STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	A. BUILDING: _____ B. WING _____	C 10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST REHAB & RESPIRATORY	727 NORTH 17TH STREET BELLEVILLE, IL 62226

(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	S9999		

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S9999	Continued From page 1	S9999		

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. (Section 2-107 of the Act)

THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY:
Based on record review and interview, the facility failed to supervise residents to prevent resident to resident altercations between confused residents for 3 of 3 residents (R1, R2 and R6) reviewed for residents to resident altercations in the sample of 6. This failure resulted in R1's repetitive physical and verbal aggressive behaviors and R2 incurring a fracture shoulder during a incident involving R1.

FINDINGS

R1's Minimum Data Set (MDS), dated 7/5/2014, documented severe cognitive impairment and physical and verbal behavioral symptoms directed toward others.

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S9999	Continued From page 2	S9999		

R1's Nurse's Notes documented that he was sent to a local emergency room on 7/21/2014, for agitation and aggression. R1's Physician Order, dated 7/21/2014 documented an order for "Haldol 0.5mg po (by mouth) q (every) HS (evening/night) agitation/aggression."

R1's Nurse's Notes documented that he was sent to a local emergency room on 9/6/2014, for, in part, aggression and agitation. R1 ' s hospital ' s Behavior Health Mental Status Report, dated 9/6/2014, documented, in part, "Aggressive and agitation. Grabbing, PPI (?), swinging w(with)/fists, cursing. Doesn't walk but rolls himself in the wheel chair and hits."

R1's Care Plan, not dated, documented that he sometimes exhibited physical and verbal aggressive behaviors. R1's Care Plan documented, in part, the following behaviors: On 9/2/2014, "kicked another res (R6) when asked to leave her room; On 9/4/2014 "grabbed another res (resident - not documented) arm"; On 9/7/2014, "grabbed another res (resident - not documented) arm mumbling something to res"; On 9/21/2014, "(R1) refused to move when asked by another res (resident not documented) r/t (related to) confusion kicked at other res"; and on 10/1/2014, "aggressive with (R2)."

R1's Situation Report, dated 10/4/2014, documented, in part, "Resident (R1) to resident (R2) resulting in fracture. (R1) reported to have pulled another resident (R2) from her wheel chair. Both residents were immediately separated and both were sent to hospital for evaluation. (R2) returned to facility with her left arm in sling and order to follow up with orthopedic related to fracture shoulder."

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S9999	Continued From page 3	S9999		

Interview of R2, on 10/15/2014 at 1:30p.m., R2 stated that her shoulder was broken during the incident with R1.

R1's Incident/Accident Reports, dated 9/2, 9/4, 9/6, 9/21 and 10/12014, did not document behavioral interventions after each incident.

R1's Nursing Notes, dated 9/2/2014 to 10/1/2014, documented R1's incidents of 9/2/2014, 9/4/2014, 9/7/2014, 9/21/2014 and 10/2/2014, but did not entirely document specific problem behaviors, interventions attempted or the outcomes associated with interventions.

R1's Care Plan, not dated, documented dates of his behavioral incidents but did not document interventions other than separate, remove, redirect, provide notification, monitor his whereabouts, close doors and provide medication as ordered. These interventions remained the same after each of R1's altercations. R1's MDS, dated 7/5/2014, documented activity preferences, in part, as showering, bathing, snacks between meals, listening to music, doing things with groups of people; however, R1's chart did not document his activity preferences as potential behavioral intervention(s).

R1's chart did not document ongoing behavioral assessments to include assessing the effectiveness of behavioral interventions.

During interview of E1, Administrator, on 10/14/2014 at 10:30a.m., E1 stated R1's physical and/or verbal behaviors were documented on his Behavior/Intervention Monthly Flow Record which was dated 7/2014. E1 also state that she could not find any other documentation.

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S9999	Continued From page 4 R1's Behavior/Intervention Monthly Flow Records, dated 7/2014, documented he was monitored for restlessness and hitting staff. It was also documented that his behaviors were not assess every shift from 9/1/2014 to 9/30/2014 or that he displayed any behaviors for the month of 9/2014. During interview of E2, Director of Nursing (DON), on 10/14/2014 at 2:15p.m., E2 stated that she would expect behaviors to be tracked and interventions put into place. The facility's Behavior Assessment and Monitoring policy and procedure, dated 4/2007, documented, in part, "Problematic behavior will be identified and managed appropriately. If the resident is being treated for problematic behavior or mood, the staff and physician will obtain and document ongoing reassessments of changes (positive or negative) in the individual's behavior, mood, and function. The staff will document (either in progress notes, behavior assessment forms, or other comparable approaches) the following information about specific problem behaviors: a. Number and frequency of episodes; b. Preceding or precipitating factors; c. Interventions attempted; and, d. Outcomes associated with interventions." (A)	S9999		

Imposed

PLAN OF CORRECTION

PROVIDER: Midwest Rehabilitation and Respiratory Center
ADDRESS: 727 North 17th Street Belleville, IL 62226
ID NUMBER: 145290
SURVEY DATE: October 9, 2014

TAG NUMBER: F323 SCOPE/SEVERITY: G

1. Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

R1 no longer resides in facility.
R2 had no further incidents with R1 and no decline in ADL.
R6 had no further incidents with R1 and no negative effects were noted.

2. How will you identify other residents having the potential to be affected by the same deficient practice?

All residents have the potential to be affected to be affected by the deficient practice.

3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

Social Service Director in-serviced on individualized approaches for resident with severe cognitive impairment with aggressive behaviors.

Staff in-serviced on supervision of residents with resident to resident altercations.

Department Managers and Licensed Nurse's in-serviced on policy of behavior assessment and monitoring.

Incidents regarding resident to resident altercations have been added to review weekly at risk review meetings, educational needs are addressed when noted.

4. How will you measure the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

Results of reviews will be discussed weekly at Nursing QA meeting for 6 weeks and quarterly at Quality assurance meeting for 3 quarters. Education needs will be addressed.

Completion Date: October 30, 2014

Acceptable