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	04/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenview Terrace	1511 Greenwood Road Glenview, IL 60025

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35432 Based on observation, interview, and record review, the facility failed to provide adequate supervision to prevent serious injury to a resident. This failure affects one of three residents (R1) reviewed for falls in a total sample of six residents. This failure resulted in injuries to R1. R1 sustained facial fractures and skull fractures, acute nondisplaced fractures of bilateral sphenoid sinuses, non-displaced fractures of basilar portion of the occipital bone bilaterally, and acute nondisplaced fractures involving the postero-lateral walls of bilateral maxillary sinuses. R1 also had a small possible C6 fracture requiring a neck collar. R1 is a [AGE] year-old male. R1's diagnoses are but not limited to fracture at the base of the skull, eye bone fracture, Parkinsonism, heart disease, atrial fibrillation, history of falling, diabetes, high blood pressure, dementia, and hypothyroidism. R1's BIMS (Brief Interview for Mental Status) dated 3/18/2025, notes R1 is not very alert. R1's care plan notes R1 is at high risk for falls related to current medication use, poor safety awareness, unsteady gait, disease process: fall history, wedge compression fracture L4, paroxysmal AFIB (Atrial Fibrillation), Hypertension, Diabetes Mellitus, Dementia, Hypothyroidism, BPH (Benign Prostate Hypertrophy), and Peripheral Venous Insufficiency. R1 requires total assistance of two-person assistance using the mechanical lift with transfers due to generalized weakness, immobility, impaired mobility, and poor weight bearing control due to compression fracture superior L4, dementia & Parkinson's. On 04/05/2025, at 11:09 AM, R1 was upright in wheelchair, with a mechanical lift pad underneath him. R1 was sleeping. R1 moaned when spoken to but is not able to talk. R1 has a neck brace around his neck. There was bruising to the left lower eye. There were purple, green, and yellow colors. There were two steri-strips to the left forehead. Progress note dated 3/19/2025, notes R1 had a fall. Readmission note dated 3/22/2025, notes R1 has neck collar, and leg boots on. R1 has scattered echymotic areas, and stitches to his head. He is not in distress and does not seem to be in a lot of pain. He has black/blue discoloration to left eye, and multiple old dark blue spots. R1 is unable to verbalize pain, due to being non- verbal, but groans which is normal for him. He groans, and slow to response, but with good eye contact. Vitals are stable. (continued on next page)

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

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	04/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenview Terrace	1511 Greenwood Road Glenview, IL 60025

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Medical professional note dated 03/27/2025, notes R1 readmitted from 3/19/25-3/22/25 after fall. Imaging shows multiple facial fractures and skull fractures, acute nondisplaced fractures of bilateral sphenoid sinuses, non-displaced fractures of basilar portion of the occipital bone bilaterally, acute nondisplaced fractures involving the postero-lateral walls of bilateral maxillary sinuses. No intracranial hemorrhage. Small possible C6 fracture. Neurosurgery was consulted. Recommended Aspen collar (neck collar) for 4 weeks. R1 remains weak and was transferred back to the facility. Left peri-orbital area with purplish discoloration, stitches on left forehead intact. Aspen collar in-place. No neuro deficit. On 4/05/2025, at 11:06 AM, V1 (Certified Nursing Assistant) stated, R1 is not alert. He is a mechanical lift transfer. We are supposed to use two aides. I was told that he fell , that is why he has the neck brace. On 4/05/2025, at 11:35 AM, R2 (R1's Roommate) stated, I was getting off the elevator. I heard a page for staff to our room. I think she (Former Aide) might have pulled the pad too hard, and he fell out of bed. But I did not see it. On 4/05/2025, at 12:39 PM, V2 (Director of Nursing) stated, I believe the date was 3/19/2025, on the 3:00 PM to 11:00 PM shift. I initiated an investigation and spoke with the aide and the nurses. R1 is not alert or oriented. He is confused and wheelchair bound. He uses the mechanical lift. The aide was V4 (Former Certified Nursing Assistant) at the time. I believe the nurse was V5 (Agency Registered Nurse). The aide told me she was planning to transfer the resident from the wheelchair to the bed. She brought the patient into the room. She told the other aide that she needs help to transfer with mechanical lift. She waited. She was in front of the patient and there was a little bit of a distance away from R1. R1 had a jerky movement. He fell face down on the floor. V4 called everyone. V5 called a rapid response. Immediately, he was taken care of. There was a cut on his head. They immobilized him and sent him out. R1 has Parkinson's. He has been seen by a neurologist. He had falls at home multiple times. He is on a tapering dose by the neurologist. I believe that is why he had a jerky movement. I made them aware that he had a fall. The medication was discontinued, and he has a follow up appointment. A care plan meeting was held with the family. On 04/05/2025, at 1:09 PM, V5 stated, I was passing medication. I heard yelling from the aide. I ran into the room. The patient was on the floor. I checked the patient. He usually moans and he does not speak. I called his name. I saw he was bleeding from his head. I do not know how he fell . I immobilized him. I called a rapid response, and everyone rushed in. The ambulance came and he went to the hospital. Before he left, I gave him something for pain. R1 was laying on his side. He was on left side. I saw bleeding from his head and there was blood on his face. The aide was in there. Eventually, she said when she was trying to transfer the patient from the wheelchair to the bed; R1 had a jerky movement and he fell . The wheelchair was in the corner. To be honest, I did not go to check the wheelchair because my focus was on the patient. The aide had worked with him before and was pretty good. The wife was there before the event occurred. (continued on next page)

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	04/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenview Terrace	1511 Greenwood Road Glenview, IL 60025

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/05/2025, at 1:33 PM, V6 (Fall Coordinator/LPN) stated, I coordinate with admissions for high fall risk patients. R1 was identified as a high fall risk before the incident occurred. Prior to admission he had already sustained a fracture. According to the aide, she was preparing R1 to be assisted to bed. I believe he requires the mechanical lift for transfers. That requires two aides. While waiting for another staff to assist her, R1 had an involuntary movement that caused the fall. There was a bed and chair alarm in place, I did not ask her the question if the wheelchair was locked. I am not aware if the wheelchair was locked but it should be to prevent it from rolling backwards, forwards, and the resident falling out. She (the aide) did not mention if the wheelchair was locked, she just stated that he had a jerky movement. According to the nurse, she was passing medication at the time. Her attention was called due to the fall. The aide was alone in the room with the resident. The root cause of the fall was tapering his medication for Parkinson's, and he had a tremor. He had sustained a fracture before and may have had poor trunk control. There should always be two aides even before preparing to transfer a resident. I would stay with the resident while waiting for assistance. I would have that patient visible and if anything happens. I would to try to prevent the fall. If there was a jerky movement, I would try to prevent the resident from hitting any hard surfaces by moving away or staying beside him or in front of him to prevent him from falling; that can cause skin breakdown and fracture. That is my opinion as a nurse. When I interviewed the aide, she was crying. This was her first time dealing with this fall. I would expect my staff to have two people when transferring. The nurse stated that she did not see anything. On 4/05/2025, at 2:01 PM, V7 (Certified Nursing Assistant) stated, I was in another room with another resident. V4 asked me if I could come help her. Usually, we transfer people with two people assisting. I told her as soon as I was done, I will join her. She went back to the room and the rapid response was called. I saw her in front of the resident. She was trying to explain to the nurse, while she was waiting, R1 had a jerky movement in the wheelchair. I heard her say that she was trying to hold him, and he had a jerky movement. He fell out of the wheelchair. He fell face down. I think I saw the wheelchair locked. The nurse called for rapid response and people rushed in. On 4/05/2025, at 2:24 PM, V9 (Nurse Practitioner) stated, the facility notified me and told me R1 had a fall. The aide was there. R1 fell forward I think; that is what they said. If there were enough people there, the injuries could have been preventable. On 4/05/2025, at 3:10 PM, V10 (R1's Wife) stated, I was not here when R1 had the fall. I usually leave here around 6:30 PM. The facility told me that he had fallen, had a bloody nose and was sent to the hospital. I went to the hospital, and I was shocked. He had the neck collar on, was bleeding from the head, but his nose was not bleeding. The hospital stated he has multiple fractures to the skull, orbital bones, C6/C7 fractures and his sinuses on the roof of his mouth. He had stitches on his head. V2 told me the following: she was so sorry this happened, it was totally our fault. V4 had R1 in the mechanical lift alone and R1 slipped out. That person no longer works for us, and we are sorry that happened. Their incident report notes that V4 was not properly trained. We have retrained and gone over proper procedures. V10 continued, V2 told the neurologist that R1 had a tremor and fell out of his wheelchair. I have gotten three different stories from V2. R2 told me that V4 was still working two weeks ago. R4, the resident council president, told me that the aide was wiping blood off the floor and was angry about it. R4 saw R1 lying on his side. (continued on next page)

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	04/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenview Terrace	1511 Greenwood Road Glenview, IL 60025

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	On 04/05/2025, at 4:16 PM in an interview with R4 and R5, R4 stated, I am the resident council president. The facility did not notify me when R1 fell . They are supposed to. R6 told me she heard the fall. There is supposed to be two people that transfer the residents with the mechanical lift. There was only one person. No one will say if she messed up or if R1 was wiggling around and fell . R1 was on the floor and there was a lot of blood on the floor and on his head. He has several fractures: a broken neck, and stitches on his head. The aide wiped up blood off the floor. I saw her folding the mechanical lift pad. The wheelchair was away from his body, and he was laying on the floor sideways. R5 stated, I heard he was in a mechanical lift wiggling and bending and he fell out. That is what I heard. On 04/05/2025, at 4:55 PM, R6 stated, I was here in my room getting ready for bed. I went outside of my room and the door was closed. The aide opened the door and yelled for the nurse. There is no way R1 could make that loud of a thump from a wheelchair. He had to be up in the air; it was a loud crashing noise. Most of the time two people transfer residents with the mechanical lift. Agency staff try to do it on their own. If he would have fallen the distance from a wheelchair, he would not have hurt himself that bad. I saw the mechanical lift that night at the end of his bed. I'm going to tell the truth. The man was already in bad condition. I really feel bad for the man; I really do. Facility policy titled Mechanical Lift Transfers, dated 8/16/2024, notes there will always be two staff to assist the resident. One staff will control the lift as the other will guide resident and support back and neck to transfer surface.