STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145489	A. BUILDING _____ B. WING _____	C 09/11/2015

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) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #1564881 / IL#79919	F 000		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and observation the facility failed to ensure secured toilet seats for three residents (R1, R2, and R3) of five residents reviewed for safe toilet seats in the sample of seven. Findings include: The Physician Order Sheet, dated September 2015, documents the following diagnoses for R1: Episodic Mood Disorder, Panic Disorder, Hypothyroidism, Muscle Weakness, and Type II Diabetes Mellitus. The Minimum Data Sheet (MDS), dated 5/18/15, documents R1 as having No Cognitive Impairment. Review of Nurse's Notes, dated 8/30/15, documents R1 as having a "dime sized abrasion on posterior Left Leg above knee." Review of Nurse's Notes, dated 9/1/15, documents the Interdisciplinary Team reviewed the 8/30/15 incident finding root cause of abrasion to R1's Left Leg to be"(R1) rubbing her	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145489	A. BUILDING _____ B. WING _____	C 09/11/2015

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) COMPLETION DATE
F 323	Continued From page 1 leg on the toilet seat." Review of Quarterly Review (Safety) for May, June and July 2015 documents new toilet seats need ordered and replaced. Documentation does not include specific rooms. Review of Safety Meeting Checklist dated August 2015 has no documentation of toilet seat issues. On 9/9/15 at 1:00 pm, E4 (Maintenance Director) states "I don't keep a copy of work orders." On 9/9/15 at 2:50 pm, E4 stated that toilet seats in (R5's) room were tightened as well as in (R1's) room. On 9/10/15, at 9:30 am, R1's toilet seat was loose, moving side to side. On 9/10/15, at 9:35 am, R3's toilet seat was loose, moving side to side. On 9/10/15, at 1:40 pm, R2's toilet seat was loose, moving side to side. On 9/10/15, at 1:45 pm, R1 stated " When I sat down, the seat shifted and pinched me." On 9/11/15, at 10:05 am, E1 (Administrator) states that E4 (Maintenance Director) went through the facility on 9/10/15 in the afternoon and tightened all loose toilet seats. On 9/11/15, at 10:15 am, E4 (Maintenance Director) noted that the toilet seat in (R1's) room remained loose, moving side to side. On 9/11/15, at 10:25 am, E4 noted that the toilet seat in (R3's) room remained loose, moving sided to side.	F 323		