

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003594	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/03/2017
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NAME OF PROVIDER OR SUPPLIER GLENCREST HEALTHCR & REHAB CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 2451 WEST TOUHY AVENUE CHICAGO, IL 60645
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(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
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S 000	Initial Comments Statement of Licensure Violations	S 000		
S9999	Final Observations Statement of Licensure Violation 300.610a) 300.1210b) 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	S9999	<p>Attachment A Statement of Licensure Violations</p>	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	<p>Continued From page 1</p> <p>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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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:</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on interview and record review the facility</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>failed to utilize a proper transfer technique for 1 of 3 residents (R2) reviewed for Accidents and Incidents in a total sample of 5. This failure resulted in R2 being transferred to the local hospital with a fracture to the left wrist.</p> <p>Findings Include:</p> <p>The Incident Report dated 11/2/16 documents that R2 was being transferred from the wheelchair to the bed by E8 (CNA) and E9 (CNA). After the transfer, R2 had complaints of pain and was noted with redness and swelling to the left wrist and informed staff that E8 had pulled the left hand while assisting the resident. The MD was notified, an x-ray was done and indicated that R2 had sustained a non-displaced fracture to the left wrist.</p> <p>A complete investigation was done and concluded that E8 assisted R2 by holding both wrists during the transfer from the wheelchair to the bed. The resident was sent to the local hospital for further evaluation and treatment.</p> <p>On 12/30/16 at 1:30pm E3 (DON) stated "The CNA's are educated on proper transfer techniques upon hire, annually and during monthly educational sessions. When I spoke with the resident, R2 did a demonstration on how the transfer occurred and stated that E8 grabbed both wrists. The resident did not notice pain right away but there was swelling not long after the transfer. During the investigation I spoke with the CNA's involved and E8 demonstrated that R2's wrists were held. E8 stated that R2 reached out so the staff member just grabbed the resident's arms. I did education regarding proper transfer techniques and using a gait belt."</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>On 12/30/16 at 1:15pm Z1 stated "R2 did have some underlying issues that would put the resident at a higher risk for fractures. R2 had Osteopenia, which is a demineralization of the bones. R2 was very frail and had a low albumin level. This fracture could have occurred from a transfer but of course I wasn't there to witness what happened."</p> <p>The Facility's Policy on a 2 Person Transfer documents that staff should place a gait belt snugly around the resident's waist. The resident should be instructed to place one or both hands on the arm rests of the chair or the sitting surface to assist in pushing. The resident should lean forward while pushing, and a gait belt is used to provide assistance.</p> <p>(B)</p>	S9999		
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