A Statement of Licensure Violations	

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

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S9999	Continued From page 1 shall include, at a minimum, the following procedures: Section 300.1210 General Requirements for Nursing and Personal Care c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 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. These Regulations were not met as evidenced by:	S9999		

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Based on interview and record review, the facility failed to follow the care plan for one resident (R9) out of four residents in a sample of 30 reviewed for falls by not properly transferring R9 with a mechanical lift. This failure resulted in R9 falling and obtaining a laceration with sutures on her forehead. In addition, facility failed to ensure R9's lateral trunk and side supports were on R9's motorized wheel chair. This failure resulted in R9 falling to the floor with no injury.

Findings include:

R9 ' s physician order sheet denotes in part the following diagnoses: Unspecified cerebrovascular disease, dominant side, diabetes type II, hypertension and bipolar disorder. R9 ' s MDS (Minimum Data Set) dated 3/17/15 denotes a score of 3/3 under Transfer section which signifies that R9 is an extensive assist with two person physical assist. R9 ' s incident reports were reviewed. R9 had falls on 6/5/14, 7/21/14, 1/17/15, and 3/13/15.
Incident report denotes the following:
On 6/5/14 at 6:45am, R9 had a fall with a cut in her forehead. Incident report denotes that R9 had a witnessed fall. R9 was being transferred by two cna ' s (E13 and E14) from bed to wheel chair. One of the cna ' s foot accidentally got caught in the wheel of the wheel chair, causing staff to fall with R9. R9 sustained a cut on the forehead from her roommate ' s bed. R9 started to bleed. R9 ' s cut was cleaned with normal saline. Dressing and sterile strips were applied. Pain medication was given. Nurse practitioner was made aware. Patient was transferred to local community hospital. Nursing notes dated 6/5/14 at 3pm indicate that the nurse followed up with the hospital. Nursing note denotes: " R9 was admitted with a diagnosis of head injury

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S9999	Continued From page 3 secondary to laceration. R9 had seven stitches done on the forehead. CT (Computerized Tomography) scan of the head, xray of the spine and left ankle was done with negative results. R9 was admitted for overnight observation. " Facility reported the initial and final reports to IDPH (Illinois Department of Public Health) in a timely manner. Care plan was updated. On 4/6/15 at 3:15pm, R9 stated, " I had a fall last June. I was so angry with the staff. They did not use a mechanical lift. I know that one of the cna ' s was E14. I forgot the other cna ' s name. The two cna ' s pulled me up from the bed with their arms (one on each side) and brought me to my wheel chair. One of the cna ' s foot got stuck in the wheel chair and I fell with the cna. I hit my head on my roommate ' s old bed which was made of steel. I started bleeding a lot. They should have used the mechanical lift. My mom couldn ' t take care of me at home. I ' m heavy and that ' s why they have to use a mechanical lift. " R9 ' s 6/5/14 incident report does not contain any statements from the two cna ' s. The incident report does not contain any information that a mechanical lift was used. E2 (Assistant Director of Nursing) provided the staffing sheet for 6/4/15 (night shift). Staffing sheet denotes that E20 (Registered nurse) and the two cna ' s (E13 and E14) were on duty that night. E2 stated that E20 no longer worked at the facility. On 4/8/15 at 7:45am, telephone interview was conducted with E14. E14 stated the following: " The other cna ' s foot got caught up in R9 ' s wheel-chair. We did not use the mechanical lift because no one told us about using a mechanical lift. The nurse never told me this information. This was my first time getting her up. We picked R9 up from the bed and transferred to her wheel chair. She slid and fell. R9 hit her head on the	S9999		

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wheel of the roommate ' s bed. R9 was bleeding. I guess I could have found out without the nursing telling me. You know it was last minute, they told us to get her ready because she had a doctor ' s appointment. And we had to hurry. That ' s why we did not use the mechanical lift. "
At 12:50pm, during facility presentation, E2 stated " Nurses are to communicate to (cna ' s) certified nursing assistants which residents require mechanical lifts and it ' s also posted on signs in the residents ' rooms. The cna ' s should have looked at the signs about how R9 should have been transferred. "
At 1:45pm, telephone interview was conducted with E13. E13 stated the following: " R9 was in a regular wheel chair and she was a 2 person assist. My leg got caught in the wheel chair. R9 was about to fall, but we eased her to the floor. R9 hit her head on the roommate ' s bed. R9 started screaming and she started bleeding. Initially, R9 stated that she did not want us to use the mechanical lift. Okay, I ' ll be honest. I never worked with R9 before. I never asked her if we should use the mechanical lift. We should have used the mechanical lift, so she would have not fallen. "
R9 ' s primary physician could not be reached. Z3 (nurse practitioner for R9 ' s physician) stated through telephone interview the following: " They should have a used a mechanical lift to transfer R9 from the bed to the wheel chair. The fall could have been prevented. It ' s difficult to say. But yes, I agree with you, using a mechanical lift will reduce the risk of her falling. "
Facility's policy titled Fall Prevention and Management Program: The Purpose of the Fall Prvention and Management Program denotes in part the use of lift aid for transfers as a fall prevention strategy/intervention. Facility failed to use this intervention on 6/5/14.

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S9999	Continued From page 5 R9 has several care plans which denote that R9 had a history cerebral vascular accidnet with right side weakness, spinal fluid leak, and VP shunt placement. R9 is to be transferred using a hoyer lift and requires the use of a chair belt due to the presence of certain medical symptoms and conditions such as poor trunk control, impaired balance and history of falls. R9 has morbid obesity and is totally dependent with transfers. R9 will transfer self from bed to wheelchair with total assist to maintain level of performance daily 6-7 days a week. R9 is a two person assist with Hoyer Transfers. Encourage R9 to keep Hoyer pad under her chair after transfer as she prefers to take it out after transfers. Facility's care plan policy denotes in part that "plans of care are developed by the interdisciplinary team, to coordinate and guide care interventions and goals for the residents." Occupational therapy screen denotes that R9 is total assist with Hoyer (from bed to wheel chair) and is to have a seatbelt while in chiair and supervision at all times. R9 exhibits right side trunk weakness and difficulty with proprioception for upright sitting in wheel chair. Incident report dated 3/13/15 denotes that R9 was observed on the floor of the speech therapy gym as a result of a witnessed fall. R9 fell on the right side from her motorized wheel chair when she lost her balance and tried to reach something on the floor. R9 hit her head on the floor, but did not sustain any injuries. R9 was assessed, vitals were done, neurological checks were done, Z3 and family were notified, and incident report was completed. R9 was transferred to the nearest hospital. X-rays of hip reveal that there is no fracture, dislocation or focal bone destruction. CT (Computerized Tomography) reveals there is no fracture or intracranial hemorrhage.	S9999		

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S9999	Continued From page 6 On 4/6/15 at 2pm, interview with E15 (Physical Therapy Assistant/ Therapy Manager) was conducted. E15 stated the following: "I was not present where R9 actually had her fall. R9 is not in therapy now. The speech therapy student was doing services for R9 for free as part of a learning experience. The speech therapy student was being supervised by E10 (Speech language pathologist). They were all in the gym downstairs. R9 leaned over to the right and started sliding. The speech therapy student, E10, and the physical therapists came and lowered her down to the floor. R9 claims she hit her head, but I think the hospital reports said there were no injuries. I noticed some parts of the motorized wheel chair were missing. The two trunk lateral supports for the right and left sides were missing and the right side leg support were missing. They are used to keep R9 alligned and to prevent R9 from falling. If she had those supports, the fall could have been prevented. The next day, I saw R9's mother. I asked her if she knew what happened to the supports. R9's mother went and got the supports from R9's closet. R9 and her mother did not know who took the supports off. I called maintenance and had them put the supports back on R9's wheel chair. R9 came to us from another facility with that motorized wheel chair. The wheel chair has no warranty. And it has not been 5 years yet. Otherwise, she's eligible to get a new one. I would just call the company. I know she complained that the supports were too snug. She was getting heavier and the supports were too tight. That's why they were probably taken off. I don't know who did it. R9 had no strength in her legs. She had poor trunk control as well. She also had a seat belt restraint as well. R9 was not in therapy anymore. Her last days of therapy were as follows: 4/3/14 (Physical	S9999		

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S9999	Continued From page 7 Therapy), 6/30/14 (Speech Therapy), and 10/13/14 (Occupational therapy). While she was in therapy, we the therapists would inspect the wheel chair to make sure it was intact and functioning well. Since R9 was not in therapy anymore, the nurses and cna's are responsible for the upkeep and maintenance of the wheel chair. If the cna's and nurses noticed the supports were missing, they should alerted someone. Also, if R9 reported the supports were too tight, the staff member should have came to me and told me. I would have called maintenance to have them readjusted. We don't have a specific policy for the upkeep and maintenance of wheel chairs." At 2:30pm, E10 stated the following: "R9 had weakness more in her legs than her hands. She was a paraplegic. After her back surgery, she had a stroke on the right side. Yes, R9's last fall was last month. My back was facing R9. I know R9 was being supervised by the speech therapy student. I know she didn't have her lateral trunk supports. I remember she said the trunk supports were annoying. She slid even though she had the seatbelt on. There were two physical therapists that came and assisted R9 back to the wheel chair. She went to the hospital and the x-rays were negative." At 2:54pm, E11 (physical therapist) stated, "R9 came to the gym. I just finished lunch and I was doing paperwork. My back was facing R9. When I heard she was falling, I stood up to help her. She felt to her right side. I know that she didn't have her lateral supports. When she was in therapy earlier last year, she had mentioned that her supports were too tight. They were not adjusted or removed then. I'm not sure who removed them. If a resident complains of the lateral supports being too tight, we should have told the nurse or maintenance to fix the chair."	S9999		

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S9999	Continued From page 8 At 3:02pm, E12 (Physical Therapist) stated, "My back was facing R9. I heard the panic and I saw R9 stooping to the right side. R9's seat belt was on on, but she did not have the supports. We unbuckled her seat belt and lowered her down. Then we called the nurse and she went to the hospital." On 4/6/15 at 3:15pm, R9 stated, "I don't remember who took my supports off from my wheel chair. I kept telling everyone that the supports were uncomfortable, but no one would do anything about it. It was too tight. My dad does maintenance on my wheel chair. Maybe, he took them off. I'll ask him today. I slid from my wheel chair (3/13/15) and smacked my face. I did not have supports on that day." At 3:25pm, E15 showed surveyor that R9's wheel chair had her supports reinstalled on her wheel chair after she talked to maintenance. On 4/6/15 at 5:45pm, telephone interview was conducted with Z15 (R9's mother). Z15 stated, "Myself and R9's father did not take the supports off R9's wheel chair. I don't know who did. Can you call me back later. I'm at the pharmacy." Facility's form titled Motorized Wheelchair Evaluation Form dated 10/17/14 and 3/9/15 denote in part that R9 has the physical capabilities for the safe performance of a motorized wheelchair. It also denotes that R9 is supervised at all times and is to lower her speed. However, there is no documentation in the Motorized Wheelchair Evaluation Forms or R9's medical record which state that R9's wheel chair was routinely checked for the maintenace. Neither was there any documentation regarding the lateral supports. (B)	S9999		