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 |
|---|---|---|---|
| | IL6003610 | A. BUILDING: ______ B. WING ______ | C 01/07/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GLENVIEW TERRACE NURSING CTR | 1511 GREENWOOD ROAD GLENVIEW, IL 60025 |

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| S 000 | Initial Comments<br><br>Complaint Investigation Survey<br><br>#2095055/IL124306.<br>#2095074/IL124327<br>#2096947/IL126418<br><br>Incident Report Investigation Survey<br><br>IL125871 -3/19/20<br>IL127343 -9/17/20 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.610a)<br>300.1210a)<br>300.1210d)3)<br>300.1210d)6)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care | S9999 | Attachment A<br>Statement of Licensure Violations | |

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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 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)
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:
3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.
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 requirements are not met as evidenced by:

Based on interview and record review the facility failed to ensure a resident was transferred using

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| S9999 | Continued From page 2<br>two people during a mechanical lift transfer. This failure lead to R4 falling out of the mechanical lift and sustaining a sacral fracture. This applies to 1 of 3 residents (R4) reviewed for falls in the sample of 8.<br><br>The findings include:<br><br>The facility's investigation report dated March 19, 2020 for R4 shows, "...On 3/19/20 at 7:15 PM resident had a fall while being transferred from wheel chair to bed via mechanical lift. CNA (Certified Nursing Assistant) was present at the time and attempted to prevent the fall but was unable... Sent resident to ER (emergency room) via 911. Called local ER at 4:30 AM talked with nurse, R4 admitted with sacral fracture..."<br><br>The progress note for R4 dated March 19, 2020 shows, "While CNA transferring resident after dinner, from wheel chair to bed using mechanical lift, mechanical lift started tilting, CNA managed to lower her and became beyond control, resident fell with the mechanical lift... Resident is sent to local hospital by calling 911 at 7:20 PM. Resident complained about back pain after the fall. Had a small cut on the left heel, 4 mm (millimeter) long..."<br><br>The local hospital's history of present illness dated March 19, 2020 shows, "R4 is a 77 year old female with past medical history of CVA (cerebrovascular accident) with right hemiparesis, OSA (obstructive sleep apnea), morbid obesity, atrial fibrillation on coumadin, diabetes mellitus type II, hypertension, hyperlipidemia, gastroesophageal reflux disease, chronic kidney disease stage 4 who presents from SNF (skilled nursing facility) with fall and low back pain. Patient says she was dropped while in | S9999 | | |

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mechanical lift at SNF. Patient reportedly fell a distance of 3 feet and landing on her low back..."

R4's ct scan of the lumbar spine with out contrast on March 19, 2020 shows, "Impression: 1. Acute fractures right L2, right L3, and probably right L5 transverse processes. Questionable right L1 transverse process fracture. 2. Acute fractures involving the right sacrum. 3. Multilevel lumbar spondylosis."

The facility's statement filled out by V3 CNA dated March 19, 2020 shows, "Did you witness the fall? If yes, please describe how the fall happened. "Yes, I was trying to put the patient (R4) to bed with mechanical lift. After lifting her up from the chair, moving her to the bed the mechanical lift swung to the side. I tried to control it but to no eval and I tried to ease the patient to the floor." Do you have any additional information that may describe how the fall occurred? "Not calling for assistance with transfer...".

The facility's record of disciplinary action for V3 CNA dated March 20, 2020 shows, "Brief description of incident/problem/misconduct: Failed to follow facility protocol on mechanical lift transfer to use two person assistance."

On January 6, 2021 at 10:04 AM, V5 CNA stated, mechanical lifts are always done with 2 people. "We train new CNAs to make sure there is 2 people no matter what."

On January 6, 2021 at 11:38 AM, V4 Nursing Supervisor stated, "It happened on PM shift. R4 was transferred by CNA (V3) and then heard she was dropped on the floor. The mechanical lift should have 2 persons for transfers. I don't know why she did the transfer by her self. We train

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| S9999 | Continued From page 4<br>them to use 2 persons."<br><br>R4's minimum data set dated January 21, 2020 shows, she is total dependence for transfers of 2 persons.<br><br>R4's care plan initiated on June 27, 2018 shows, Focus: Self care- R4 has an ADL (activities of daily living) self care performance deficit related to CVA with left side weakness, status post fall with sacrum fracture. Interventions: Transfer with 2 person total assist, use mechanical lift.<br>(A) | S9999 | | |