STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007413	A. BUILDING: _____ B. WING _____	C 05/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE ACRES REHAB & LIVING CTR	1212 SOUTH SECOND STREET DEKALB, IL 60115

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S9999	Final Observations Statement of Licensure Violation: 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. \ 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. (A, B) (Section 2-107 of the Act) These Requirements are not met as evidenced by: Based on observation, interview and record review the facility failed to ensure a resident's safety after the resident left the facility without approval, with her husband for an overnight stay.	S9999		

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S9999	Continued From page 2 This failure resulted in R1 returning to the facility with a fractured clavicle and skin tear to the arm. This applies to 1 of 3 residents (R1) reviewed for safety in a sample of 3. The findings include: The undated Resident Admission Record for R1 lists her diagnoses to include muscle weakness, history of falls with injury, urinary tract infection, hypertension, cystocele, dizziness, Meniere's disease, osteoarthritis, and history of displaced fracture of the surgical neck of the humerus. The admission profile sheet shows R1 was a resident at the facility from July 2015 till December 2015. R1 was discharged to supportive living. On February 16, 2016, R1 was readmitted to the facility for long term care. R1 is 91 years old. The Minimum Data Set (MDS) of March 5, 2016 shows the Brief Interview for Mental Status (BIMS) score for R1 is 9. A score of 8 - 12 indicates a resident has moderate impairment in decision making in activities of daily living. The MDS shows R1 feels depressed, has trouble concentrating and is fidgety or restless nearly every day. R1 requires extensive assist of 2 persons for bed mobility and dressing, extensive assist of 1 person for transfer, walking, toilet use, hygiene and is totally dependent on staff for bathing. R1 is not steady with transfer and requires staff assistance to stabilize while moving from seated to standing position, walking, turning around, on and off the toilet and transfer from the bed to the chair. R1 is frequently incontinent of urine and bowel. R1's abuse/neglect risk assessment of February 15, 2016 (on admission) states, "R1 has a history of being abused by her husband."	S9999		

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S9999	Continued From page 3	S9999		

The initial MDS assessment of February 15, 2016 shows R1 had history of fall in the last month prior to admission. The MDS show R1 had a fracture related to a fall in the 6 months prior to reentry to the facility.
The physician order sheet for April 2016 shows an unapproved standing order for a therapeutic pass from the facility. There is no order on April 26, 2016 that with the POA approval, R1 may leave the facility with the husband.
On May 3, 2016 at 12:40 PM, E5 (Registered Nurse - RN) stated on April 26, 2016, he entered R1's room to administer her 5:00 PM scheduled medications. R1 told him she was going home to spend the night with her husband. R1's husband was with the resident helping her gather her belongings. E5 stated not knowing what to do, he called E3 (Director of Nurses - DON). E5 stated E3 advised him to call the physician to get his approval for her to leave with the husband and send her medications with her. E5 stated he was not aware of any restrictions regarding R1 leaving the facility with her husband, nor the husband's ability to provide care for R1. E5 stated while he was still trying to make contact with the physician, R1 left the facility with her husband. E5 stated he felt R1 was alert and orientated and able to make her own decisions. E5 stated he had seen R1's husband take her out the previous week. E5 stated (after R1 had left the facility) the physician office returned the call and stated he did not want R1 to leave with the husband unless it was approved by the POA (power of attorney). E5 stated he incorrectly read the resident profile information and saw that R1 was responsible for herself; he was not aware she had a POA for healthcare therefore he did not call the POA after R1 left. E5 stated he had not thought about R1 not having her medications. E5 stated Z1 (POA) called him later in the shift and was very angry

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that R1 left with her husband. Z1 told him R1 was not supposed to be out with him, the physician and she did not approve the leave. E5 stated he was not aware if R1 had prior physician approval to go on any outings or overnight stay with the husband. E5 stated he had heard there was "gossip" about R1's husband having abusive behaviors, but never in an official capacity.
On May 3, 2016 at 2:55 PM, Z2 (physician) stated he was not aware that R1 had previously left the facility with the husband for a day pass. Z2 stated the family tells me he (husband) is hurting R1. I cannot let R1 go with him without the POA approval.
On May 3, 2016 at 3:05 PM, Z1 (POA) stated R1 called her after 6 PM and told her she was at her home and would be staying there all night with her husband. R1 told her she did not have any medications. Z1 stated she called the facility and the nurse told her R1 had left, and the physician cleared the leave and everything was fine. Z1 stated E5 did not seem concerned about her safety and the husband's ability to provide care for R1.
Z1 (POA) stated she has asked the facility to not let the husband take her out. Z1 was told by the facility there was nothing they could do, as R1 is able to make her own decisions, and they can't control her decisions. On the first day after she was readmitted, Z1 asked the facility is there was any way he could again be restricted in his visits and contact with R1, and she was told they were unable to do that. Z1 stated she did not feel the husband was able to lift her if she would fall; she was afraid she would be hurt and is not safe at home. Z1 stated if the facility had called her about leaving with the husband she would have told the nurse no, do not to let her go as she knew she would get hurt.
On May 4, 2016 at 3:20 PM, E3 (Director of

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S9999	Continued From page 5 Nurses - DON) stated she told E5 (RN) to call the physician and get an order, and also get permission from the POA. E5 did not tell her that R1 left before he spoke to the physician. E5 should have absolutely notified herself or the administrator that R1 left without the POA's permission. E3 stated, "If I had been notified, I would have called the POA myself" to assure the resident safety. On May 4, 2016 at 8:50 AM, R1 was seated in a wheelchair in her room with a sling stabilizing her left arm. R1 pointed to her shoulder and stated it is all broke up here and it is painful. I fell and I guess I landed on that shoulder. I get dizzy and fell at home. On May 4, 2016 at 10:15 AM, E4 (Social Services) stated after R1 left the facility, E5 (RN) should have notified administration to ensure the resident was safe. If a resident wants to go home, therapy can provide caregiver training to safely meet the resident needs at home. E4 stated I would not have recommended an overnight stay because R1 needs more help than the husband can give her. On May 3, 2016 at 11:30 AM, E1 (Administrator) stated she and E2 (ADON) were not notified until the next morning (April 27, 2016) after R1 left the facility without approval. On May 4, 2015 at 10:50 AM, E1 (Administrator) stated if the POA did approve a home stay, R1 would have to have a home care aide to visit to help with hands on care. R1's husband would not be able to care for her. E1 stated there should also be a physician order for an overnight stay, and the POA needs to determine it is ok. E1 stated she expected someone from administration to be notified that R1 left the facility (without approval). E1 stated she would have went to the home and asked her to come back had she known.	S9999		

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S9999	Continued From page 6 On May 3, 2016 at 10:30 AM, E8 (Licensed Practical Nurses - LPN) stated R1 left the facility the night before (April 26, 2016) with her husband without permission. R1 returned the next morning with a skin tear to the top of the left forearm and was complaining about shoulder pain. R1 had an x-ray that day that showed a left clavicle fracture. The undated facility policy titled out on pass with medications states, the nurse will obtain an order from the physician for a therapeutic pass for a resident leaving for a long period of time that requires medications to be sent. Notify the POA, if the responsible party is not the POA. (B)	S9999		