STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007918	A. BUILDING: _____ B. WING _____	C 03/27/2014

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

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S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 300.1210a) 300.1210b) 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 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 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	S9999		

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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.

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. (Section 2-107 of the Act)

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to ensure that safety interventions were implemented for 1 of 3 residents reviewed for

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falls, that was agitated (R1). These failures resulted in R1 being left sitting on the bed unsupervised, falling and sustaining facial trauma that required sutures

Findings include:

Admission Record with a print date of 3/1/14 read R1 was admitted to the facility on 11/21/13. Diagnoses include: Dementia.

Physician Order Sheet dated 2/24/14 diagnoses include: end stage renal disease with hemodialysis and altered mental status.

Facility Screening for Assessment for Indicators of Aggressive and/or Harmful Behavior dated 1/14/14 reads: History or recent episode of aggressive/agitated behavior [aggression toward others, including destruction of property, fire setting, or other violent acts] and/or non-compliance with medications, treatment regimen, resisting care. Score of 2 was given which indicates substantial or significant problem.

On 3/7/14 at 10:53 am, E5 (licensed practical nurse) stated "She was sitting on the side of the bed. I know she's a fall risk, so I got a certified nurses assistant (CNA) [E6] to assist to transfer to the chair." R1 "refused, became combative, didn't want to be bothered. She became real agitated, so we backed away. We all left the room. After 5 minutes I came back and she was on the floor. I assessed her, she had a cut below her lip. Sometimes she can get combative, she's not always combative. Redirection wasn't working, she was becoming more angry. We would frequently monitor her because she was a fall risk. When I left her she was sitting on the side of the bed."

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A witness statement documented on 2/26/14 from E5 reads: Upon making rounds R1 was noted sitting up on the side of the bed in an unsafe manner. E6 and E5 attempted to intervene and assist her to get up in the chair. R1 became very agitated with us and quickly became combative lashing out and attempting to fight with us. We left her alone for a while to calm down. I went back to the room later and she again became combative and refusing for us to touch her. We left again to try to give her time to calm down. Shortly after leaving the room she tried to get up from the bed and fell to the floor.

On 3/7/14 at 11:25 am E4 (certified nurses assistant) stated "I was doing round and heard a commotion. She [R1] was cursing out the nurse. She always combative. She screams and cusses out. I been working with her [R1] and she usually calms down. I left and the nurse was in there. I heard her stop cursing then 10 minutes after that I heard a lot of bumping then about 1-2 minutes later, I went in her room [R1] and I saw her on the floor and blood around her. I called the nurse [E5] and she was in another room with another resident. She [R1] was sitting on the bed when I left. It's not a safe position and that's why we try to get her in the chair. I usually sit and watch her when she sits on the bed."

A witness statement documented on 2/26/14 from E4 reads: We couldn't get her to calm down so I left the room and [E5] left behind me. Shortly after we all left the room I was in the room next door. I heard some bumping and went back to her room and she was on the floor with blood coming from her face. And no one was in the room but her.

On 3/20/14 at 2:06 pm E6 (certified nurse

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assistant) stated R3 "was sitting on the side of the bed attempting to stand up. We were scared she was gonna fall. She became combative when we attempted to transfer her."

A witness statement documented on 2/26/14 from E6 reads: We went to the room and R3 start cursing us out saying she don't know either one of us so she is not going anywhere and that we can forget about trying to touch her. I went back to my assignment. About 20 minutes later I heard that she had fell and she was on her way out with 911. R1 was sent to the local hospital for evaluation and treatment.

Hospital record review:

Physician Progress Note with a print date of 3/7/14 read: Admitting diagnoses: 1. Oral bleeding like mouth bleed due to coagulopathy and recent trauma and falls. The patient also has significant contusion, soft tissue tenderness and a mandibular fracture and maybe submitted hematoma.

Nurses Notes dated 2/26/14 at 6:00 am reads: Resident returned to the facility with four sutures to the inside of the mouth that will dissolve. Seven sutures under the lower lip to be taken out in 3-5 days.

Facility care plan, date initiated 12/4/13 reads: The resident exhibits the symptoms of resisting care as manifested by refusing care and refusing dialysis. Resident is also being physical and aggressive with staff by scratching them during care. Resisting care is related to: misunderstanding caregiver requests. Interventions: emphasize soothing, kind slow, and compassionate speech. Do not rush or hurry the

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resident. Use body language that communicates patience. Refer the resident to the consulting psychiatrist for a psychiatric evaluation, as warranted.

Facility care plan, date initiated 12/11/13 reads: Is at high risk for falls characterized by multiple risk factors related to: impaired balance, poor judgement, and poor safety awareness. Interventions: 1/29/14 Resident educated to use call light for assistance when needed. Staff to make frequent rounds when resident is in room alone to ensure safety. Staff to get resident up from bed when not feeling tired. 2/14/14 physical therapy to screen to resident due to new onset attempted mobility.

Psychiatric Evaluation dated 1/30/14 reads:
Previous symptoms: excessive anxiety
Insight judgement: Impaired judgement, Impaired insight
Overt Behavior(s): memory loss and confusion

Behavior Management Policy reads: In the event of a behavior emergency, appropriate staff will attempt to diffuse the situation, notify the attending physician and the psychiatrist and maintain the safety of the resident with escalating behavior as well as the other residents in the immediate area.
Maintaining safety was not implemented .Staff left the resident alone sitting on the side of the bed. There is no documented evidence that the physician was notified of behaviors prior to the fall incident.

On 3/20/14 at 10:35 am E2 (director of nurses) stated "They should have stayed with the resident, not touched her, but stayed with her until she calmed down. They should not have left her

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