| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145268 | A. BUILDING _____ B. WING _____ | C 01/07/2021 |

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

| (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) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS<br><br>Complaint Investigation Survey<br><br>#2095055/IL124306-No def.<br>#2095074/IL124327-No def.<br>#2096947/IL126418-No def.<br><br>Incident Report Investigation Survey<br><br>IL125871 -3/19/20-F689 cited<br>IL127343 -9/17/20-No def. | F 000 | | |
| F 689 SS=G | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the facility failed to ensure a resident was transferred using two people during a mechanical lift transfer. This failure lead to R4 falling out of the mechanical lift and sustaining a sacral fracture. This applies to 1 of 3 residents (R4) reviewed for falls in the sample of 8.<br><br>The findings include:<br><br>The facility's investigation report dated March 19, 2020 for R4 shows, "...On 3/19/20 at 7:15 PM resident had a fall while being transferred from wheel chair to bed via mechanical lift. CNA | F 689 | 1. Corrective Actions which will be accomplished for those residents found to have been affected by the citation:<br><br>• R4 is no longer a resident at Glenview Terrace, but was sent to ER and treated appropriately at the time of incident.<br>• V3 was educated on the correct procedures for transferring residents via hoyer lift.<br><br>2. How the facility will identify other residents having the potential to be affected by the same citation. | 1/25/21 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 01/25/2021

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| F 689 | Continued From page 1<br>(Certified Nursing Assistant) was present at the time and attempted to prevent the fall but was unable... Sent resident to ER (emergency room) via 911. Called local ER at 4:30 AM talked with nurse, R4 admitted with sacral fracture..."<br><br>The progress note for R4 dated March 19, 2020 shows, "While CNA transferring resident after dinner, from wheel chair to bed using mechanical lift, mechanical lift started tilting, CNA managed to lower her and became beyond control, resident fell with the mechanical lift... Resident is sent to local hospital by calling 911 at 7:20 PM. Resident complained about back pain after the fall. Had a small cut on the left heel, 4 mm (millimeter) long..."<br><br>The local hospital's history of present illness dated March 19, 2020 shows, "R4 is a 77 year old female with past medical history of CVA (cerebrovascular accident) with right hemiparesis, OSA (obstructive sleep apnea), morbid obesity, atrial fibrillation on coumadin, diabetes mellitus type II, hypertension, hyperlipidemia, gastroesophageal reflux disease, chronic kidney disease stage 4 who presents from SNF (skilled nursing facility) with fall and low back pain. Patient says she was dropped while in mechanical lift at SNF. Patient reportedly fell a distance of 3 feet and landing on her low back..."<br><br>R4's ct scan of the lumbar spine with out contrast on March 19, 2020 shows, "Impression: 1. Acute fractures right L2, right L3, and probably right L5 transverse processes. Questionable right L1 transverse process fracture. 2. Acute fractures involving the right sacrum. 3. Multilevel lumbar spondylosis." | F 689 | • It is the responsibility of Glenview Terrace Nursing Center to assure that all residents are free of accidents.<br><br>3. The measures the facility will take or systems the facility will alter that the problem will be corrected and will not recur.<br><br>• Orientation and annual competencies have been put in place to assure staff are trained on the use of hoyer lift with 2 persons.<br>• All staff have been in-serviced on the importance of having two persons assist with the use of a hoyer lift<br>• A QA Audit tool has been created to assure we are staying in compliance with using hoyer lifts appropriately.<br><br>4. Quality Assurance Plans to monitor facility performance to ensure that corrections are achieved and are permanent.<br><br>The Restorative Director, and or designee will be responsible for monitoring facilities compliance. QA Audit tools and all of these issues will be reviewed and discussed at the QA meetings to ensure the systems, forms and policies in place are effective. | |

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| F 689 | Continued From page 2 | F 689 | | |

The facility's statement filled out by V3 CNA dated March 19, 2020 shows, "Did you witness the fall? If yes, please describe how the fall happened. "Yes, I was trying to put the patient (R4) to bed with mechanical lift. After lifting her up from the chair, moving her to the bed the mechanical lift swung to the side. I tried to control it but to no eval and I tried to ease the patient to the floor." Do you have any additional information that may describe how the fall occurred? "Not calling for assistance with transfer...".

The facility's record of disciplinary action for V3 CNA dated March 20, 2020 shows, "Brief description of incident/problem/misconduct: Failed to follow facility protocol on mechanical lift transfer to use two person assistance."

On January 6, 2021 at 10:04 AM, V5 CNA stated, mechanical lifts are always done with 2 people. "We train new CNAs to make sure there is 2 people no matter what."

On January 6, 2021 at 11:38 AM, V4 Nursing Supervisor stated, "It happened on PM shift. R4 was transferred by CNA (V3) and then heard she was dropped on the floor. The mechanical lift should have 2 persons for transfers. I don't know why she did the transfer by her self. We train them to use 2 persons."

R4's minimum data set dated January 21, 2020 shows, she is total dependence for transfers of 2 persons.

R4's care plan initiated on June 27, 2018 shows, Focus: Self care- R4 has an ADL (activities of daily living) self care performance deficit related to CVA with left side weakness, status post fall

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| F 689 | Continued From page 3<br>with sacrum fracture. Interventions: Transfer with 2 person total assist, use mechanical lift. | F 689 | | |