STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003792	A. BUILDING: _____ B. WING _____	C 02/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIPER CITY REHAB & LIVING CENTER	600 MAPLE STREET PIPER CITY, IL 60959

(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) 300.1210b) 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.	S9999	Attachment A Statement of Licensure Violations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003792	A. BUILDING: _____ B. WING _____	C 02/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIPER CITY REHAB & LIVING CENTER	600 MAPLE STREET PIPER CITY, IL 60959

(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 1 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 observation, interview and record review, the facility failed to ensure resident supervision during release of a physical waist restraint, resulting in a fall requiring four sutures. This applies to one of three residents (R1) reviewed for falls with injury, in a sample of four. The findings include: Physician Communication and Progress Note For New Symptoms, Signs and Other Changes in Condition (SBAR) for 1/25/16 states R1 was	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003792	A. BUILDING: _____ B. WING _____	C 02/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIPER CITY REHAB & LIVING CENTER	600 MAPLE STREET PIPER CITY, IL 60959

(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 2	S9999		

observed to have fallen out of her wheelchair in the dining room. R1 hit the left side of her head and sustained bleeding. Nurse's Note dated 1/25/16 states R1 was observed on the floor on her left side. Bleeding was noted to her left temple. Physician was notified and R1 was transferred to the hospital on 1/25/16 at 5:25 PM.

Progress Note dated 1/25/16 at 10:00 PM, states R1 returned to the facility with stitches intact. New orders were received and noted for antibiotic therapy due to diagnosis of sinus infection. On 2/9/16 at 1:30 PM, E5 (Licensed Practical Nurse) stated R1 had four sutures to her left eyebrow area. E5 stated she removed the sutures from R1's left eyebrow area, on a later date.

Nurse's Note dated 12/20/15 at 9:10 AM states Z1 (Physician) was called and informed R1 was trying to get out of her wheelchair, refusing redirection, and refusing oral medications. Antibiotics were changed from orally to intramuscularly and Lorazepam cream was increased. A waist restraint while in wheelchair was ordered.

On 2/9/16 at 11:40 AM, E1 (Social Services Director) stated R1's fall on 1/25/16 was not witnessed by staff. E1 stated R1's waist restraint was not on R1 when the fall occurred. E1 stated staff had removed R1's waist restraint when taking R1 to the dining room, then staff left R1 to bring other residents to the dining room. On 2/10/16 at 11:00 AM, E6 (Administrator) stated E9 (Certified Nursing Assistant/CNA) removed R1's waist restraint and left R1 unsupervised in the dining room.

On 2/9/16 at 12:35 PM, Z1 stated R1 has dementia and weakness. Z1 stated R1 is a fall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003792	A. BUILDING: _____ B. WING _____	C 02/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIPER CITY REHAB & LIVING CENTER	600 MAPLE STREET PIPER CITY, IL 60959

(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 3 risk. Z1 stated the use of a waist restraint was intended for R1's safety and R1's fall risk status was the reason for the intervention of a waist restraint. Z1 stated R1's fall, resulting in sutures, could have been prevented if R1 was utilizing the waist restraint. On 2/9/16 at 12:10 PM, R1 was in the dining room. R1's waist restraint was released. R1 was being assisted with lunch by E4 (CNA). E4 stated R1's waist restraint is released every 2 hours and at all meals. E4 stated staff must stay near R1 when the restraint is released. The facility's Physical Restraint policy, revised 8/18/11, does not address resident supervision during restraint release. (B)	S9999		