STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145424	A. BUILDING ______ B. WING ______	C **05/22/2006**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENSHIRE NURSING & REHAB CTRE	**22660 SOUTH CICERO AVENUE** **RICHTON PARK, IL 60471**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETION DATE
F 324	Continued From page 31 monthly on all shifts. Door alarm drill report will be completed and presented to the Safety Committee during the next meeting. e. Any identified trends and patterns identified during rounds, clinical record review will be forwarded to the Quality Assurance committee for further review and recommendations until resolved. Although the Immediate Jeopardy was removed on 4/27/06 based on completion of staff inservicing, the facility remains out of compliance at a severity level 2 to allow for implementation of all of the above responses and time for the facility to evaluate the efficacy of their interventions.	F 324		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.690a)2) 300.1210a) 300.1210b)6) 300.2900d)2) 300.3240a) Section 300.690 Serious Incidents and Accidents a) The facility shall notify the Department of any incident or accident which has, or is likely to have, a significant effect on the health, safety, or welfare of a resident or residents. Incidents and accidents requiring the services of a physician, hospital, police or fire department, coroner, or other service provider on an emergency basis shall be reported to the Department. 2) A narrative summary of each accident or incident occurrence shall be sent to the Department within seven days of the occurrence.	F9999		

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F9999	Continued From page 32 Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must 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 assessment and plan of care. 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: b) 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 300.2900 General Building Requirements d) Doors and Windows 2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.	F9999		

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F9999	Continued From page 33	F9999		

Continued From page 33

These Requirements are not met as evidenced by:

Based on direct observation, clinical record review and interviews the facility staff failed to ensure that 1 resident (R23) was free from neglect as evidenced the facility staff's failure to monitor a resident at risk for wandering which resulted in a fall with serious injuries.

Findings include:

1. R23 is a 52 year old male who was admitted to the facility at approximately 2:00pm on 4/26/06 . He was admitted from the hospital with diagnoses that included altered mental status and history of alcohol abuse. The transfer form from the hospital indicated that wandering was a concern for the resident and while he was hospitalized, he had a sitter 24 hours per day.

2. According to the nurses' notes dated 4/27/06 at 12:20am staff heard the fire door alarm activated. The note also stated that a CNA saw the resident go through the door, but was unable to find him. According to the notes and staff interviews, only one of the CNAs responded by going through the door after the resident. However, he was combative and uncooperative so she had to go back on the unit to ask others for help. When they returned, the resident was gone. According to the statements provided by the facility as part of their investigation, E16 (CNA) was assigned to R23 and followed him through the door and E17 (CNA) and E19 (CNA) heard the alarm but did not respond until E16 came back and asked for help. On interview on 5

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F9999	Continued From page 34	F9999		

/17/06 E16, E17 and E19 confirmed that when they went back through the fire door to find the resident, he was no where to be found.

3. On the other side of the fire door is an area of the floor that is closed off. There are no residents on that floor and the rooms are mostly used for storage. On tour on 5/9/06, E (Administrator) stated that all of the doors to the rooms are kept locked. On 5/9/06 it was noted that they were locked. In the room above where the resident was found, it was noted that it was storage for carts and ventilators. There were carts up near the window and it was noted that the window was open and their was no screen. There were chains on the window on 5/9/06 limiting the amount that the window could be open. In reviewing the police report, it was noted that on 4/27/06 (the date of the incident), at the time of the incident, there was a person from the ventilator company working in that store room. On the police report and on interview on 5/16/06, Z4 (from the ventilator company) confirmed that he was working in that room and also that he left the room for a short while to use the bathroom. He stated on interview that when he left the room, he left the door open. He could not say specifically how long he was gone. He denied seeing R23 that night. This information was not included in the facility's investigation and they provided no statement from Z4.

4. When the CNAs could not find R23, a "Code Green" was called (announcement of elopement for staff). The resident was eventually found outside the southeast door of the building which is directly under the store room that was left unlocked. There was no documentation by the

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F9999	Continued From page 35	F9999		

facility of exactly what time the resident was found. There was no documentation regarding the resident's appearance, location, condition, medical status, vital signs or mental status. There are some inconsistencies in the statements given by staff, however at some time E15 (Supervisor), E18 (Security Officer), E19 (CNA), E20 (CNA) and E21(nurse) were outside of the building with the resident and there is no documentation describing the positioning of the resident, the condition of the resident and time frames. According to the report from the fire department, they arrived on the scene at 12:52 am. Their comments state, "Called to nursing home for injured subject. On arrival found patient lying on ground outside. Noted compound fracture to right femur, possible dislocation to right shoulder. Appeared that patient fell from 4th floor window to grating below. Unknown how long patient had been outside Patient cold to touch."

5. The police report dated 4/27/06 stated that there was an open window on the 4th floor directly above the place where the resident was found. Upon investigation, the officer stated the room was a storage room where Z4 was repairing ventilators. The officer noted that the windows were open and one of them did not have a screen. The report indicates that the officer's determination was that the R23 fell from the 4th floor window and that it was of his own doing.

6. The incident report for R23 was not in the file with the facility's other incident reports. It was noted in the resident's closed chart. The incident report described the resident's injuries as a

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F9999	Continued From page 36	F9999		

broken leg and some scratches on his head. Review of the clinical record from the hospital indicated that R23's injuries were more serious and they required surgical intervention. The injuries were stated as follows:
- Severe compound comminuted fracture of the right distal femur;
- Rupture of the right quadriceps muscle;
- Fracture of the left humeral head;
- Fracture and displacement of the left scapula;
- Posterior rib fractures - left 3, 4, 5 and 6th ribs;
- Lateral rib fracture - left 7th rib;
- Anterior rib fracture - left 1st rib;
- Non-displaced fractures on the transverse processes of L1 and L2; and
- Contusion within the left upper lobe, anterior to the rib fracture;
- 2 - 3 inch lacerations to his forehead.

There was no information at the facility in the resident's chart, incident report or investigation that described or addressed the extent of his injuries. The resident was still hospitalized 13 days after the incident.

7. The facility has offered no information as to what happened to this resident. The investigation was limited to statements from 5 staff persons but failed to provide statements from the nurse who was on duty on the fourth floor (Z3), the CNA who first spotted the resident outside (E20), the person who was working in the store room and left it unlocked (Z4) and the nurse who responded to the CNA who found the resident (E21). The reports that were sent to Illinois Department of Public Health simply indicate that he had an unwitnessed fall and that he had an injury to his right leg. There was no