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 07/10/2014

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
S9999	Final Observations STATEMENT OF LICENSURE VIOLATION 300.610a) 300.1210b) 300.1210d)6) 300.1220b)3) 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 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.	S9999		

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 07/10/2014

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
S9999	Continued From page 1 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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. 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 are not met as evidenced by:	S9999		

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 07/10/2014

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
S9999	Continued From page 2	S9999		

Based on record review and interview the facility failed to ensure one resident (R2) in the sample of four reviewed for falls with injury received immediate care and services after a change in medical conditon after two separate fall incidents which resulted in major injuries to R2's right eye and face and altered mental status. This failure resulted in the delayment of treatment and services and subsequent hospital admission.
In addition facility failed to develop individualized interventions to decrease risk of falls and provide adequate supervision for one resident (R2) who experienced 3 out of 4 unwitnessed fall incidents with major injury in the sample of four residents reviewed for falls with major injury. This failure resulted in R2 sustaining facial trauma.

Findings include:

1. R2 is a 80 year old resident with diagnoses including Senile Dementia, Episodic Mood disorder and Chronic Obstructive Bronchitis with exacerbation. R2 has a personal history of falls while living in the community.

The incident note and incident/accident report both dated 2/18/14 indicate it was brought to E6's (night nurse supervisor) attention that R2 was sitting down in the middle of the hallway. No shoes or socks noted on his feet. R2 was assisted back to bed. MD (medical doctor) paged, awaiting return call.
There is no documentation to indicate if the MD answered the page. This was R2's second fall.

The health status note dated 2/19/14 at 2:16am indicates R2 received alert with periods of confusion. Receiving oxygen at 4 liters per nasal cannula. Oxygen saturation at 90%

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 07/10/2014

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
S9999	Continued From page 3	S9999		

At 3am, E6 noted R2 with labored breathing, unresponsive to tactile stimulation. Vital signs checked, Temperature 97.8, pulse 88, respirations 26, blood pressure 126/52, oxygen saturation 78% at 3 liters via nasal cannula. Oxygen increased to 6 liters.
There is no indication E6 notified R2's physician or E2 (director of nursing) of R2's change in condition.

At 7:05am, E4 (nurse) documents received R2 in room up in wheeled recliner warm to touch with eyes closed, labored breathing, responding slowly to verbal commands with jerking motions to upper and lower extremities. Oxygen nasal cannula in place, oxygenation 80%. Staff assisted R2 to bed. At time time R2's primary physician was notified. Orders were received to send R2 out to the hospital for evaluation. R2 was admitted to the hospital with a diagnosis of Altered Mental status.

The written statement dated 2/18/14 by E10 (CNA/certified nurse aide) indicates in part that R2 was not feeling well on the 11pm-7am shift. E10 informed the nurse (E6) what was going on. Written statements by E9 (dated 2/21/14) and E11 (dated 2/19/14) both CNAs (certified nurse aide) indicate E6 was made aware of R2 being slow to respond to stimulation and having difficulty breathing and E6 did not address R2's change in condition.

The Employee Memorandum (Progressive Disciplinary Form) dated 2/24/14 indicates:
E6 violated a general conduct rule when she neglected to ensure that a resident (R2) SBAR (Situation Background Assessment Response) assessment was completed, due to the resident having a change in his condition. In addition to

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 07/10/2014

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
S9999	Continued From page 4	S9999		

that, the resident (R2) continued to decline throughout the night, yet employee did not intervene and treat appropriately. Moreover, the resident had to be sent to the hospital by the relieving nurse (E4) and was admitted to ICU (intensive care unit).

E6 was terminated shortly thereafter and was not available for interview.

The policy and procedure for Physician Notification of Resident Change of Condition indicates:

Policy:
The resident's attending physician will be notified of changes that occur in the residents condition by Licensed Personnel as warranted. Physician notification is to include, but not limited to the following:

b. significant change in /or unstable vital signs.

d. Any Accident or Incident with or without injury. i.e. falls, skin tears,
bruising, etc.

j. Change in Level of Consciousness

Responsibility:

It is the responsibility of the Charge Nurse to notify the physician of any changes in a resident's condition.

Procedure:

When a change has been noted in a resident's condition, the Charge Nurse must assess the resident, document the change in the resident's

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 07/10/2014

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
S9999	Continued From page 5	S9999		

medical record and notify residents attending physician.

2. The incident note dated 5/14/14 at 6:50pm indicates R2 was found on the floor. R2 sustained a hematoma to the right forehead and complained of head pain.

The Health Status Note dated 5/15/14 indicates at 7:45am R2 was noted upon assessment with right pupil fixed and dilated. R2's primary physician was notified and gave orders to send R2 to the hospital for evaluation and treatment related to change in LOC (level of consciousness). At 7:55am the ambulance was called. ETA (estimated time of arrival) of 20 minutes.

The investigation Report (5/15/15) indicates at 8:03am E8 (night shift supervisor) called the hospital and spoke to the ER (emergency room) nurse who stated to hang up the phone and call 911.

On 5/29/14 at 4:20pm via telephone, E8 stated, "my last time seeing him (R2) was around 6:30am for meds. All he said was ok."
After reading E8's written statement and was asked why 911 wasn't called initially, E8 stated, "we have the liberty to call 911. I was following the doctor's order to sent him out to the hospital. Yes, I did speak to the ER (emergency room) nurse at the hospital. She did say call 911. To be honest, everything was moving pretty fast."

At 8:15am, the ambulance was canceled, 911 called. R2 was transported via stretcher at documented time of 8:30am. Unresponsive to verbal stimuli.
A total of 25 minutes passed before 911 was

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 07/10/2014

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
S9999	Continued From page 6	S9999		

called. An additional 20 minutes passed before R2 was transported out of the facility.

On 7/1/14 at 12:50pm via telephone Z1 stated, "the hospital staff told us if he (R2) could have been sent out sooner, they could have drained the fluid off his brain and maybe he wouldn't have died so quickly. They couldn't do anything else, it was too late."

Review of the hospital records dated 5/15/14 - 5/16/14 indicate R2 was admitted to the CCU (coronary care unit) with diagnoses of Intraparenchymal hemorrhage of brain, Subdural hemorrhage, Uncal herniation, Respiratory failure and Blunt head trauma, initial encounter.
R2 went into cardiac arrest and expired on 5/16/14 at 3:08am.

The Certification of Death Record indicates the immediate cause of death as Cerebral Injuries due to Fall.

The accident/incident report dated 1/18/14 indicates at 3:40pm, R2 was observed on the floor in a sitting position, face against the wall on the right side. R2 sustained a quarter sized hematoma over the right eye.
The Health Status Note dated 1/19/14 indicates R2 developed swelling and bruising dark in color noted to right side of face with eye closed. R2 informed E4 (nurse) he fell the previous night when he got out of the chair.

The fall assessment dated 1/17/14 indicates a score of 11.0, moderate risk.
The fall assessment dated 1/18/14 indicates a score of 13.0, moderate fall risk.

The physician's orders dated 1/26/14 indicates to

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 07/10/2014

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
S9999	Continued From page 7	S9999		

use a soft waist belt for decreased sitting balance and poor trunk stability. The fall assessment dated 1/21/14 indicates R2 is a high risk, score of 19.0 Individualize the care plan intervention

On 5/28/14 at 1:15pm E3 (assistant director of nursing/ADON) stated, "we assessed him. A clip alarm was tried before the soft belt. The clip alarm wasn't effective. He would get up and want to walk. The belt was a (brand name) hook and loop belt. He could take it off sometimes."
When asked what medical symptom is being treated by using this belt, E3 stated, "confused state of mind. It helped him stay seated."

The care plan (initiated 1/20/14) has interventions for safe environment, anticipate and meet needs of the resident, ensure call light within reach, low bed with bilateral floor mats, refer to therapy, educate resident family and caregivers, ensure resident wears appropriate footwear, follow facility fall protocol.

The incident note and incident/accident report both dated 2/18/14 indicate it was brought to E6's (night nurse supervisor) attention that R2 was sitting down in the middle of the hallway. No shoes or socks noted on his feet. R2 was assisted back to bed. MD (medical doctor) paged, awaiting return call.
There is no documentation to indicate if the MD answered the page. This was R2's second unwitnessed fall.

On 5/22/14 at 7:10pm E2 (director of nursing) stated, "I'm the fall coordinator. The first thing the nurse is to do after a fall is an assessment, determine the severity of the injury, neuro checks, assist the resident back to bed or chair and if there are injuries, get physician's orders."

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 07/10/2014

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
S9999	Continued From page 8	S9999		

The revised care plan interventions dated 2/18/14 are:
1) educated D wing staff on the importance of ensuring resident has proper footwear on
2) educated staff on importance of ensuring that residents call light is attached to his chair or side rail for easy access.
There is no intervention listed for increased monitoring of R2.

The readmission fall assessment dated 2/26/14 indicates a score of 15.0, moderate fall risk.

The incident note dated 5/11/14 at 7:45am indicates upon entering the room R2 was noted in chair, back on chair against the floor, head on the wall. R2 noted to have shoes, floor free from clutter. R2 assessed, no injuries noted.
The fall assessment dated 5/12/14 indicates a score of 14.0, indicating R2 is a moderate fall risk.

The care plan intervention dated 5/11/14 indicates "added anti-tippers to resident's wheelchair to prevent resident from leaning backwards while sitting in the wheelchair, recommend MD (medical doctor) evaluate resident for any un-diagnosed medical condition, which might contribute to falls.
There are no interventions listed for increased monitoring of R2.

On 5/29/14 at 9:45am E2 stated, "he (R2) was leaning backwards in his chair. He was in a wheelchair. The back of the chair was on the floor and his head was against the wall. The anti-tippers for the wheelchair was the only intervention added to the careplan. That was for the staff. There is no intervention for the

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 07/10/2014

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
S9999	Continued From page 9	S9999		

resident."

The incident note dated 5/14/14 at 6:50pm indicates R2 was found on the floor by his roommate. R2 was attempting to walk to bathroom and fell to floor. R2 sustained a hematoma to the right forehead and complained of head pain. Resident assessed, given acetaminophen 650mg for pain.

The fall assessment dated 5/14/14 indicates a score of 19.0, high fall risk.
The care plan intervention dated 5/14/14 is neuro checks initiated, ice pack applied to site of hematoma.
All of the care plan interventions do not include the information from the fall assessments to aid in developing and implementing a individualized care plan for R2.

On 5/29/14 at 9:45am E2 stated, "he (R2) got out of bed with the nasal cannula attached to the concentrator. It drew him backwards and he fell to the floor near the roommate's foot of the bed. At 4:35pm E9 (CNA/certified nurse aide) stated, "he (R2) used to try to crawl out of the bed. I usually sit in his doorway so I could monitor him He wasn't steady."

The Health Status Note dated 5/15/14 indicates at 7:45am R2 was noted upon assessment with right pupil fixed and dilated. R2's primary physician was notified and gave orders to send R2 to the hospital for evaluation and treatment related to change in LOC (level of consciousness).
The next Health Status note entry at 3:36pm indicates R2 was in CCU (cardiac care unit) admitted with intracranial bleeding.

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 07/10/2014

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
S9999	Continued From page 10 Review of the hospital records dated 5/15/14 - 5/16/14 indicate R2 was admitted to the CCU (coronary care unit) with diagnoses of Intraparenchymal hemorrhage of brain, Subdural hemorrhage, Uncal herniation, Respiratory failure and Blunt head trauma, initial encounter. R2 went into cardiac arrest and expired on 5/16/14 at 3:08am. The Certification of Death Record indicates the immediate cause of death as Cerebral Injuries due to Fall. On 7/1/14 at 12:50pm via telephone Z1 stated, "the hospital staff told us if he (R2) could have been sent out sooner, they could have drained the fluid off his brain and maybe he wouldn't have died so quickly. They couldn't do anything else, it was too late." Several unsuccessful attempts were made to interview Z2 regarding R2's falls. The Facility Fall Program (dated 5/22/14) includes several interventions including Update Fall Assessment, Initiate Fall Interventions and Update Care Plan. On 7/9/14 at 12:20pm via telephone, E2 (director of nursing) was asked if the Facility Fall Program document is considered their fall policy and procedure. E2 stated, "no, I can fax a copy to you." E2 faxed a copy of the facility's Accident's & Incidents policy and procedure. Review of this policy and procedure does not specifically indicate nursing staff's responsibility related to fall incidents.	S9999		

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 07/10/2014

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
S9999	Continued From page 11 At 2:25pm via telephone, E1 (admnistrator) was asked if the Accidents & Incidents policy and procedure is considered the fall policy and procedure. E1 stated, "that's what we use for falls. The fall check off is what we use also. It's a mirror of the Accident & Incident policy." (AA)	S9999		

GLENWOOD HEALTHCARE COMPLAINT SURVEY OF JULY 10, 2014
PLAN OF CORRECTION

Preparation and execution of this Plan of Correction does not constitute an admission or a greement by Glenwood Healthcare and Rehabilitation Center to the allegation or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by provisions of federal and state law. None of the actions taken by the facility pursuant to its Plan of Correction should be considered an admission that a deficiency or that additional measures should have been in place at the time of survey

F309: 483.25
The facility will continue to ensure all residents must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care.

- **R2** was discharged from the facility on **5/15/2014.**
- **E6** was disciplined, on **2/24/14**, for failure to complete the SBAR (Situation, Background, Assessment, and Recommendation) form.
- No other residents were affected.

Plan of Correction:

1. All licensed nurses were re-inserviced on **07/16/14** on the facility's policy and procedures on reporting a change in a resident's condition. (Exhibit # 9)
2. All licensed nurses were re-inserviced on **07/16/14** on the importance of completing the SBAR form to document any resident's change in condition. (Exhibit # 10)
2. The facility implemented a new policy & procedure for Accidents/Incidents with Head Involvement/Injury, on **05/30/2014**, which gives detailed instructions for immediate actions to take, up to and including calling 911 for emergency services and treatment, of resident's with head injuries. (Exhibit # 11)
4. DON/Designee will conduct routine Change in Condition Audits, at least 2-3 times per month, for the next 3 months, to ensure that all licensed Nurses are follo wing the facility's
   Policy and Procedures on reporting a change in the resident's condition. (Exhibit # 12-16)
6. DON responsible for achieving and maintaining compliance.
7. Administrator will oversee for continued compliance.

Date of Completion – July 18, 2014

GLENWOOD HEALTHCARE COMPLAINT SURVEY JULY 10, 2014
PLAN OF CORRECTION

The preparation and execution of this Plan of Correction does not constitute and admission or agreement by Glenwood Healthcare & Rehab to the allegations or conclusion set forth in the statement of deficiencies. The Plan of Correction is prepared and executed solely because it is required by provisions of Federal and State law. None of the actions taken by the facility pursuant to its Plan of Correction should be considered and admission that a deficiency existed or that additional measures should have been in place at the time of the survey.

F323: 483.25 (h) Accidents/Hazards/Supervision & Devices

The facility will continue to ensure that the resident environment remains as free of accident hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

- On **5/30/14**, the facility implemented a more comprehensive Fall Program including a Fall Management Progression scale, Fall Meeting Guidelines, Fall Prevention Tool Box, Timeline Investigative Report, and several different types of individualized Fall Interventions. (Exhibit # 17-21)
- **R2** was discharged from the facility on **5/15/2014**.
- No other residents were affected.

Plan of Correction:

1. All Nursing staff was inserviced on the facility's updated Fall Program on **06/02/14**. (Exhibit # 22)
2. All licensed nurses were inserviced on mandatory compliance of IDPH tags F221, F309, and F323 via an Outside Consulting agency, on **7/15/14**. (Exhibit # 23-24)
3. All licensed nurses were re-inserviced on **7/16/14**, regarding their respective roles and responsibilities for implementing individualized interventions for residents, immediately after any Accident/Incidents. (Exhibit # 25)
4. The DON/Designee will perform random audits of Resident Incidents and Accidents at least weekly, to ensure that the facility's Fall Program protocols are being followed. (Exhibit # 26-30)
5. Audit results will be reviewed weekly by the Administrator. Audit results will also be incorporated into the facility's existing Quality Assurance process with evaluation of trends/patterns and corrective actions as indicated.
6. Director of Nursing will be responsible for achieving and maintaining compliance.
7. Administrator oversees for continued compliance.

Date of Completion – July 18, 2014