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 03/08/2018

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

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S 000	Initial Comments Facility Reported Incident of 2-27-18/IL100750 Statement of Licensure Violations:	S 000		
S9999	Final Observations Licensure 1 of 2 300.690c) Section 300.690 Incidents and Accidents c)The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. This REQUIREMENT was not met as evidenced by: Based on interview and record review the facility failed to send a narrative summary of an incident to the Illinois Department of Public Health within seven days after the occurrence.	S9999	Attachment A Statement of Licensure Violations	

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This applies to 1 of 1 resident (R1) reviewed for incident reporting in the sample of 6.

The findings include:

R1's Final Incident Investigation report was dated March 7, 2018 (8 days after the occurrence). The report shows that on February 27, 2018, R1 sustained a right tibiofibular fracture due to a transfer.

On March 7, 2018 at 1:08 PM, V1 (Administrator) said that she is just finishing up the final incident report for R1.

On March 7, 2018 at V2 (Director of Nursing) said that she faxed the preliminary incident report on February 28, 2018 (24 hours after) and she would fax the final report within 5 working days of when the preliminary report was faxed and not the incident.

(AW)

Licensure 2 of 2
300.610a)
300.1210b)5)
300.1210d)6)
300.3240 a)

Section 300.610 Resident Care Policies

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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.

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

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

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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. (A, B) (Section 2-107 of the Act)

These REQUIREMENTS were not met as evidenced by:

Based on observation, interview and record review the facility failed to ensure a mechanical lift sling was the correct size to accommodate a resident's weight and in good repair before transferring a resident. These failures resulted in two of the sling attachment straps to rip apart, resulting in R1 falling to the floor on February 27, 2018. R1 sustained a fractured right leg requiring surgical repair. These failures contribute to R1's fear and anxiety about using the mechanical lift device again.

This applies to 1 of 4 residents (R1) reviewed for transfers in the sample of 6.

The findings include:

R1's Minimum Data Set Assessment dated January 8, 2018 shows that her cognition is intact and she is totally dependent on two persons for transfer. R1's undated Face Sheet shows a diagnosis of morbid obesity. R1's weight log printed on March 7, 2018 shows that she was 360 pounds on February 18, 2018.

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R1's Final Incident Report dated March 7, 2018 shows that on February 27, 2018, staff were transferring R1 from her bed to her chair when two of the mechanical lift slings (attachment loops) snapped during the transfer process.

On March 7, 2018 at 12:50 PM, R1 said that she was being transferred with a mechanical lift and the top right loop and bottom right loop of the sling broke during her transfer. R1 said that she fell to the floor and broke her right leg and had to have surgery. R1 said that she got back from the hospital 2 days ago (March 5) and has not gotten up out of bed yet because she is too nervous and scared that it will happen again. R1 said that the pain in her leg is sometimes a 10 on a pain scale of 0-10.

R1' s hospital records dated February 27, 2018 show, "Fracture of right tibia and fibula with right tibia intramedullary nailing ...Patient complains of pain after surgery ..."

On March 7, 2018 at 12:00 PM, V9, Certified Nursing Assistant (CNA) said that she went into R1's room and put a mechanical lift sling under her. V9 said that the slings do not have sizes on them, they just know what sizes need to be used for what resident. V9 said that slings come in two sizes, R1 requires the bigger size (extra large) due to her weight. V9 said that the sling was hooked to the mechanical lift and when (V9) moved R1 off of the bed, R1 just fell to the floor. V9 said that the right purple and right green loop split in half.

On March 7, 2018 at 10:30 AM, V1 (Administrator) said that they no longer have the sling that broke during the transfer of R1.

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On March 7, 2018 at 2:00 PM, V9 brought the surveyor a sling that was a blue cloth material and said this sling is the exact fabric and size of sling that she used to transfer R1.

At 2:15 PM, V1 (Administrator) brought in a sling that was a blue cloth material and said that it was the cloth type of sling that was used to transfer R1 but it was a size large and not extra large. V1 said that she could not find any extra large slings. The two slings were compared and they were the same in size. Both slings had a tag on the fabric. One tag was unreadable due to fading and the other tag was ripped and missing pieces.

A sling tag on another sling was then observed and the size and washing instructions could be read.

On March 7, 2018 at 2:58 PM, V2 (Director of Nursing) said that if a resident is above 300 pounds, an extra large sling should be used. V2 said that the tag on R1's sling was faded and unable to be read. V2 said that sometimes the tags get faded with washing. V2 said that they did a mass order of slings one year ago.

On March 7, 2018 at 2:10 PM, V3 (Restorative Nurse) said that the size of sling that is used is according to the residents size and weight. They have size large and extra large slings and the size is indicated on the slings. V3 said that R1 would require an extra large sling. V3 said that there is not a list of what size sling each resident needs, the CNAs just decide which size to use.

R1's Care Plan dated January 12, 2108 shows, R1 requires use of full body lift for transfer. Diagnosis includes: morbid obesity. R1's care

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plan does not show what size sling is required for transfer.

The facility undated Patient Sling Reference Guide shows that a resident would need a size extra large sling if they are 360 pounds.

The facility undated Mechanical Lift Transfer Policy shows, "Follow manufactures recommendations". The policy does not show how to select a sling for the size and weight of a resident. The policy does not include inspecting the sling for wear prior to use.

On March 7, 2018 at 12:00 PM, V9 said that slings are used once by each resident and when it is taken off, it is put in the laundry and a new one is found the next time that the resident needs to get up.

On March 7, 2018 at 1:08 PM, V1 said that they purchased a bunch of new extra large slings about 1 year ago. The slings were not numbered or logged when they came in. V1 said that the facility does random audits for wear and tear but does not have any documentation of these inspections.

A packing list dated August 21, 2017 shows that 7 extra large slings were ordered.

On March 7, 2018 at 11:15 AM, V11 (housekeeping manager) said that slings are supposed to be washed using chemical number 8. At 2:00 PM, V11 said that slings should be washed using chemical formula number 1. At 1:50 PM, V13 (laundry) said that she does not know how to wash slings or what number to put the machine on. At 2:15 PM, V14 (laundry) said that she would put slings on formula number 7.

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S9999	Continued From page 7 There was a sign on the wash machine that had a list that showed different linen types and what formula should be used. Slings were not listed on this list. V11 said that slings are inspected after each wash but they are currently not logged. An email from the wash formula vendor dated March 7, 2018 shows that five of the eight wash formulas dispense bleach. The email also shows, "All formulas are washed at 150 degree temperature." The facility provided manufacturer information states, "Useful life of this product is six months from date of purchase under normal use, however, heavy use or excessive washing may reduce the useful life of the product .....This warranty does not cover device failure due to owner misuse or negligence ... ...excessive washing or incorrect washing and drying ....hand wash only in water temperature of not more than 120 degrees. Do not use bleach; bleach will damage the integrity of the sling and strap materials which may result in failure causing injury or death to the patient ..." (A)	S9999		