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
	IL6006647	A. BUILDING: _____ B. WING _____	C 03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENLAKE TERRACE NURSING & REH	2222 WEST 14TH STREET WAUKEGAN, IL 60085

(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
S 000	Initial Comments Licensure Findings	S 000		
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS 300.1210 d)6) 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. These Regulations were not met as evidence by: Based on observation, interview, and record review, the facility failed to ensure staff positioned a resident requiring two-person assist for bed mobility, in a safe manner. This applies to 1 of 3 residents (R1) reviewed for falls and injuries in the sample of 3. The findings include: R1 current diagnosis list in her electronic medical record includes a history of falls and obesity. On March 3, 2016 R1 did not respond to verbal stimuli. R1's December 11, 2015 Minimum Data Set (MDS) shows she is totally dependent with assist of two persons for bed mobility and weighs 238 pounds. R1's December 12, 2015 Fall Assessment shows R1 is at as high risk for falls. On March 3, 2016 at 9:15 AM, E5, Licensed	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
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
	IL6006647	A. BUILDING: _____ B. WING _____	C 03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENLAKE TERRACE NURSING & REH	2222 WEST 14TH STREET WAUKEGAN, IL 60085

(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	Continued From page 1	S9999		

Practical Nurse (LPN) described R1 as "semi-comatose."
On March 8, 2016 at 9:30 AM, E9 Certified Nursing Assistant (CNA) stated he was leaning R1 forward in bed and R1 slid from the bed to the floor on January 11, 2016. E9 stated he was alone. E9 stated the head of R1's bed was elevated, and while he positioned R1's torso forward, R1 slid down the bed and to the floor. E9 stated R1's mattress is slick, and when E9 lifted her forward, she started sliding. E9 stated the momentum of both of R1's feet sliding out caused her to just keep sliding with the sheet, so he guided her to the floor. E9 stated the R1's foot barrier is not usually up.
R1's December 11, 2015 fall care did not have any interventions to prevent R1 from sliding out of her bed. No documented interventions were seen on R1's plan of care after her fall on January 11, 2016. On March 3, 2016, 12:30 PM, E1 (Director of Nursing) stated no interventions were added to prevent R1 from falling from bed after her January 11, 2016 fall. R1's Fall care plan shows "Reviewed 1/11/16: Resident seen lying on her back on the floor" and does not explain how the fall occurred.
On March 8, 2016 at 9:45 AM, E9 stated he talked to E1 and E11 (nurse caring for R1 January 11, 2016) about R1's fall. E9 stated he was told to make sure R1's foot rail/flap was up. When asked if R1's foot rail/flap could have stopped R1 from sliding out of the bed, E9 stated he believes it could have stopped her.

(B)