STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000640	A. BUILDING: _____ B. WING _____	C 11/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BALLARD RESPIRATORY AND REHAB	9300 BALLARD ROAD DES PLAINES, IL 60016

(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 300.1210a)b)c) 300.1210d)6) 300.3240a) 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 the active participation of the resident and the resident's guardian or representative, as applicable. 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	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. Section 300.1210 General Requirements for Nursing and Personal Care 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. Based on observation, interview and record review the facility failed to implement a resident's plan of care for fall prevention, modified a resident's individualize care plan after a fall based on an identified cause factor, and provide supervision for a cognitive impaired resident while close to stairs. This applies to three residents of four residents (R1, R2 and R3) reviewed for falls,	S9999		

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S9999	Continued From page 2 in a sample of five. As a result, R2 a cognitively impaired resident was allowed to remain near stairs and fell from the wheelchair down the flight of 10 stairs and fractured a shoulder bone and the pubic bone in two places. Findings Include: 1. R2's face sheet diagnoses include intellectual disabilities, dementia, depressive disorder, abnormal gait and generalized muscle weakness. R2's fall risk assessment dated 9/11/15 indicates that R2 was at high risk for falls, with intermittent confusion and had 1-2 falls in the last three months. R2's Minimum Data Set (MDS) dated 9/10/15 indicates R2 was moderately impaired with poor decisions and cues and supervision required. R2's MDS under signs and symptoms of delirium indicates that R2 had disorganized thinking. According to the facility's incident reports: -On 9/09/15 R2 fell from her wheelchair with no injuries involved. -On 11/13/15 R2 was noted sitting in the floor in front of the wheelchair, with complaint of pain to her right leg. The initial report does not indicate that R2 fell down the stairs. R2's final for fall incident 11/13/15 indicates: an alarm was heard and when staff responded R2 was observed with the wheelchair going over the lobby stairs causing her to fall. R2's hospital admission and discharge records indicate R2 was admitted for a fall on 11/13/15 and discharged back to the facility on 11/19/15. R2's shoulder x-ray dated 11/14/15 indicates R2 had a distal clavicle fracture. R2's pelvis x-ray	S9999		

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S9999	Continued From page 3	S9999		

dated 11/15/15 indicates R2 had a fracture of the right pubic bone and superior pubic ramus.

R2's fall care plan with an initiated date of 4/15/15 indicates R2 was at high risk for falls. R2's fall care plan includes interventions to do hourly round checks on R2 for safety and provide activities that minimize the potential for fall while providing diversional distraction.

R2's fall care plan includes an intervention dated 11/19/15 to continue with fall prevention program, falling star, bed and chair alarm and floor mat added for safety. R2's care plan does not include interventions to address R2's routine of sitting in the lobby at the top of the stairs in her wheelchair.

The facility's fall policy undated indicates that the facility will implement individualized approaches/interventions based upon resident risk and approaches/interventions should focus on risk factors identified.

On 11/24/15 at 11:09 am E9 (Front Desk Receptionist) stated she saw R2 as she (R2) was falling down the stairs. E9 stated she heard a beeping sound and looked up to see R2 falling down the stairs along with her wheelchair. E9 stated R2 frequently sits on the landing in the lobby at the top of the stairs in her wheelchair. At the reception area there are two flight of stairs. One leading to a lower lever and one leading to the upper area. It was this upper level in which R2 fell from the wheel chair. The upper level set of stairs, contained 10 stairs.

On 11/24/15 at 11:15 am E3 (R2's Physician/Medical Director) stated R2's normal behavior is to sit in the lobby at the top of the stairs in her wheelchair. E3 stated that R2 had

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S9999	Continued From page 4	S9999		

the mental capacity of a 6 or 7 year old and suffered from mental retardation. E3 stated that R2 was too unsteady to walk independently and used the wheelchair to navigate throughout the facility.

2. R3's fall risk assessment dated 11/2/15 indicates that R3 is at high risk for falls with intermittent confusion and three or more falls in the past three months.

On 11/23/15 at 10:00 am R3 was observed resting in bed with an over bed table resting on the floor toppled on its side, positioned on top of the fall mat. R3's bed was not in the lowest position.

On 11/23/15 at 3:00 pm R3 was observed with a non-working body alarm in place. R3's body alarm did not sound when it was checked for operational status.

R3's fall care plan dated 10/2/15 includes interventions to maintain an environment free of clutter, pressure sensitive body alarm and to place floor mat or landing mat on the floor next to bed.

3. On 11/23/15 at 12:00 pm, 1:45pm and 3:00pm R1 was observed without a personal alarm on the bed or attached to R1's body.

R1's physician order sheet includes an order dated 11/19/15 for a body alarm. In addition, R1's fall care plan dated 11/13/15 includes an intervention for a body alarm.

(A)

IMPOSED PLAN OF CORRECTION

NAME OF FACILITY: Ballard Respiratory and Rehab

DATE AND TYPE OF SURVEY: November 25, 2015
Complaint Investigations
1596306/IL81571
1596399/IL81673

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 the active participation of the resident and the resident's guardian or representative, as applicable.*

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.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

Section 300.1210 General Requirements for Nursing and Personal Care

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.*

THIS WILL BE ACCOMPLISHED BY THE FOLLOWING:

1. A committee consisting of, at a minimum, the Medical Director, Administrator, and Director of Nursing (DON) will review and revise the policies and procedures regarding adequate nursing supervision and recognition of situations that would require Physician notification.

    A. Recognition of situations that could lead to resident injury and/or death.
    B. Appropriate reporting procedures for staff.
    C. Appropriate and thorough investigations and follow-ups of accidents, incidents, adequate supervision and physician notification.
    D. The facility's responsibilities to prevent further potential abuse and/or neglect.
    E. The facility taking appropriate corrective action when an alleged violation is verified.

2. The facility will conduct MANDATORY in-services for all staff within 30 days that addresses, at a minimum, the following:

    A. Any new or revised policies and procedures, including actions needed to follow them that are developed as a result of this Plan of Correction.
    B. All staff will be informed of their specific responsibilities and accountability for the care provided to residents.
    C. Documentation of these in-services will include the names of those attending, topics covered, location, day and time. This documentation will be maintained in the Administrator's office.

3. The following action will be taken to prevent re-occurrence:

   A. The above in-service education will be review with all staff on a regular basis.
   B. Supervisory staff will ensure that the State Regulations are followed.

4. The Administrator and Director of Nursing will monitor items 1 through 3 to ensure compliance with this Imposed Plan of Correction.

COMPLETION DATE: Ten days from receipt of the Imposed Plan of Correction.