

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145967	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/27/2013
NAME OF PROVIDER OR SUPPLIER MCALLISTER NURSING & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 18300 S. LAVERGNE AVE TINLEY PARK, IL 60477		
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F 456	Continued From page 12 Based on observation and interview, the facility failed to maintain beds in a safe condition for five residents (R21 - R24) of a total 18 resident beds monitored for safety. Findings include: On 8/21/13 at 10:30 AM, accompanied by E 18(Director of Maintenance), observation of R21 thru R24 beds all appeared to have two chunky bolts sticking out about 1 inch in length, located about 2 feet from the middle of the bed frame. Interview with E18 on 8/21/13 at 10:35am,"about 1 inch in length, located about 2 feet apart from the middle of the bed frame. E18 said, "Those are the bolts for the siderail. Someone removed the siderail."	F 456			
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.610a 300.1210b) 300.1210c) 300.1220b)3) 300.3100d)2 300.3240a 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	F9999			

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F9999	<p>Continued From page 13</p> <p>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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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.</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including:</p> <p>3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as</p>	F9999			

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F9999	<p>Continued From page 14</p> <p>are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.</p> <p>Section 300.3100 General Building Requirements</p> <p>d) Doors and Windows</p> <p>2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These requirements are not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to follow their clinical alarms policy by failing to apply a bed alarm for one resident (R16) out of three residents reviewed for falls. This failure resulted in R16 sustaining a right hip</p>	F9999			

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F9999	Continued From page 15 fracture and the facility failed to follow their elopement policy/procedure for one resident (R12) of three residents reviewed for elopement risk. This failure resulted in R12 leaving the facility unsupervised. Findings Include: 1. Review of facility ' s clinical alarm policy denotes Purpose: To provide intervention for residents at increased risk for falls and decreased cognition related to their own safety. Policy: When a resident has experienced one or more falls a clinical alarm such as a chair, personal, and/or bed alarm may be used as an intervention to assist in decreasing and/or preventing future falls. The alarm will remain in place indefinitely, or until deemed no longer necessary for that specific resident. The Director of Nursing and/or designee will routinely check alarms for proper function and/or placement. R16 care area assessment summary dated 4-13-13 denotes care area triggered falls: wandering occurs, R16 requires assist x1 with transfer. R16 has unsteady gait and balance. R16 fall risk assessment dated 5-9-13 denotes score of 18; score above 10 represents high risk. R16's fall prevention care plan denotes 4-30-13 R16 got up from wheelchair lost balance and fell on her back, no apparent injuries. 5-9-13 R16 slid out of her wheelchair no apparent injuries. R16's fall prevention care plan dated 7-11-13 denotes R16 will have no fall thru next review; intervention bed alarm, chair alarm and place near nurses station. R16's nurse note dated 7-19-13 at 1:45 AM, R16 was noted lying on the floor on her right side, head to toe assessment R16 verbalized no complaints nor concerns and doctor notified. R16 nurse notes dated 7-19-13 at 12:36 PM, denotes R16 complained of pain when right leg is moved,	F9999			

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F9999	<p>Continued From page 16</p> <p>yells out and guards leg. Medical Doctor called and given orders to send to hospital.</p> <p>R16 ' s hospital X-ray dated 7-19-13 denotes " Findings: There is a subacute fracture neck of femur with some impaction. Impression: Subcapital fracture, neck of right femur with impaction.</p> <p>Interview with Z2 (Medical Doctor) on 8-15-13 at 10:50 AM," R16 ' s hospital X-ray results revealed that she did fracture her right hip and that one of the bones impacted into the other. With this injury, R16 had to have stood up and fell. If the facility had assessed R16's need for a bed alarm ; it would have been helpful to have utilized it. Because R16 is confused, the bed alarm would have at least notified staff that she was trying to get out the bed."</p> <p>Interview with E12 (Licensed Practical Nurse) on 8-14-13 at 4:30 PM," During the early morning on 7/19/13,I heard some noise from R16's room. I got up from the nursing station and went to R16's ' room and saw her on the floor. I did not see a bed alarm. I did not know R16 was supposed to have a bed alarm.</p> <p>Interview with E11 (Certified Nurse Aide) on 8-14-13 at 1:40 PM," on 7-19-13, E12 called me from R16's ' room and when I got there, E12 told me that she heard R16 fall. I saw R16 on the middle of the floor. I did not see a bed alarm on her bed."</p> <p>Interview with E2 (Director of Nursing) on 8-15-13 at 11:20 AM," Restorative nurses assessed R16 to need the bed alarm. The restorative nurse was supposed to get the alarm from storage and place it on R16' bed; then restorative was to let nursing know R16 needed a bed alarm. It was not communicated to nursing that R16 needed a bed alarm nor that R16 care plan was updated with new intervention; the bed alarm."</p>	F9999			

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F9999	Continued From page 17 2. R12 is 86 years old with a diagnosis of Dementia. R12 lived independently prior to hospitalization and subsequent admission to the facility due to declining mental status. From the day of admission, R12 has been documented to attempt to elope from the facility. R12 is alert, very confused and ambulates independently. The comprehensive care plan dated 6/5/13, noted that prior to admission, R12 had a history of wandering from home and being picked up by police, according to a family member. On the 2nd day of admission, the evening nurse documented that R12 made an elopement attempt; staff to monitor closely. On the 3rd day of admission, another nurse documented that R12 was up most of the night, trying to go home ; that night, R12 was noted walking down the hall, dragging buckets filled with belongings. Two weeks later, a nurse documented on 7/23/13 that R12 exited the building through the employee break room exit at 7:44 AM. On 8/01/13 at 11:00 AM, E11, Administrator stated that when a resident is assessed to be of high risk for elopement, the resident is assigned 1:1 monitoring by a CNA (Certified Nurse Aide). Review of the facility policy and procedure for high risk for elopement residents stated, in part: When a resident displays escalating behaviors, the Charge Nurse immediately places the resident on high risk protocol, and notifies the Director of Nursing. The Charge Nurse will assign an observation staff member. The assigned CNA	F9999			

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F9999	<p>Continued From page 18</p> <p>(Certified Nurse Aide) must make visual contact with that resident every 15 minutes, and must respond to all door alarms that sound. Assign another CNA to monitor during the primary aide's breaks and lunch.</p> <p>Review of the visual contact records showed that visual monitoring did not begin until 7/23/13, the date of R12's elopement.</p> <p>On 8/01/13, 11:00 AM, E1 stated that on the day that R12 eloped, R12 had a 1:1 monitoring CNA. The CNA went to lunch after reporting off to the Charge Nurse. When the nurse heard the door alarm, the nurse went to the door and closed the door, never looking out or going out to look for R2. E1 stated that had the nurse stepped through the door, R12 would have been seen. As a result, R12 continued out beyond the grounds of the facility which is bordered by very busy, heavy vehicle trafficked major streets. Someone took R12 to the fire department and finally the police department. On 8/01/13, 11:00 AM, R1 stated that the facility sits on 7 acres of land.</p> <p>Review of the facility policy and procedure for when a door alarm sounds:</p> <p>When any door alarm sounds the facility staff shall: Check the exit door for any exiting resident by means of a visual check. Visual check means observing the area around the exit, and may require leaving the building.</p> <p>On 8/01/13, 1:30 PM, E18, Director of Maintenance stated that all exits, except for the main entrance, were alarmed and had to be cleared by staff using a key pad code. While</p>	F9999			

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F9999	Continued From page 19 observing the exits from the building on 8/01/13, along with E18, it was noted that 7 of the 11 alarmed exits did not function as stated. The southeast door to exit the building did not have an alarm. E18 stated that the alarm was not needed because that door was protected by administrative office door which was alarmed. However, E18 agreed that the office door alarm was not set until office staff left sometime in the evening. (B)	F9999			