Illinois Department of Public Health

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 10/12/2018

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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S 000	Initial Comments Complaint Investigation 1896372/IL106139 1896073/IL105816 1895795/IL105509 1895465/IL105129 - F610, F684, F776	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 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	S9999	Attachment A Statement of Licensure Violations	

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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.

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)

This requirement was not met evidenced by:

Based on observation, interviews, and record review the facility failed to conduct an initial assessment and evaluation of a swollen arm for 1 (R2) of 4 residents reviewed for quality of care. This failure resulted in R2 being observed with a swollen arm on 8/6/2018 and no assessment, evaluation or X-ray until 8/9/2018 and another delay in reporting the results of the abnormal x-ray until 8/11/2018 with findings that R2 had a dislocated right shoulder.

Findings:

On 9/25/18 at 11 AM a review of the resident records was conducted. On 8/6/18 at 7:10 AM V12 (Hospice Registered Nurse / RN) notes "Patient noted with edema to the upper right arm..., Informed facility nurse (R2's assigned nurse V9 (Licensed Practical Nurse) of the

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edema to R2 right arm." R2's resident record noted 8/7/18 at 1:28 PM by V9 (Licensed Practical Nurse / LPN) "Nurse alerted to observe resident. (Alerted by Hospice Certified Nursing Assistant (V13)). Right upper arm appears swollen. Resident was able to move arm with help from nursing staff. (Assistance with movement up and down and circular. R2 had no physical impairments to her upper extremities prior to the incurring edema to her upper arm. Taken from Minimum Data Sheet Report dated 8/12/18 Section G Functional Limitation in Range of Motion Upper Extremities coded 0 No Impairment) No distress or pain noted while assessing patient. Nurse Practitioner notified. (Nurse Practitioner informed nurse to have Hospice Nurse assess arm the following day 8/8/18).Will Follow Up with hospice."

On 8/8/18 at 2:27 PM V14 (Registered Nurse / RN) noted "Read in progress note that this resident had swelling to her right upper arm. Nurse Practitioner made aware of this condition last night. Resident is able to lift arm with assist. No contractures, no bruising, no pitting edema. Appears to be in no pain. Hospice nurse is to arrive on PM shift and decide if she wants to order an x-ray. Nurse Practitioner, Hospice Nurse, and Director of Nursing notified of situation. Right arm elevated high on pillow. Arm feels normal body temperature. Will continue to monitor."

On 8/8/18 No Hospice Nurse arrived at facility to examine resident on 8/8/18 but the scheduled Hospice Certified Nursing Assistant attended to R2. No Order for x-ray obtained or reached out for by facility.

On 8/9/18 at 10 AM V15 (Hospice Licensed

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Practical Nurse) notes "Arm elevated on pillow, x-ray ordered..., Edema Right Arm."

On 8/9/18 at 10:08 PM V8 (Licensed Practical Nurse) notes "Resident continues on hospice.., right arm noted with edema. Range of Motion to right upper extremities tolerated well without pain or limits. Medical Doctor (Not MD (V17) but Nurse Practitioner (V7)) noted orders obtained for x-ray of entire right upper extremity. Mobile x-ray company contacted will be out tonight."

On 8/11/18 at 5:10 AM V11 (Licensed Practical Nurse) noted "call placed to mobile x-ray to follow up on x-ray results of right arm. Impression: right shoulder, scapula, clavicle, and humerus: antererior dislocation of the humeral head with no fracture noted at this time. (Head of bone out of socket of arm.) Right arm is swollen and warm, painful to the touch..., Hospice nurse contacted and made aware of results. Hospice Nurse (V16) stated "we will not give any orders and the facility should contact primary care physician. Primary Care Physician should follow up with this matter." Medical doctor (V17) paged two times still awaiting a response. Nurse Practitioner, Director of Nursing, House Supervisor, Nurse Consultant, Administrator, and Family all made aware. Received order from nurse consultant to send resident out to the hospital emergency room for evaluation due to injury of unknown origin...,"

On 9/26/18 at 2 PM V2 (Director Of Nursing / DON) stated "Staff did not get ahold of me on 8/7/18. I later noted that R2 had edema to her right arm (8/9/18) but no pain and no abnormalities in range of motion." They were informed by the Nurse Practitioner to contact hospice to see what hospice wanted to do. (Hospice informed facility that R2's admission to

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Hospice was for Organic Brain Issues and Dementia and they had no oversight regarding the edema to the arm). On 8/9/18 the nurse called the Nurse Practitioner and obtained an order for an x-ray. We obtained the x-ray on 8/9/18. We have been having problems with our mobile x-ray company requiring us to call for the results of our X-rays, we did not get the results till we called on 8/11/18. After speaking with mobile x-ray we learned of the dislocation on 8/11/18. The x-ray was ordered on 8/9/18 at 10:55 PM and taken an hour or so after that. Did not know results till we contacted the mobile x-ray company and they faxed results over on 8/11/18. Resident was then sent to the hospital for evaluation of the arm. That is when V1 (Administrator) began investigation for injury of unknown origin."

On 9/27/18 at 2 PM V18 (Mobile X-ray Director) stated "We obtained the x-ray order on 8/9/18 at 10:54 PM. The x-ray was obtained after 11 PM that night. The results were read early the next morning on 8/10/18. We waited till 5:52 AM on 8/10/18 to fax the order. On 8/10/18 at 6:10 AM we attempted to call the facility three times. No one answered the phone. We tried one additional time to call the facility at 6:15 AM. There was still no answer. However we had already faxed the results that morning at 5:52 AM." Surveyor asked about the mobile x-ray's policy of calling. V18 stated "We fax the results and call." Surveyor asked Do you call till you get someone? V18 answered "We call till we get someone but did not accomplish that on this incident." Surveyor asked for a copy of the facility policy and the x-ray results with the callers initials on the results with times of fax and calls as V18 claimed he had the copy indicating attempts and fax time. After two requests, never received requested material.

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S9999	Continued From page 5 On 9/27/18 at 10 AM V7 (Nurse Practitioner) stated "I was out of town during this weekend of R2's edema to her arm. I was taking call via phone text messages and return phone calls. On 8/7/18 V9 (Licensed Practical Nurse) messaged me about R2's arm. I called back and was informed that the arm had edema but no pain, deformity, or limitations to her movement. As R2 was under the care of hospice, I informed the nurse to have the hospice nurse assess the resident when she comes to the facility." V7 was asked about her expectations regarding monitoring R2 during this time of edema from an unknown origin. V7 stated "I would expect the nurses to assess for any pain, deformity, comfort, and document these observations on every shift..., I felt they did monitor her." V7 further added "Yes R2 could have tolerated range of motion to her arm with the dislocation. The range of motion may even have been easier. I am a nurse practitioner, I do not need to call to inform the medical doctor as I can operate independently." On 10/3/18 at 9 AM V2 (Director of Nursing) stated "I never spoke with the nurses on 8/6/18 through 8/8/18. I did note that V14 (Registered Nurse) had documented on the chart that she contacted me on 8/8/18 but I did not receive any communication from her on that day. In addition, R2 was a under the care of hospice here at the facility. Due to R2's age and clinical condition it was not uncommon for a hospice patient to have swelling. Swelling was nothing to be alarmed about. I was first made aware of R2's arm on 8/9/18. When we received the x-ray results of the dislocation on 8/11/18, I then came into the facility. V1 (Administrator) had begun an investigation of injury of unknown origin on 8/11/18."	S9999		

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On 10/3/18 at 11 AM V1 (Administrator) provided the policy for Accident Incident Reporting Policy (dated 8/3/17). The policy notes " Any accident/incident may be reported immediately to the nurse or appropriate person designated to be in charge. A report may be completed for any individual involved in an accident or an incident while residing in the facility..., The physician/nurse practitioner may be informed of any changes in the resident's condition that have been identified. Orders for treatment/intervention may be obtained as deemed necessary. If the attending physician or physician on call can not be reached, the Medical Director should be notified and orders obtained as necessary. Any actions or communications are to be documented in the resident's medical record."

On 10/3/18 at 11 AM V1 provided the policy entitled Change in Resident's Condition or Status (dated 6/26/11). The policy notes "The Nurse will notify the resident's attending physician when the resident is involved in any accident or incident that results in an injury including injuries of unknown origin..., There is a significant change in the resident's physical, mental, and psychosocial status..., A significant change in condition is a decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions, impacts more than one area of the resident's health status, and requires interdisciplinary review and/or revision of the care plan..., the nurse will record in the resident's medical record any changes in the resident's medical condition or status."

On 10/8/18 at 1 PM a review of R2's Medical

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Record was conducted. It was noted that R2's documentation of her medical condition was noted on 8/7/18, 8/8/18, 8/9/18, 8/11/18. On 8/7/18 documentation occurred at 1:28 PM and 10:25 PM. There was no documentation on night shift. On 8/8/18 documentation at 2:27 PM. There was no documentation on afternoon shift or night shift. On 8/9/18 there was documentation at 10:08 PM. There was no documentation on day shift or night shift. On 8/10/18 there was no documentation on days, afternoons or night shifts. On 8/11/18 documentation at 1:02 AM and 5:10 AM. After having received orders to transfer resident to hospital for evaluation at 5:10 AM, there are no further documentation of resident assessment, ambulance transfer, nor notifications documented in resident chart.

On 9/27/18 at 10 AM V7 (Nurse Practitioner) stated "I was out of town during this weekend of R2's edema to her arm. I was taking call via phone text messages and return phone calls. On 8/7/18 V9 (Licensed Practical Nurse) messaged me about R2's arm. I called back and was informed that the arm had edema but no pain, deformity, or limitations to her movement. As R2 was under the care of hospice, I informed the nurse to have the hospice nurse assess the resident when she comes to the facility." V7 was asked about her expectations regarding monitoring R2 during this time of edema from an unknown origin. V7 stated "I would expect the nurses to assess for any pain, deformity, comfort, and document these observations on every shift..., I felt they did monitor her." V7 further added "Yes R2 could have tolerated range of motion to her arm with the dislocation. The range of motion may even have been easier. I am a nurse practitioner, I do not need to call to inform

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S9999	Continued From page 8 the medical doctor as I can operate independently." On 9/26/18 at 10 AM V7 (Nurse Practitioner) stated "I was texted on 8/7/18 of the edema to R2's arm. (See narrative above). No one ever interviewed me regarding the arm for any incident or injury or unknown origin." On 9/27/18 at 1:10 PM V11 (Licensed Practical Nurse) "I worked with R2 on 8/11/18 and called for the x-ray results. However, I was not questioned about the injury or incident regarding R2." On 10/3/18 at 10 AM V12 (Hospice Registered Nurse) stated "I saw the edema to R2's arm. I reported it to the facility nurse (V9) on 8/6/18. No one ever asked me about the injury or incident." On 10/3/18 at 9 AM V2 (Director of Nursing) stated "I never spoke with the nurses on 8/6/18 through 8/8/18. I did note that V14 (Registered Nurse) had documented on the chart that she contacted me on 8/8/18 but I did not receive any communication from her on that day. In addition, R2 was a under the care of hospice here at the facility. Due to R2's age and clinical condition it was not uncommon for a hospice patient to have swelling. Swelling was nothing to be alarmed about. I was first made aware of R2's arm on 8/9/18. When we received the x-ray results of the dislocation on 8/11/18, I then came into the facility. V1 (Administrator) had begun an investigation of injury of unknown origin on 8/11/18." On 10/3/18 at 11 AM V1 (Administrator) provided the policy for Accident Incident Reporting Policy (dated 8/3/17). The policy notes " Any	S9999		

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accident/incident may be reported immediately to the nurse or appropriate person designated to be in charge. A report may be completed for any individual involved in an accident or an incident while residing in the facility..., The physician/nurse practitioner may be informed of any changes in the resident's condition that have been identified. Orders for treatment/intervention may be obtained as deemed necessary. If the attending physician or physician on call can not be reached, the Medical Director should be notified and orders obtained as necessary. Any actions or communications are to be documented in the resident's medical record."

On 10/3/18 at 11 AM V1 provided the policy entitled Change in Resident's Condition or Status (dated 6/26/11). The policy notes "The Nurse will notify the resident's attending physician when the resident is involved in any accident or incident that results in an injury including injuries of unknown origin..., There is a significant change in the resident's physical, mental, and psychosocial status..., A significant change in condition is a decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions, impacts more than one area of the resident's health status, and requires interdisciplinary review and/or revision of the care plan..., the nurse will record in the resident's medical record any changes in the resident's medical condition or status."

On 10/8/18 at 1 PM a review of R2's Medical Record was conducted. It was noted that documentation of R2's medical condition was noted on 8/7/18, 8/8/18, 8/9/18, and 8/11/18. On 8/7/18 documentation occurred at 1:28 PM and

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S9999	Continued From page 11 new Director of Nursing. However I did not read the 24 hour report. The night shift nurse did not give me report as we should have done on 'stand up and no I did not read the hospice communication log..., To me when I observed the shoulder, it looked to me as some sort of fluid filled sack on the ball joint of the shoulder." On 10/2/18 at 10 AM V1 (Administrator) stated "I did not know about the arm swelling on 8/6/18. Although when I was aware of the edema, I did not read the Hospice Communication Log." (The communication log was taken back by Hospice on the day she was sent to the hospital for evaluation. When Hospice was called to get the log, they stated it was an internal communication material and destroyed when it was returned to the hospice office.) V1 stated "I did not know of the incident/unknown injury until 8/11/18. Staff have been trained on what to do when there is an injury of unknown origin. I believe they followed our policy on change in condition when they got the x-ray results. I am not sure where any other documentation may have been communicated besides the progress notes, 24 hour log and the hospice communication log. I am aware that there was no documentation regarding R2's arm on 8/18/18 and am not sure why none was recorded. We did not start the investigation until 8/11/18 as we did not believe there was an injury or incident until 8/11/18 when we learned of the x-ray results. I agree there was a period of time delay from the injury till the x-ray was taken. This occurred as this patient is a hospice patient and hospice becomes the primary whenever they have a patient. We did not suspect abuse when we learned the first reports on 8/7/18. We did not initiate a reported from 8/6/18 through 8/10/18. We started the reportable of injury of unknown origin on 8/11/18. I had the shift nurse supervisor	S9999		

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(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 12	S9999		

do the interviews. I sent in the initial report and the final was completed by the Director of Nursing."

On 10/2/18 at 2 PM V17 (R2's Primary Care Physician) stated "This patient is a hospice patient and has been for over a year and a half. The nurses and nurse practitioner reported to me that there was no pain or deformity to the patient's arm. The patient was able to have range of motion to her arm with assistance. As hospice is comfort care, we provided comfort for R2 by placing her arm on a pillow to decrease the swelling. We do not normally send hospice patients out or do any intervention that are aggressive." Surveyor asked if V17 thought a hospice nurse should have been sent out or called hospice or facility medical directors. V17 stated "This was just swelling to the arm. Hospice patients have swelling commonly. If hospice drops the ball, the facility nurses should then call me. In this situation as they were not able to contact me, they did not need to call the facility medical director as this was just swelling or the arm in the beginning and the nurse did not report any deformity or pain. Patient care come first."

On 9/26/18 at 10:50 AM V8 (Licensed Practical Nurse) stated "I noted the swelling and the resident did not appear to have any pain. I called the nurse practitioner (V7) and she gave an order for the x-ray. At the time the arm looked pretty swollen. I do not remember if it was swollen all the way down to the hand. I left a message with the Power of Attorney (POA). I took vital signs and they were within normal limits. I left a message with the hospice 24 hour phone line around 7 to 8 PM. I believe the hospice nurse was there that day on 8/9/18." On 10/3/18 V8 stated "I did do range of motion with R2 when I

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 10/12/2018

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S9999	Continued From page 13	S9999		

assessed her. I would lift the arm up in front of her and to the side. I also did small circular motions. I did not see any facial grimacing nor did she moan. During this time, I did try calling V17 (Medical Doctor) but only paged and did not receive a return call. I called the mobile x-ray around 10:55 PM on 8/9/18. They have up to 4 hours to come and do the x-ray as this was not a Stat (emergency) x-ray. We generally get the results the next day. I did not have anyone ask to interview me regarding R2's injury, incident or change of condition."

On 9/26/18 at 3:45 PM V6 (Hospice Director of Nursing) stated "As a hospice nurse or certified nursing assistant our duty is to report any issues to the facility nursing staff in charge of the patient. We intervene only when it is regarding any issue that the patient has been admitted for by hospice. R2 was admitted to hospice for organic brain issues or dementia. The edema to her arm was not under our reason for providing care."

On 10/8/18 at 10 AM V19, V20, V21 and V22 (Certified Nursing Assistants) stated "We were never interviewed regarding an investigation of a fall of unknown origin."

On 10/11/18 at 9 AM V20 (Certified Nursing Assistant) stated "I don't know how R2 incurred the injury to her arm. I worked with her all the way back from 8/7/18. In addition, I was never interviewed regarding any investigation of an injury of unknown origin."

(B)