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 01/18/2019

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
S 000	Initial Comments Complaint Investigations: 1897980/IL107904 1897159/IL107014 1990366/IL108752 Facility Reported Incident FRI of 1/2/2019 IL108580 Statement of Licensure Violations	S 000		
S9999	Final Observations Licensure 1 of 2 300.610a) 300.1210a) 300.1210b)5) 300.1210c) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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Section 300.1210 General Requirements for Nursing and Personal Care

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)

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. Restorative measures shall include, at a minimum, the following procedures:

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.

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S9999	Continued From page 2 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. 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 were not met as evidenced by (1) Based on observation, interview and record review, the facility failed to use two staff members to assist a resident with bed mobility and dressing. This applies to one of three residents (R2) in a sample of 5 reviewed activity of daily living. This failure resulted in R2 sustaining a fracture of the right tibia. Findings Included: R2 was 70 years old who was first admitted to facility on 2/14/2014 and readmitted on 5/24/2018. His diagnoses included Multiple Sclerosis. His mental status was mildly impaired with a Brief Interview for Mental Status (BIMS)	S9999		

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score of 13 out of 15 in the Minimum Data Set(MDS) dated 11/05/2018. According to the MDS, R2 needed 2 staff members for dressing and transfer.
Section G0400 documented R2 had limited movement to one upper extremity and to both lower extremities.

Care plan for R2 noted he had contractures to the right shoulder, right elbow and right fingers. There was no care plan for R2 for transfers.
Fall risk assessment for R2 dated 12/7/2018 scored 11 considered moderate risk for falls.

Incident report for R2 dated 10/24/2018 documented R2 was observed lying on floor on back next to bed. According to report, there were two Certified Nursing Assistants (CNAs/ V20,V21) at bedside.
R2 was sent to community hospital for complaint of pain to the leg. He was diagnosed with fracture of the lower end of the right Tibia.

On 1/11/2019 at 1:25PM, V20 (Certified Nursing Assistant/CNA) said R2 rolled out of the bed on the left side when he turned too quickly. She did not answer when asked if there was another staff to help her.

On 1/15/2019 at 3:00PM, V21 said she was not in the room when R2 fell. She said she went into room to assist V20 to transfer R2 in chair with a mechanical lift. V21 said V20 dressed R2 by herself and was not finished. She said she left the room to return. According to V21, when she returned, R2 was on the floor on the left hand side.

On 1/17/2019 at 11:40AM, V22 (Nurse) said she was the nurse on duty when R2 fell. She said

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when she was called to the room, V20 (CNA) was the only staff present with R2 who was on the floor on the left side of the bed. According to V22, R2 required 2 staff members for bed mobility and dressing and he could not turn by himself.

On 1/10/2019 at 11:20AM, R2 laid in bed. V2(Director of Nursing/DON) and V8 (Nurse) assisted to turn R2 in bed. R2 could not move his upper body without assistance. He was repositioned to the right side with extensive effort by staff. R2 was able to initiate the turn to the left side by staff extensive assistance to help him reach the rail on the left side, His grip was loose on the rail. R2 fell out of bed on the left side on 10/24/2018.

On 1/9/2019 at 10:15AM, R2 was alert, awake and was in power wheelchair in room. His right hand was contracted by the elbow and right fingers were also bent. When asked to move his legs he said he could not move them. He said he could not turn by himself but can hold on to the side rail on the right side with his left hand and someone had to assist him. According to him he could turn to the right side better than the left. R2's bed had two bar rails which were about 12 inches wide and were on the upper ends of the bed.

He said the reason why he fell out of bed on the left side in October was because he tried to hold on to the left side rail with his right hand which was contracted and V20 who stood on his right side picked up his feet and "threw" them over to the left side so far that he slid right out of the bed. He said she was by herself and dressed him by herself.

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(2) Based on interview and record review the facility failed to plan and implement fall interventions to avoid a resident fall or decrease possible injury due to a fall, for a resident who was at risk for fall. This applies to one of three residents (R4) reviewed for fall in a sample of six. As a result, R4 a confused resident, sustained some broken ribs and a punctured lung as a result of a fall.

Findings Included:

R4 was 74 years old admitted to facility on 9/12/2018 at 7:00PM with Diagnoses to include Dementia with behavioral disturbance.

Nurse notes on 9/12/2018 upon admission documented: R4 was a fall risk and was confused and provided with floor mats. On 9/13/2018 at 5:48AM, nurse wrote, " noted R4 crawling on carpet next to her bed".
On 9/13/2018 at 7:43PM, nurse wrote," Resident was combative with staff, destroying phone wires and trying to knock down the computer, daughter was called and verbalized she will be there."
On 9/13/2018 at 8:33PM, nurse documented V15 (Family) left facility and notified her that R4 was asleep. According to nurses' note of 9/13/2018 at 8:37PM, call light was clipped to covers on bed of R4 by V13 (family member).
On 9/13/2018 at 8:37PM, V9 wrote R4 was observed on floor sitting upright in between the sink and the toilet seat. R4 was then observed holding on to her right side and complained of pain. She was subsequently sent out to community hospital.

The nurses' notes of 9/13/2018 had no documentation that floor mats were next to bed and there was no documentation that added

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interventions were implemented after the first observation of R4 being on the floor.

R4's baseline care plan for the admission of 9/12/2018 was not individualized and did not include any safety measures for falls.

R4's hospital records dated 9/13/2019 noted, "Multiple right sided rib fractures with adjacent chest wall emphysema. Suspicious for right pneumothorax."

On 1/15/2019 at 2:30PM V9(Nurse) said she could not remember if any fall intervention was in place for R4 who was at risk for falls. She said when the family left (9/13/18), they clipped the call light to the covers of R4.When asked if R4 was able to use the call light, V9 said "Maybe not". She said she should have pinned the call light to R4's clothing.

On 1/17/2019 at 3:10PM, V29 (Nurse) said upon admission he documented R4 was a fall risk because hospital papers stated she had bilateral side rails. He said he did not speak with family in relation to falls of R4.

On 11/15/2019 at 12:40PM, V27 (Certified Nursing Assistant/CNA) said she could not remember if R4 had any fall interventions in place when she fell.

Facility's policy on falls dated 1/12/2013 noted," Provide ongoing risk reducing interventions and, Identify and implement related care link interventions."
(B)

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300.610a)
300.1210a)
300.1210b)2)
300.1210b)4)
300.1210b)5)
300.1210c)
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

Section 300.1210 General Requirements for Nursing and Personal Care

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

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S9999	Continued From page 8 the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. Restorative measures shall include, at a minimum, the following procedures: 2) All treatments and procedures shall be administered as ordered by the physician. 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. 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.	S9999		

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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.

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 were not met as evidenced by:

Based on interview and record review the facility failed to provide a resident with a mechanical soft diet as ordered, supervise a resident with a behavior which puts the resident at risk for choking during meal time and have a staff member within the dining room to immediately start procedures to dislodge food from a resident throat while choking.

This applies to 1 of 1 resident (R5) with a modified diet in a sample of 17 residents. As a result, R5 who was identified with swallowing difficulties, choked on regular food served to him. R5 expired soon after the choking incident.

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Findings include:

R5 was 58 years admitted to facility on 2/25/2013 with Diagnoses to include Dysphasia /Oropharyngeal phase. R5 ' s brief interview for mental status (BIMS) dated 12/20/2018 scored 5 out of 15 and his mental status was severely impaired. According to his Minimum Data Set (MDS) dated 12/20/2018, R4 required extensive assistance of one staff for eating. R5's January 2019 physician ' s order was for a mechanical soft diet with honey thickened liquids.

Nurses' notes for R5 documented on 1/2/2019 at 5:30PM, R5 was served a meal to include fried chicken sandwich (Regular diet). According to the notes, the tray was placed in front of him and he started to stuff a lot of the food in his mouth. He was then noted by staff to be choking and staff summoned the nurses. The Heimlich maneuver was performed by two nurses, one of whom was able to take out some food from his mouth.

The facility's incident report dated 1/08/2019 received by the state agency read: On 1/02/2019 at approximately 5:50PM; nursing staff was notified by CNA (Certified nurse aide) that R5 seemed to be choking in the main dining room. Two nurses responded immediately, and initiated the Heimlich maneuver, where particles of food were expelled. R5 became unresponsive and 911 was called. CPR was initiated until EMS arrived and EMTs continued CPR as R5 was transferred to the hospital.

On 1/03/2019 the facility was notified from the hospital the R5 had expired in the emergency department of the hospital.

On 1/10/2019 at 11:00AM, V2 (director of

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nursing) said for the residents who needed supervision or assistance for eating, she expected that when the tray was placed in front of the residents, the staff sat down right away to supervise or feed them.

On 1/10/2019 at 2:30PM, V11 (CNA) said she was the staff who saw R5 stuffing the food in his mouth. She said the staff knew R4 had a problem of stuffing food in his mouth and then he would start to spit out the food when his mouth was too full. She said "All the staff knew about it." V11 said the tray was in front of R5 and no staff member was at the table to supervise him. In addition she said she told him to stop but he did not and she moved him away from the table when he spat food on her face accidentally. She said she left to wash her face and when she returned she noticed he did not look good, so she called the nurse. When asked about the risk faced by R5 with his mouth full with food she said he could choke. She did not answer when asked why she did not alert someone that R5's mouth was full of food. She said she did not check to see what he had on his tray. V11 said she had no knowledge who gave R5 his tray.

On 1/10/2019 at 11:30AM, V10 (Dietary supervisor) said R5 should have never been given a chicken sandwich when his diet was mechanical soft. He said the mechanical soft diet should have been Ham and Beans, Mashed potatoes and greens. He said the regular diet was Chicken (fried) patty on a bun, fried potatoes, mixed greens and corn bread.

On 1/10/2019 at 2:50PM, V12 (CNA) said all the staff knew that R5 had a problem of stuffing food in his mouth and had a potential for choking and that was why he was supposed to be assisted

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S9999	Continued From page 12 with meals.. On 1/10/2019 at 3:25PM, V19 (Speech Therapist) said any resident on a modified diet should at least be supervised and if the resident was to be supervised for eating then he should not have given a tray without supervision. On 1/11/2019 at 3:15PM, V14 (attending physician) said if the patient required supervision or assistance for eating, his tray should not have been placed in front of him unattended. He also said he should have been served the prescribed diet. Hospital records for R5 dated 1/2/2019 documented: Pt (patient) arrived from nursing home for witnessed choking that led to cardiac arrest. Pt was given Epi X 4 by EMS. Upon arrival pt. was unresponsive and in cardiac arrest. Facility's undated policy on Diet Standardization noted: Mechanical Soft diet documented: The texture and consistency of the general/ regular or therapeutic diet is modified. Food may be served as ground or chopped. Whole food may only be served if it is soft in consistency. (A)	S9999		