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 03/24/2016

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) 300.1210b) 300.1210d)6) 300.1220b)3) 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. 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. 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 Requirements are not met as evidenced by: Based on record review and interview, the facility failed to assess and implement safety measures to reduce the risk of injury for one of three residents (R1) reviewed for fall in a sample of 4 residents. This failure resulted in R1 being hospitalized and treated for an acute intracranial bleed. Findings Included: Medical Record for R1 noted a 51 year old admitted to facility on 11/25/2015 with Diagnoses	S9999		

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S9999	Continued From page 2	S9999		

to include Convulsions. Past medical history of R1 included left Craniotomy on 10/18/2015 due to intracranial bleed which caused seizures from a fall at the Community hospital.
R1's face sheet generated at the facility did not list the Diagnoses to include Intracranial bleed and craniotomy.

On 3/24/2016 at 10:20AM, E4(Admitting Registered Nurse,RN) said she was aware that R1 had an Intracranial bleed and Craniotomy in October, 2015. She said she did not know why the Diagnoses were not added to other Diagnoses.

Fall risk assessment completed on 11/25/2015 scored 25. Fall risk scale presented by facility noted 0.0 to 5.0 was low risk; 6.0 to 15.0 was moderate risk and 16.0 to 60.0 was high risk for falls.

Completed admission assessment done on 11/25/2015 noted R1 had multiple falls, non-ambulatory, unable to use call light, exhibited behavior problems like spitting on staff, had orders for anti-seizure, antihypertensive and sedative medications, incontinent of bowel and bladder and memory and recall ability was never.

On 11/25/2015, Interim care plan for R1 had no interventions in place based on the assessment and Diagnoses of R1. Facility's Interventions for R1 included,"Provide reality orientation: Keep call light within reach at all times while in bed and provide verbal cues as often as necessary to remind resident to use the call light before attempting to get out of bed unassisted."

According to care plan of 11/28/2015, bed and chair alarms were initiated on 11/27/2015 and

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S9999	Continued From page 3	S9999		

,"the bed in low position at night." There was no other documentation in the medical record about interventions to keep R1 from injury.

On 11/27/2015 at 10:16PM, R1's gastrostomy tube came out and R1 was sent to the hospital according to medical record.

On 11/28/2015 at 6:45AM, nurse wrote," Resident received via ambulance from St James Hospital with a Diagnosis of G-tube replacement. resident is very disoriented on arrival, screaming and kicking around, placing her legs over the side rails in an attempt to get out of bed."
Side rail assessment done on 11/25/2015 noted no side rails.

On 11/28/2015 at 12:38PM, nurse's notes documented,"Resident noted supine position bedside spitting, kicking, punching and screaming."
R1 was sent to acute care facility in the community after the unwitnessed fall from the bed.

On 11/28/2015 at 9:35PM, nurse wrote,"R1 admitted to hospital into Critical care unit with Diagnosis of Internal Cranial bleeding."

On 3/17/2016 at 12:30PM, E5(Certified Nursing Assistant, CNA) said she was the staff taking care of R1 on 11/28/2015. She said R1 was agitated and verbally aggressive to staff so she assisted her in the bed. E5 said that R1 calmed down and she went to assist in the dining room. However, E5 said when she returned from the dining room, R1 was on the floor on her back." E5 said she summoned the nurse right away. When asked about the bed alarm, E5 said,"I only heard the alarm when I went into the room because the

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S9999	Continued From page 4	S9999		

battery was low."

Medical record from Hospital on 11/28/2015 noted,"Hyperdense blood collection within the subdural space along the left frontal bone measured 4mm. Findings are comparable with acute subdural hemorrhage."

On 3/17/2016 at 1:30PM, Z1(Physician) said he spoke with the Neurosurgeon when R1 was in the hospital. He said the bleeding would have been caused by the fall.

Facility's policy on Falls dated 1/12/2013 documented,"Review hospital records for fall related information."

Facility's policy on Admission dated 7/21/2015 documented that to qualify for admissions,"all of the needs of the resident can be met at the facility."

Facility's policy on Care Planning revised on 8/3/2015 noted that the goal should be resident centered and reflect the problem focus."

(A)

Imposed Plan of Correction
NAME OF FACILITY: Glenwood Healthcare & Rehab
DATE AND TYPE OF SURVEY: March 24, 2016
Complaint # 1691327/IL83971

300.610a)
300.1210b)
300.1210d)6)
300.1220b)3)
300.3240a)

Attachment B
Imposed Plan of Correction

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

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.

300.1220b)3)Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up to date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physicians orders,

and personal care and nursing needs. Personnel representing other services such as nursing, activities, dietary, and such other modalities as ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.3240 Abuse and Neglect

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

This will be accomplished by:

I. Provide education for all departments on facility's policy and procedures for prevention of incidents/accidents and safe environment

II. Director of Nursing or Designee will conduct audits of resident assessments, update care plans accordingly and provide staff education and updates as changes arise.

III. Director of Nursing or Designee will review all referral packets prior to admit and will ensure all interventions are in place for the resident at the time of admission.

IV. Director of Nursing will be responsible for achieving and maintain compliance.

V. Facility Administrator to provide oversight for continued compliance.

Date of completion: Ten days from receipt of the Imposed Plan of Correction

Joanne C Palmer May 24, 2016