STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004642	A. BUILDING: _____ B. WING _____	C 11/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PONTIAC HEALTHCARE AND REHAB	300 WEST LOWELL PONTIAC, IL 61764

(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: 300.1210a) 300.1210b) 300.1210d)6) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. 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. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following	S9999		

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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 requirements and not met as evidenced by:

Based on record review, observation and interview, the facility failed to ensure safety/supervision during toileting and correct positioning to prevent falls for two residents (R1, R3) reviewed for falls from a sample of three. These failures resulted in R1 sustaining facial fractures and cerebral hemorrhage, and R3 sustaining a laceration and dislocated toe.

Findings include:

1. R1's Physician Order Sheet (POS) dated November 2014 documents diagnoses of Dementia, Seizure Disorder and Parkinson's Disease.
The Minimum Data Set (MDS) dated 9/1/14 documents R1 as severely cognitively impaired and having disorganized thinking and inattention. R1 is not stable and is only able to stabilize herself with staff assistance during sitting. R1 is non-ambulatory. The Fall Risk assessments dated 12/23/13, 3/17/14 and 9/1/14, document R1

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as a high risk for falls. R1's Plan of Care updated 9/9/14, directs staff to recline R1's geriatric chair since "(R1) tends to lean forward." The careplan also states that R1 is to have a tab alarm on at all times.

A facility report titled "Resident Incident Report" and dated 9/9/14 documents R1 with an unwitnessed fall from her geriatric chair in the hallway and found on the floor. R1 had bleeding from the forehead and was sent out to the Emergency Room (ER) for evaluation. R1 returned to the facility with sutures to her forehead. Intervention for this fall is documented as "reiterate to staff to recline (R1) slightly if left in (geriatric) chair."

The Resident Incident Report dated 10/15/14 documents E7, Activity Aid wheeled R1 to the dayroom in the geriatric chair, then went to get some paperwork from a cabinet. E7 turned around from the cabinet and saw R1 suddenly falling straight forward onto her head. The report states the root cause as the geriatric chair not being reclined.

The Resident Incident Report dated 10/24/14 states that R1 was toileted on a bedside commode by E8, Certified Nursing Assistant. After sitting R1 on the bedside commode, E8 turned and walked across the room to get a piece of clothing for R1 from the closet. The report documents "(R1) suddenly leaned forward and fell onto the floor, bleeding was noted from a laceration on left side of face...." This report goes on to document that R1 was sent out to the local ER and was subsequently sent to a trauma hospital for further follow up due to facial fractures and a cerebral bleed.

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An ER report dated 10/24/14 documents that R1 was treated for a laceration to the left orbital region requiring three sutures. A head Computed Tomography (CT) report dated 10/24/14 documents, ". . . Traumatic subarachnoid hemorrhage. . . . Foci of intraparenchymal hemorrhage . . . . . Multiple facial bone fractures including left zygomaticomaxillary complex fracture and left orbital fractures . . . Discussed with neurosurgeon, who accepted (R1) for transfer to (Trauma Hospital) for further evaluation and treatment."

On 11/13/14 at 10:05 am R1 had faded bruising was noted on her entire face, with a small crusted laceration to the left orbital area.

On 11/13/14 at 11:05 am E1, Administrator acknowledged that E8 should not have walked away from R1, leaving R1 alone on the commode.

On 11/13/14 at 3:50 pm E4, MDS and Care Plan Coordinator stated "we do in-services all the time with our staff instructing them not to leave residents alone on the toilet if they have tab alarms or have been assessed at high risk for falls. (E8) should not have left (R1's) side since R3 is a high risk for falls."

2. R3's POS dated November 2014 documents diagnoses including Alzheimer's Disease, Seizure Disorder, Dizziness, Vertigo and Anxiety.

The MDS dated 7/14/14 documents that R3 is cognitively impaired, is not stable and is only able to stabilize with staff assistance. R3 requires one assist with walker for walking and transferring. R3 also uses a wheelchair for mobility.

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The Resident Incident Report dated 9/19/14 documents R3 being toileted by E6, CNA. The report states that once R3 was finished with toileting, R3 could not lift her left hand to the walker. E6 took R3's closed hand and placed it on the walker. R3 could not open her hand to grasp the walker. The report documents that E6 held R3's closed hand on the walker and proceeded to walk her. When R3's hand slipped off the walker, R3 lost her balance and E6 lowered R3 to the floor. The report documents that R3 later complained of pain to her left foot. Upon assessment, "R3's second toe was bleeding with what appeared to be bone exposed. The second toe was at a 90 degree angle to the other toes." R3 was sent to the ER for evaluation and treatment.

The ER notes dated 9/19/14 document R3 with an apparent open fracture from a fall. The x-ray dated 9/19/14 documents, "There is dorsal dislocation of the middle and distal phalanges of the second toe without definite fracture . . . ." The ER notes document that R3's toe was reduced and sutured with a dressing applied. R3 returned to the facility at 9:45 pm on 9/19/14 per Nursing Notes. R3 had new orders for antibiotics and daily dressing changes.

On 11/13/14 at 3:00 pm E4 acknowledged that E6 should not have transferred R3 when R3 could not lift or open her left hand. E4 stated "(E6) should have immediately got the nurse to come and do an assessment. (R3) obviously was not in any shape to use a walker safely."

On 11/1314 at 3:05pm, E2, Director of Nursing acknowledged that E6 should not have walked R3 without both hands having proper grasps on

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S9999	Continued From page 5 the walker. E2 stated "Of course if you don't have control of the walker you're going to lose your balance." E2 agreed that E6 should have gotten a nurse before any attempts to walk R3. (B)	S9999		