STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005904	A. BUILDING: _____ B. WING _____	C 02/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCALLISTER NURSING & REHAB	18300 S. LAVERGNE AVE TINLEY PARK, IL 60477

(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 Violations 300.610a) 300.1210a) 300.1210b)5) 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 provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. Restorative measures shall include, at a minimum, the following procedures: 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. 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. These requirements are not met as evidenced by: Based on observation, interview and record review, the facility failed to follow their policy and implement fall interventions from the care plan to	S9999		

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S9999	Continued From page 2 prevent falls for 2 of 6 residents (R1, R2) reviewed for falls in the sample of 7. This failure resulted in R1 being left unsupervised in the hallway, falling out of the wheelchair, and sustaining a fractured left nasal bone. Findings include: On 2/18/15 at 6:15am, four residents were lined up in wheelchairs against the wall across from room 102. E8 (Nurse) was standing behind the desk as the nurse's station, out of line of site of the four residents. E8 heard a moaning sound, leaned forward across the desk, and saw R2 on the floor in front of the wheelchair. The alarm was not activated. R2 sat on the floor with the chair alarm clipped to her sweatshirt, the cord was slack and extended all the way to the alarm box. The tab did not pull away from the box, therefore, the alarm was not activated. At 6:30am, E8 stated the cord was too long and should have been shortened when R2 was up in the wheelchair. Closed record documents R1 was admitted to the facility on 6/2/14, and transferred to the hospital on 2/5/15 after a fall. Mainstreet 24 Hour Report Sheet 2/5/15 documents R1 was in a wheelchair in the hallway, then fell on the floor face down while trying to get out of the wheelchair. R1 was bleeding from the nose and there was a hematoma on the left side of the face. R1's assigned aide was alerted by another aide, first aid was administered, family and physician were called, R1 was transferred to the hospital. E9 (Nurse) was in another room passing medications. Fall Care Plan documents R1 slid from the wheelchair on 10/8/14, 11/14/14, 12/3/14, 12/26/14, 1/30/15, and 2/5/15. Interventions include structured location monitoring and explain safety concerns 8/9/14,	S9999		

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S9999	Continued From page 3	S9999		

frequent monitoring 9/10/14, anticipate needs and provide assistance to prevent falls 10/12/14, and place at nurses station for monitoring 10/8/14. Minimum Data Set (MDS) 2/1/15 Section C Cognitive Patterns scores R1 8 out of 15, indicating moderate cognitive impairment. R1 is assessed as having inattention and disorganized thinking; difficulty focusing attention, easily distracted, difficulty following what was said, irrelevant conversation, unclear flow of ideas. Section G Functional Status assesses R1 as needing extensive assistance with one person physical assist for transfers, is not steady and only able to stabilize self with assistance from another person during standing from a seated position. Section J Health Conditions documents R1 has had 4 falls since the last MDS Assessment on 11/7/14.

Incident Report 2/5/15 documents R1 fell to the floor face down from the wheelchair, swelling noted to the left side of the face, physician was notified, and R1 was transferred to the hospital. Hospital record documents R1 was sent to the emergency room after a fall from the wheelchair. R1 has a hematoma to the left side of the head, swelling around the left eye, and a cut to the lower lip. X-ray and Computer Tomography 2/5/15 document R1 has a fractured left nasal bone.

On 2/18/15 at 6:10am, E5 (Nurse Aide) stated on 2/5/15 around 5am, R1 was up in the wheelchair and placed in the hallway. R1 kept standing up from and leaning forward in the wheelchair, activating the chair alarm. While E5 was in another room, an alarm sounded, E5 looked out of the room, and saw R1 on the floor bleeding. E5 called for help. E5 stated R1 was very confused and cries.

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S9999	Continued From page 4	S9999		

On 2/18/15 at 7am, E6 (Nurse Aide) stated she got R1 up first on 2/5/15 around 5am. E6 sat R1 in the wheelchair in the hallway, then went to get other residents up out of bed. E6 stated R1 did not like getting up that early but her name is on the list to get up on the night shift. R1 was falling asleep that morning while E6 tried to get her dressed and out of bed. E6 stated an alarm was activated, other staff called for E6. When E6 came out of another room, R1 was on the floor in the hallway bleeding. E6 stated R1 was agitated.

On 2/18/15 at 7:50am, E2 (Director of Nursing) stated R1 would slide herself to the edge of the wheelchair and fall out, it was a behavior of R1. On 2/5/15, R1 fell out of the wheelchair, hitting her face on the tile floor. Staff get residents up on the night shift. Sometimes there is not anyone at the nurse's station because everyone is busy getting other residents out of bed. R1's "get up time" was adjusted to get her up last.

On 2/18/15 at 8:05am, E7 (Restorative) stated R1 had behaviors of sliding out of the wheelchair.

On 2/18/15 at 11:30am, E3 (Assistant Director of Nursing) stated residents are brought to the nurse's station so staff can "keep an eye on them." A staff member is around or near the nurse's station and can see the residents that are sitting there.

On 2/18/14 at 1:50pm, E1 (Administrator) stated the cord on R2's chair alarm should have been shortened when sitting up in the wheelchair.

On 2/18/15 at 3:20pm, E9 (Nurse) stated she was in another room passing medications when she heard an alarm. E9 came out into the hallway and saw R1 on the floor. R1 had a hematoma on the

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S9999	Continued From page 5 left side of her face and was bleeding from the nose. E9 stated R1 is agitated and cries all the time. On 2/19/15 at 10:30am by phone, Z1 (Physician) stated if all 3 staff members stated they were not at the nurse's station watching R1, then all 3 are responsible for leaving R1 alone in the hallway, not watching R1, and she fell. Fall Prevention and Restorative Nursing - the focus of the care plan should be to address the underlying cause or causes of the resident's falls, or if the resident has not sustained a fall, the factors that place him or her at risk for falling. Fall Incidents - If a resident is noted attempting to get up from wheelchair, intervene to assist to sit back down to prevent fall incident. (A)	S9999		

IMPOSED PLAN OF CORRECTION

F323

1. The following actions have been taken for those residents noted to be affected by this alleged deficient practice: R1 has been discharged to the hospital. R2 fall prevention plan was reviewed . Interventions to prevent falls include: completion of the fall assessment, low with bed with mats on the floor and a wheelchair chair alarm, and fall risk care plan was reviewed and updated upon re-admission.

2. All residents are identified as having the potential to be affected by this alleged Deficiency: All new admits and readmits will be assessed for fall risk and receive prompt interventions to prevent falls. All current residents will have their fall assessments updated and re-assessed at least quarterly for fall risk. Residents identified as risk will be placed on the fall program and evaluated for appropriate interventions.

3. A directed in-service was given on 02/18/15, 2/19/15, 2/20/15 and will be repeated on 03/02/15 which will include but not limited to the facility must ensure that Nursing staff will be re-educated on the fall program and interventions to prevent falls including not leaving the residents unattended in the dining room. The staffing sheet will include who is to be assigned to monitor each dining room. The facility will implement a fall committee team and they will meet daily to review any new incidents and at least weekly to discuss trends and formulate corrective action if deficient practice is found. The DON will be notified of all falls so that immediate interventions are implemented. Ongoing education will be provided to nursing staff until all employees have been received training. All new nursing employees will be educated on the fall program.

4. Quality assurance plans to monitor for the next 3 months the DON or Designee will complete random audits to monitor that fall prevention interventions are implemented timely and are in place as ordered, fall assessments are completed on admission, re-admission and quarterly as due that the supervision is being provided in the dining room. The DON will bring identified trends to the QA Committee, and the interdisciplinary team will formulate a plan of action as needed until resolution.

5. Date of corrective action will be completed by 10 DAYS FROM RECEIPT OF NOTICE

Attachment B
Imposed Plan of Correction

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	145967	A. BUILDING _____ B. WING _____	C 02/19/2015

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F 000	INITIAL COMMENTS Complaint Investigation 1590684/IL74836 - F221, F323 1590690/IL74844 - F221, F323	F 000		
F 221 SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow their policy by using devices as fall prevention interventions and not obtaining informed consent, physician order, or having an indication for use prior to the use of a device as a restraint for 4 of 6 residents (R3, R4, R5, R6) reviewed for falls/restraints in the sample of 7. Findings include: On 2/18/15 from 12:00pm-12:30pm, R3 sat in a high back reclining chair with a lap tray in front of him, preventing him from getting out of the chair. R4 and R5 sat in high back recliners with a lap tray in the dining room. R6 sat in a high back recliner with a seat belt secured around the waist. R3, R4, R5, and R6 did not have valid informed consents or orders with an indication for use of a restraint, and none of the residents were able to release the devices on their own. At 12:40pm, E7	F 221		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LTC07202

COMPLAINT DETERMINATION FORM

FAC. NAME: MCALLISTER NURSING AND REHAB COMPLAINT #: 0074836
LIC. ID #: 0049502
DATE COMPLAINT RECEIVED: 02/06/15 16:16:00

IDPH Code	Allegation Summary	Determination
104	NEGLECT	2
105	IMPROPER NURSING CARE	1
131	RESIDENT INJURY	1

✓ The facility has committed violations as indicated in the attached*
___ No Violation

*Facilities participating in the Medicare and/or Medicaid programs will not receive a copy of the certification deficiencies as they have already received a copy through the certification program process.

Determination Codes

1 = VALID - A complaint allegation is considered "valid" if the Department determines that there is some credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

2 = INVALID - A complaint allegation is considered "invalid" if the Department determines that there is no credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

3 = UNDETERMINED - A complaint allegation is considered "undetermined" if the Department finds there is insufficient information reported to initiate or complete an investigation.

RESIDENT INJURY - Per the P&A v. Lumpkin consent decree, allegations of resident injury will always be "valid" if the resident who is the subject of the allegation was injured.

LTC07202 COMPLAINT DETERMINATION FORM

FAC. NAME: MCALLISTER NURSING AND REHAB COMPLAINT #: 0074844
LIC. ID #: 0049502
DATE COMPLAINT RECEIVED: 02/09/15 09:25:00

IDPH Code	Allegation Summary	Determination
104	NEGLECT	2
105	IMPROPER NURSING CARE	1
131	RESIDENT INJURY	1
409	POLICY AND PROCEDURES	1

✓ The facility has committed violations as indicated in the attached*
___ No Violation

*Facilities participating in the Medicare and/or Medicaid programs will not receive a copy of the certification deficiencies as they have already received a copy through the certification program process.

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