STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003875	A. BUILDING: _____ B. WING _____	C 01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK POINTE HEALTHCARE & REHAB	1223 EDGEWATER MORRIS, IL 60450

(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) 300.1010h) 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 which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or	S9999	Attachment A Statement of Licensure Violations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003875	A. BUILDING: _____ B. WING _____	C 01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK POINTE HEALTHCARE & REHAB	1223 EDGEWATER MORRIS, IL 60450

(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	Continued From page 1	S9999		

manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

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 care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003875	A. BUILDING: _____ B. WING _____	C 01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK POINTE HEALTHCARE & REHAB	1223 EDGEWATER MORRIS, IL 60450

(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	Continued From page 2	S9999		

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 Regulations were not met as evidenced by:

Based on interview and record review the facility failed to monitor, complete the neurological assessment, notify the physician and obtain emergency medical care for one resident R1 who was on blood thinning medication and fell with injury to the head. This applies to one resident (R1) reviewed for falls.

This caused R1 a delay in immediate care and treatment for a head injury. Four hours after the fall, R1 was transported to the local hospital and expired.

The findings include:

R1 was admitted to the facility on 10/04/14. On 12/19/14, R1 was readmitted to the facilities long term care unit after being hospitalized. The admission physician order sheet showed R1 had diagnoses of Cerebral Vascular Accident, Atrial fibrillation, Polycythemia, Deep Vein Thrombosis, Pulmonary embolism and Seizure Disorder.

The physician order sheet also showed that R1 was on Coumadin therapy (blood thinner).

On 12/22/14, a note was written at 1:38am by E5 (Licensed Practical Nurse). E5 wrote a late addendum regarding a fall R1 had on 12/21/14 at 4:45pm. The note showed that R1 was found on the bathroom floor at 4:45pm. R1 was conscious and complaining of head pain. The note showed that R1 had a hematoma to the forehead. The note showed only one set of vital signs. There was no time documented.

On 12/22/14, a nursing note timed 1:31am was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003875	A. BUILDING: _____ B. WING _____	C 01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK POINTE HEALTHCARE & REHAB	1223 EDGEWATER MORRIS, IL 60450

(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	Continued From page 3	S9999		

documented as a late entry for 12/21/14 at 4:45pm. The note showed that R1 was observed by the Certified Nursing Assistant on the floor in the bathroom. E5 (Licensed Practical Nurse) wrote an assessment at that time. The assessment showed that R1 had a large hematoma on the left forehead. The note showed that R1 had pain and received 500 milligrams of Tyelenol from E5. The note also showed that E10 (Medical Doctor) was paged times two. E10 was on call for E9 (Medical Doctor/Director). The note then shows that a fax will be sent in the morning to notify the doctor.

The vital signs in the nursing note match the vital signs done at 4:45pm on the Neurological flow sheet. The neurological flow sheet dated 12/21/14 instruct the nurse to assess neuro status every 15 minutes times one hour, then every 30 minutes times one hour, then every hour for four hours, then every four hours for 24 hours. The sheet for R1 dated 12/21/14 showed only seven sets of vital signs. The vital signs are not timed nor signed by the examiner. R1 fell at 4:45pm. The nursing note for 12/22/14 at 1:30am showed that R1 was sent out to the hospital at 8:25pm on 12/21/14.
A Neurological Flow Sheet dated for 12/21/14 showed that around 4:45pm R1 was transferred by two assists to the bed and then to the chair. The Neurological Sheet showed that around 7:45pm the resident had no change. The sheet is not complete and is not signed or timed.

On 1/4/14 at 2:30pm, E4 (Certified Nursing Assistant) stated, " I took vital signs every 15 minutes until I left at six o ' clock. I did them five times. I gave report to the next shift to continue to monitor " . The Neurological Flow sheet showed only two more sets of untimed vital signs

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003875	A. BUILDING: _____ B. WING _____	C 01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK POINTE HEALTHCARE & REHAB	1223 EDGEWATER MORRIS, IL 60450

(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	Continued From page 4	S9999		

after the ones taken by E4. The sheet does not show all of the vital signs that were to be done per the instructions on the sheet. The sheet is not complete and is not signed or timed.

The incident report generated for R1, by E5 (Licensed Practical Nurse) on 12/21/14 at 4:45pm show only one set of vital signs. At 6:30pm, E5 wrote R1 continues with a headache and neuro checks are within normal limits. At 8:15pm, E5 wrote that R1 was found lethargic and responsive to tactile stimulation only. There are no vital signs or neurological checks documented. The note showed that R1 was being sent to the community hospital emergency room. R1 was then sent out to the community hospital and expired.

The Nursing progress note dated 12/22/14 at 1:39am, showed that at 8:25pm R1 was sent out to the hospital. The clinical record showed no documentation of the neurological checks or vital signs prior to transfer.
On 1/5/14 at 9:50am, via telephone interview, E5 (Licensed Practical Nurse) stated that she knew R1 was on Coumadin therapy. E5 stated, " R1 had swelling to the forehead. R1 complained of headache and dizziness. The vital signs and neurological checks were normal " . The interview process with E5 was difficult due to a language barrier. E5 was unable to understand all of the questions asked and had difficulty expressing answers that could be understood.

On 1/5/14 at 3:00pm, E8 (Registered Nurse) stated, " I was in charge that night. E5 called me down to check on R1. R1 had swelling on the forehead and was complaining of pain. I anticipated that R1 would have gone out to the hospital for a check. I told E5 to put a call out the physician. If I didn't hear back from the doctor I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003875	A. BUILDING: _____ B. WING _____	C 01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK POINTE HEALTHCARE & REHAB	1223 EDGEWATER MORRIS, IL 60450

(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	Continued From page 5 would have called the Emergency room physician to see if he could page the doctor " . On 1/4/15 at 1:40pm, E1 (Administrator) stated that E5 had not performed an investigation of the fall or followed the facility policy regarding head injuries. E1 said that she became aware of the incident the morning of 12/22/14. E1 said that if E5 was unable to reach the doctor there were many other options including calling E1. On 1/5/15 at 1:45pm, E9 (Medical Doctor and Medical Director) stated, " I just found out today that R1 fell and expired. If we are not answering our pages the staff is to call the hospital emergency room physician. There are also two other doctors that could have been called. Even so I was on vacation and had my cell phone with me and on. They know they could have called me. I would have wanted to know right away if R1 fell and I would have sent R1 out to the hospital for evaluation right away " . Facility policy updated 5/12/11 entitled, "Post Fall Assessment Policy" documents "If there is any head involvement or the resident unsure if head involvement occurred neurological checks will be initiated for an assessment period of 72 hours." "The nurse will notify the resident's physician and responsible party in an appropriate time frame." (A)	S9999		

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

Imposed Plan of Correction

Facility Name: PARK POINTE HEALTHCARE & REHAB
Survey Date: JANUARY 8, 2015
Survey Type: COMPLAINT: 1475882/IL74023

300.610a)
300.1010h)
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 which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.

Section 300.1010 Medical Care Policies

h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

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 care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

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.*

This will be accomplished by:

Resident assessments were reviewed to ensure that those residents who are at risk for falls/injuries have appropriate interventions on their care plans. The facility must ensure that the resident environment remains free of accident hazards as is possible; and each resident receives adequate supervision and assistance to prevent accidents.

Post Fall Assessments shall be initiated by the Nurse and evaluate patient for possible injuries. Provide First Aid as needed; notify Physician or Physician on call regarding injury and assessment ASAP. Notify Relative or Guardian as indicated immediately. Document the above as per policy. Notify Illinois Department of Public Health immediately of Fall/Injury as per guidelines.

Assess Patient frequently for change or decrease in medical status, and notify Physician or 911 as necessary for at least 72 hours or as otherwise indicated.

The facility will conduct an investigation of Fall/Injury and needed training. Take appropriate actions to see that employees involved will receive education and training as needed regarding the above topic.

Staff are to educated on the process to maintain resident safety, and on the facility's Fall Policy, including preventative measures, implementing interventions after a fall, and identifying the root cause of the fall

The facility will review residents who sustain a fall at the morning IDT meeting to determine if appropriate interventions/documentation had been implemented. Findings will be presented to the Quality Assurance Committee monthly for three months for review and recommendations.

The facility is responsible for an audit to be done, at least, monthly to verify that this procedure is completed as mandated per this imposed plan of correction.

The facility Administrator or designee will be held responsible to monitor logs and/ or audit tools used to verify compliance with imposed plan of correction.

Completion date: 20 Days from Receipt of Notice