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 _____	10/26/2015

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

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S9999	Final Observations Ststement of Licensure Violations 300.610a) 300.1210b) 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 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 shall include, at a minimum, the following procedures: 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. These Regulations were not met as evidenced by: Based on interview and record review, the facility failed to assure that effective fall prevention monitoring and interventions were implemented for one resident (R13) out of four residents reviewed for falls in the sample of 24. This resulted in, R13 sustained repeated falls, pain and injury. Findings include:	S9999		

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S9999	Continued From page 2 R13's medical record indicates R13 has a history of falls and upon readmission 7/1/15, R13 was assigned a staff member to function as a sitter for supervision. From 8/8/15 to 9/14/15, R13's Fall Risk Assessment progressed from a fall risk score of 12 to 20, consistently classified as High Risk for Falls. On 8/8/15 at 11:00 AM, R13's Accident/Incident Report and Investigation includes a witness statement from E37 (Sitter) that described R13's fall from the wheelchair that occurred in the resident room. E37's written statement indicates E37 was distracted by R13's roommate, and reads in part "Resident in B Bed was in wheelchair looking through her bedside drawer. Every time she moved the chair alarm would alarm. I turned to turn the alarm off. That's when I saw all the knots in the cord. I disconnected the alarm and out of the corner of my eye I saw [R13] move. I turned with my arm stretched out but [R13[fell, scraping her arm on the wheelchair..... [R13} said elbow hurt." R13 was assessed to have an abrasion on the right arm, below knee and bump on right side of the head. On 8/20/15 at 4:00 PM, R13's Accident/Incident Report and Investigation, under Analysis of Findings, reads "Sitter left the room to call somebody and let them know he is leaving. Resident observed sitting on the floor. Nurse called by roommate's family member." R13 fell from the wheelchair, no injuries were sustained. A Care Plan History form indicates that on 8/22/15 "Staff was reeducated to stay with the resident at all times while up in chair." On 10/26/15 at 1:50 PM, E2 (Director of Nursing) named R13's sitter during this event as E42 (Activity Aide).	S9999		

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S9999	Continued From page 3	S9999		

On 9/2/15 at 5:15 PM, R13's Accident/Incident Report and Investigation notes "fifteen minutes after monitoring patient, [R13] was observed on the floor crawling." No mention was made of a sitter being present at the time of R13's fall. On 10/26/15 at 1:50 PM, E2 stated a sitter was assigned to R13 on 9/2/15 at 5:15 PM, naming E43 (Ward Clerk/Certified Nurse Aide). The fall was attributed to R13 trying to get out of bed. No injuries were sustained.

On 9/10/15 at 4:45 PM, R13's Accident/Incident Report and Investigation included a witness statement from E37 that reads in part "I wheeled [R13] from BINGO. We turned on television, I tilted the chair back a little and placed the chair parallel with bed, locked the chair. I turned to write in the log book (about 20-30 seconds) when I heard resident fall."
R13 was assessed and sustained two parallel half-inch cuts with bleeding on the head. First was was documented as given with sterile wound adhesive strips applied to R13's cuts.

On 10/14/15 at 1:20 PM, R13's Accident/Incident Report and Investigation includes a witness statement from E37 reads in part "I walked behind [E38 -Certified Nurse Aide] and said "I'm going". She was facing the television and she turned her head slightly....I realize now her head gesture was not an acknowledgement to me but a random movement." The Analysis of Findings reads "Resident not within the close proximity of staff."
R13 was assessed as having an abrasion to the right forehead and was treated for pain.

On 10/22/15 at 10:35 AM, E39 (Restorative Nurse) and E3 (Assistant Director of Nursing) indicated R13 was at high risk for falls and a key

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intervention for R13's fall prevention plan was providing a sitter, which began on or before 7/1/15. E39 stated "Sitters are to report off to one another before leaving the resident." The prevention plan also was to include evaluating R13's activity interests to keep her engaged and prevent attempts to get up.

R13's care plans include interventions that read:
8/8/15 - Resident continue to have 1:1 close monitoring.
9/3/15 - [R13] should be in direct supervision while up in the chair.
(undated) - Resident will not be left alone when changing staff.

On 10/22/15 at 2:45 PM, Z7 (Physician) stated R13's falls are related to a diagnosis of Dementia, leading to poor judgement and that R13 has weakness that results in falls after movement. Z7 stated R13 has Parkinson's disease but does not have sudden, involuntary movements that would cause falls. Z7 stated a sitter and close supervision are part of the plan to prevent falls for R13 "as long as they are doing their job."

Personnel files indicate that on 10/15/15, E37 was disciplined by E2 in the form of a documented verbal warning, noting "Employee failed to provide continued surveillance for safety. Employee was counseled." On 10/22/15 at lunchtime, E37 was again present as the sitter for R13.

On 10/22/15 at 5:05 PM, Z6 (Family) expressed frustration that E37 continues to be used as a sitter for R13, since three falls occurred in E37's presence.

The facility policy, Fall Prevention and

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S9999	Continued From page 5 Management Program, ver 073115, reads in part: Falls and Accident/Incidents Resident Management Review, I. Interdisciplinary team meeting, C. Identify trends for residents or facility early. (B)	S9999		