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 05/19/2022

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

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S 000	Initial Comments Complaint Investigation 2293373/IL146387 2293469/IL146531 Facility Reported Incident of 04/24/2022/#IL145531	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210 b)5) 300.1210 c) 300.1210d)6) 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	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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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.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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 requirements are not met as evidenced by:

A. Based on interviews and record reviews, the facility failed to have effective fall interventions in place for a resident assessed to be at high risk for falls, confused, and with poor safety awareness. This failure applied to one (R281) of one resident reviewed for accidents and supervision and resulted in R281 being emergently transferred to the hospital with a diagnosis of an acute comminuted periprosthetic fracture in the mid to distal left femur.

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B. Based on interviews and record reviews, the facility failed to safely assist a resident with feeding who is diagnosed as legally blind and is dependent on staff for assistance with feeding. This failure applied to one (R219) of one resident reviewed for accidents and supervision and resulted in R219 obtaining a second degree burn on the left side of the abdomen as a result of hot water being spilled on her while staff was assisting with feeding.

Findings include:

A. R281 is a 93 year old female, admitted in the facility on 03/01/2022 with diagnoses of Periprosthetic Fracture Around Internal Prosthetic Left Hip Joint, Subsequent Encounter Unspecified Fracture of Shaft of Left Femur, Subsequent Encounter For Closed Fracture with Routine Healing; Difficulty in Walking, Not Elsewhere Classified and History of Falling.

According to incident report dated 03/24/2022, it was noted that at around 8:20 PM, R281 was heard calling for help and was found on the floor next to her bed. She complained of pain on the left lower extremity and was sent out to the emergency room as ordered.

R281's hospital records documented the following in part but not limited to the following:
1. Orthopedic History and Physical dated 03/25/2022:
History of present illness: Patient is a 92 year-old, female with left distal periprosthetic fracture from a fall occurring last evening. Patient states she was going to the bathroom and fell. She has recent THA (total hip arthroplasty) revision and ORIF (open reduction internal fixation) on

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02/25/22.
Imaging - Xray Left femur - acute comminuted periprosthetic fracture in the mid to distal left femur.
Xray Left hip: 2. There appears to be an acute periprosthetic fracture in the mid to distal left femoral diaphysis.
2. Physician Discharge Summary 03/28/22: Procedures/Surgery done: Open reduction and internal fixation, left distal third femoral shaft fracture with plate and screws.

On 05/17/2022 at 5:55 PM, V7 (Registered Nurse) was asked regarding R281's fall incident on 03/24/2022. V7 stated, "It was right after dinner. Her room was just right next to where I was at the time. I did the rounds on her, when I checked on her, it was late, she was on the floor already. She fell. I asked her (R281) what happened and she said, 'I just want to get up.' It was very hard to deal with her, she wanted to get up all the time. I assessed her after the fall, her range of motion and vital signs. I noticed that her blood pressure was high, her range of motion in the upper extremities were fine. She had limited range of motion on lower extremities, I noticed that the left thigh was red and swollen. It was the bad leg. She was sent out to the hospital as ordered. Unfortunately, there was a fracture. She did not use her call light. She is confused. She got up and wanted to get out of bed. She has this behavior. Everyone knows about her behavior of getting up and out of bed. There was no alarm or mobility alarm on at the time. There was no alarm."

R281's Care plan, initiated 03/01/2022 documented: Risk for falls related to confusion, gait/balance problems, incontinence, poor communication/comprehension, unaware of

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safety needs: Intervention - Follow facility fall protocol; The resident (R281) uses chair/bed electronic alarm. Ensure the device is in place as needed.

On 05/18/22 at 11:39 AM, V6 (1 West Nurse Manager) was interviewed regarding R281 and falls. V6 verbalized, "On 03/24/2022, she was sent out due to a fall incident. Before the fall, V7 checked on her. Shortly after 20-30 minutes after he (V7) went in there, the fall happened. According to him (V7), she (R281) was screaming, and she was found on the left side of the bed, on the floor. She was assessed, does not remember what happened when I asked her. She was sent out for further evaluation and treatment as ordered. She had the fall because she was confused, she did not ask for help to get up. She does have a behavior of getting up and getting out of bed without calling for help. She does know how to use the call light, but she is confused. For confused residents and high risk for falls, staff needs to do frequent monitoring every one to two hours. Her room is close to the nurses' station so everybody can see her; her bed in lowest position; she has a mobility alarm on. When she had the fall, she had the mobility alarm on. Her bed alarm/chair alarms are supposed to be implemented at all times. All staff are trained regarding use of mobility alarms, even agency staff. That time of incident, she (R281) should have the mobility alarms on. Her fall was caused by poor safety awareness and confusion."

Nursing Comprehensive Assessment dated 03/17/2022 reads: High risk for Falls, score 10.0

On 05/18/22 at 02:25 PM, V13 (Nurse Practitioner) was interviewed regarding R281's cause of fall. V13 replied, "She is in her 90s, has

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a little bit of cognitive impairment. She is frail and repetitive. She needs total assist in everything. She broke her hip at home, was hospitalized, had surgery left hip repair and admitted in facility for rehab. She had a fall on 03/24/2002 - due to confusion and cognitive ability." V13 was asked on what interventions should be implemented on R281 to prevent fall incidents. V13 stated, "Staff needs to follow fall prevention program. She cannot retain things, unable to use call light and couldn't retain the instructions, there should be increase supervision and follow interventions in the care plan."

V2 (Director of Nursing) was also interviewed on 05/18/2022 at 3:50 PM regarding fall prevention in the facility. V2 verbalized, "Staff needs to know everything about the residents' condition and needs; follow fall protocol and follow care plan interventions in placed."

Facility's policy titled "Fall Prevention Policy" dated 10/2021 documented in part but not limited to the following:
Purpose: This facility is committed to minimizing resident falls to maximize each resident's physical, mental and psychosocial well-being. While preventing all resident falls is not possible, it is this facility's policy to act in a proactive manner to identify and assess those residents that are at risk for falls, plan for preventative strategies, and facilitate a safe environment as possible.

Policy: A fall assessment shall be completed on each resident on admission/readmission, quarterly, and with each occurrence of a fall. The Fall Risk Assessment shall at a minimum include history of falls, contributing factors, gait, balance, mental status, and medications. A resident who is

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identified on admission as high risk for falls will have an interdisciplinary plan of care, which includes initial interventions to prevent injuries and fall occurrences. At least quarterly and with each fall occurrence, the effectiveness of each resident's care plan as it relates to fall prevention shall be reviewed and updated when necessary.

Facility's policy titled "Fall Management Protocol" dated 08/2021 stated in part but not limited to the following:
Purpose: Major components of the safety and accident prevention of our residents are the determination of risk. This includes fall risk and management of resident falls.

B. R219 is a 61-year-old female admitted to the facility on 05/17/2018 with diagnosis including but not limited to Multiple Sclerosis, Chronic Obstructive Pyelonephritis, Legal Blindness, Contracture of Muscle, and Paraplegia. According to MDS (Minimum Data Set) dated 05/01/2022 under section C, R219 has BIMS (Brief Interview of Mental Status) score of 12 indicating moderately impaired cognition.

R219's eating total dependence dated 08/16/2018 reads in part, Feed resident allowing adequate time to chew/swallow food.

R219's vision impairment care plan dated 07/17/2018 reads in part, Place personal items on the side so that R219 can see them; Relocate food from side of tray to center of tray during meals.

On 05/16/2022 at 11:21 AM surveyor interviewed R219 regarding the incident that the resident suffered on 04/07/2022, R219 stated, "V14 (CNA - Certified Nursing Assistant) placed food tray on

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the side table, then he put his cell phone on my bed and had his earphones in his ears. There were two cups on the tray, one with cold, one with hot water to steep my tea. I told V14 that I don't want to get burnt with the hot water, so I asked him for cold water that was next to it and then V14 knocked over the cup of hot water with his elbow. It fell on me and burnt my abdomen. V14 didn't even notice when it happened, I screamed, and another staff came in and helped me, I don't remember who it was."

On 05/16/2022 at 12:37 PM surveyor interviewed V4 (three west unit manager). Surveyor asked about the incident that happened on 4/07/22 involving R219, V4 stated, "The resident got burnt from the hot water spill, during breakfast time. I was told that V14 (CNA), who was feeding R219 at the time, accidentally knocked over a cup from the tray. R219 suffered burn to the left side of her upper abdomen. The resident notified V9 (RN - registered nurse) who told me about the incident. I went into the room and did an assessment. I noticed redness on her abdomen. I notified V21 (MD - Medical Doctor). I also notified wound care team and they continued the treatment. I sent V14 home for not telling me about the incident. I was also going to write him up, but he never returned to our facility. I notified the scheduler of the incident and that V14 didn't tell me directly about the incident."

Progress note dated 04/07/2023 at 10:05 AM written by V9 reads in part, upon assessment, blenched redness noted to the left side of her abdomen and left breast. Complaining of pain, voiced 7/10. Tenderness upon palpitation. No open area noted. Scheduled pain medication given. V21 (MD) made aware with orders to apply ice to affected area. POA notified.

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Order dated 04/07/2022 at 11:59 PM written by V21 (MD) reads in part, Cold Pack - Apply to left side of abdomen topical one time for comfort and prevention of swelling. Completed 04/07/2022

R219's redness on the left quadrant of abdominal area dated 04/07/2022 reads in part, Apply Silverdine cream to left quadrant abdominal area; identify potential causative factors and eliminate/resolve when possible.

Wound Care Assessment dated 04/13/2022 written by V22 (NP - Nurse Practitioner) reads in part, Burn of Second Degree of abdominal wall present; size 13cm x 26cm x 0.1cm; 25% intact blisters; 75% open dermis; light serous exudate present.

Order dated 04/13/2022 written by V21 (MD) Reads in part, Silvadene Cream 1% - Apply to left abdomen topically everyday shift for wound cleanse with normal saline, pat dry, apply Silvadene, apply Adaptec and dry dressing. Completed 04/22/2022,

Skin and Wound Evaluation dated 04/18/2022 at 11:59 AM written by V21 (MD) reads in part, first degree burn to upper left abdomen.

Wound Care Assessment dated 04/20/2022 written by V22 (NP) reads in part, burn to left abdomen intact.

On 05/18/2022 at 11:45 AM V2 (DON - Director of Nursing) indicated that injury report wasn't done at the time of the incident because R219 did not acquire an actual injury, she just had some redness on her abdominal area.

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On 05/18/2022 at 1:30 PM surveyor interviewed V2 (DON). Surveyor asked about the incident from 04/07/2022 involving R219, V2 stated, "One of the contracted staff (V14) spilled coffee over R219 and the nurse (V9) went and took care of the resident. We called wound care nurse (V22), and R219's wound assessed as was only redness. We also called physician (V21); he gave an order to ice the area. We investigated the incident internally. We called the agency to talk to V14 and do an in-service, but he did not do that and refused to sign, so we terminated him." Surveyor asked what would be the expectation to prevent burns during feedings, V2 stated, "My expectation is to prevent all the incident and accidents. We do in-services, we also tell staff to be careful when handling hot liquids. Incidents that need treatment or hospital visits need to be reported. If I know cause and it's a mild injury, I can do the internal investigation. Staff needs to report all accidents and incidents."

On 5/18/22 at 2:16 PM surveyor interviewed V14 (CNA) via phone. Surveyor asked V14 to clarify what happened on 04/07/2022 when he fed R219, V14 stated, "I went into R219's room, I was adjusting her tray and I spilled a cup of hot water on her. R219 told me to notify the nurse. I left the room, but I didn't see any nurse on the unit. I had to go downstairs for a moment. I came back after 15 min. V4 and V9 called me, and they told me what happened and then rebuked me. I worked for the rest of the day but didn't go back to R219's room. The agency did the safety in-service for me, but I didn't work at this facility again."

On 5/18/22 at 3:11 PM Surveyor interviewed V9 (RN - Registered Nurse). Surveyor asked about the incident that happened on 04/07/2022 involving R219, V9 stated, "I went in to give R219

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her routine morning medications. R219 told me that she got burnt to the left side of her abdomen. R219 said that V14 knocked over a cup with hot water while he was feeding her. I assessed R219; she had some blanchable redness, R219 also complained of some tenderness and pain. I called V21 (MD); he told me to put some ice at the burn site and monitor. Then I called R219's POA. I also told V4 (three west unit manager); V4 also assessed R219. I haven't worked with V14 after that." Surveyor asked who reported the incident to him, V9 stated, "Nobody report the incident to me, I just came in to give R219 her medications. She was done with lunch and the tray was gone by the time I came in."

05/18/22 at 02:41 PM Surveyor interviewed V13 (NP - Nurse Practitioner). Surveyor asked about burn classification, V13 stated, "Sometimes burn is just a redness, that would indicate stage 1 and stage 2. If skin comes in contact with something really hot, the skin may develop blister. Burn is a trauma." Surveyor asked what is an indication to use Silvadene cream, V13 stated, "Silvadene cream is an anti-infective, promotes healing. We would use it instead of oral antibiotic, it's usually a medication for burns. Ice is also a good treatment for burns."

5/19/2022 11:38 AM Surveyor interviewed V11(Wound Care Coordinator). Surveyor asked about the incident that happened on 04/07/2022 involving R219, V11 stated, "The water spilled on her abdominal area. It was just red upon an assessment, there was no skin opening at the time. V21 ordered ice pack and monitoring." Surveyor asked about V11 expectation when resident suffers a burn, V11 stated, "Depends on the severity of it, if skin is open, we call the doctor and start the treatment. If the injury was

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superficial, and R219's was, we prescribe ice and monitor."

B. R219 is a 61-year-old female admitted to the facility on 05/17/2018 with diagnosis including but not limited to Multiple Sclerosis, Chronic Obstructive Pyelonephritis, Legal Blindness, Contracture of Muscle, and Paraplegia. According to MDS (Minimum Data Set) dated 05/01/2022 under section C, R219 has BIMS (Brief Interview of Mental Status) score of 12 indicating moderately impaired cognition.

R219's eating total dependence dated 08/16/2018 reads in part, Feed resident allowing adequate time to chew/swallow food.

R219's vision impairment care plan dated 07/17/2018 reads in part, Place personal items on the side so that R219 can see them; Relocate food from side of tray to center of tray during meals.

On 05/16/2022 at 11:21 AM surveyor interviewed R219 regarding the incident that the resident suffered on 04/07/2022, R219 stated, "V14 (CNA - Certified Nursing Assistant) placed food tray on the side table, then he put his cell phone on my bed and had his earphones in his ears. There were two cups on the tray, one with cold, one with hot water to steep my tea. I told V14 that I don't want to get burnt with the hot water, so I asked him for cold water that was next to it and then V14 knocked over the cup of hot water with his elbow. It fell on me and burnt my abdomen. V14 didn't even notice when it happened, I screamed, and another staff came in and helped me, I don't remember who it was."

On 05/16/2022 at 12:37 PM surveyor interviewed

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S9999	Continued From page 12 V4 (three west unit manager). Surveyor asked about the incident that happened on 4/07/22 involving R219, V4 stated, "The resident got burnt from the hot water spill, during breakfast time. I was told that V14 (CNA), who was feeding R219 at the time, accidentally knocked over a cup from the tray. R219 suffered burn to the left side of her upper abdomen. The resident notified V9 (RN - registered nurse) who told me about the incident. I went into the room and did an assessment. I noticed redness on her abdomen. I notified V21 (MD - Medical Doctor). I also notified wound care team and they continued the treatment. I sent V14 home for not telling me about the incident. I was also going to write him up, but he never returned to our facility. I notified the scheduler of the incident and that V14 didn't tell me directly about the incident." Progress note dated 04/07/2023 at 10:05 AM written by V9 reads in part, upon assessment, blenched redness noted to the left side of her abdomen and left breast. Complaining of pain, voiced 7/10. Tenderness upon palpitation. No open area noted. Scheduled pain medication given. V21 (MD) made aware with orders to apply ice to affected area. POA notified. Order dated 04/07/2022 at 11:59 PM written by V21 (MD) reads in part, Cold Pack - Apply to left side of abdomen topical one time for comfort and prevention of swelling. Completed 04/07/2022 R219's redness on the left quadrant of abdominal area dated 04/07/2022 reads in part, Apply Silverdine cream to left quadrant abdominal area; identify potential causative factors and eliminate/resolve when possible. Wound Care Assessment dated 04/13/2022	S9999		

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 05/19/2022

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S9999	Continued From page 13	S9999		

written by V22 (NP - Nurse Practitioner) reads in part, Burn of Second Degree of abdominal wall present; size 13cm x 26cm x 0.1cm; 25% intact blisters; 75% open dermis; light serous exudate present.

Order dated 04/13/2022 written by V21 (MD) Reads in part, Silvadene Cream 1% - Apply to left abdomen topically everyday shift for wound cleanse with normal saline, pat dry, apply Silvadene, apply Adaptec and dry dressing. Completed 04/22/2022,

Skin and Wound Evaluation dated 04/18/2022 at 11:59 AM written by V21 (MD) reads in part, first degree burn to upper left abdomen.

Wound Care Assessment dated 04/20/2022 written by V22 (NP) reads in part, burn to left abdomen intact.

On 05/18/2022 at 11:45 AM V2 (DON - Director of Nursing) indicated that injury report wasn't done at the time of the incident because R219 did not acquire an actual injury, she just had some redness on her abdominal area.

On 05/18/2022 at 1:30 PM surveyor interviewed V2 (DON). Surveyor asked about the incident from 04/07/2022 involving R219, V2 stated, "One of the contracted staff (V14) spilled coffee over R219 and the nurse (V9) went and took care of the resident. We called wound care nurse (V22), and R219's wound assessed as was only redness. We also called physician (V21); he gave an order to ice the area. We investigated the incident internally. We called the agency to talk to V14 and do an in-service, but he did not do that and refused to sign, so we terminated him." Surveyor asked what would be the expectation to

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S9999	Continued From page 14	S9999		

prevent burns during feedings, V2 stated, "My expectation is to prevent all the incident and accidents. We do in-services, we also tell staff to be careful when handling hot liquids. Incidents that need treatment or hospital visits need to be reported. If I know cause and it's a mild injury, I can do the internal investigation. Staff needs to report all accidents and incidents."

On 5/18/22 at 2:16 PM surveyor interviewed V14 (CNA) via phone. Surveyor asked V14 to clarify what happened on 04/07/2022 when he fed R219, V14 stated, "I went into R219's room, I was adjusting her tray and I spilled a cup of hot water on her. R219 told me to notify the nurse. I left the room, but I didn't see any nurse on the unit. I had to go downstairs for a moment. I came back after 15 min. V4 and V9 called me, and they told me what happened and then rebuked me. I worked for the rest of the day but didn't go back to R219's room. The agency did the safety in-service for me, but I didn't work at this facility again."

On 5/18/22 at 3:11 PM Surveyor interviewed V9 (RN - Registered Nurse). Surveyor asked about the incident that happened on 04/07/2022 involving R219, V9 stated, "I went in to give R219 her routine morning medications. R219 told me that she got burnt to the left side of her abdomen. R219 said that V14 knocked over a cup with hot water while he was feeding her. I assessed R219; she had some blanchable redness, R219 also complained of some tenderness and pain. I called V21 (MD); he told me to put some ice at the burn site and monitor. Then I called R219's POA. I also told V4 (three west unit manager); V4 also assessed R219. I haven't worked with V14 after that." Surveyor asked who reported the incident to him, V9 stated, "Nobody report the incident to me, I just came in to give R219 her medications.

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S9999	Continued From page 15 She was done with lunch and the tray was gone by the time I came in." 05/18/22 at 02:41 PM Surveyor interviewed V13 (NP - Nurse Practitioner). Surveyor asked about burn classification, V13 stated, "Sometimes burn is just a redness, that would indicate stage 1 and stage 2. If skin comes in contact with something really hot, the skin may develop blister. Burn is a trauma." Surveyor ask what is an indication to use Silvadene cream, V13 stated, "Silvadene cream is an anti-infective, promotes healing. We would use it instead of oral antibiotic, it's usually a medication for burns. Ice is also a good treatment for burns." 5/19/2022 11:38 AM Surveyor interviewed V11(Wound Care Coordinator). Surveyor asked about the incident that happened on 04/07/2022 involving R219, V11 stated, "The water spilled on her abdominal area. It was just red upon an assessment, there was no skin opening at the time. V21 ordered ice pack and monitoring." Surveyor asked about V11 expectation when resident suffers a burn, V11 stated, "Depends on the severity of it, if skin is open, we call the doctor and start the treatment. If the injury was superficial, and R219's was, we prescribe ice and monitor." (A)	S9999		