STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003206	A. BUILDING: _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAXTON HEALTHCARE AND REHAB	1240 NORTH MARKET STREET PAXTON, IL 60957

(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	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 are not met as evidenced by: Based on interview and record review the facility failed to ensure that post fall interventions were implemented for (R13) 1 of 8 residents reviewed for falls in a sample of 15. R13 sustained a fall on 6/11/15 which resulted in R13 receiving a laceration on the left brow requiring sutures. R13 is one of eight residents reviewed for falls in a sample of 15. Findings include: The Physician's Order Sheet dated July 2015 lists the following diagnoses for R13: Femoral Neck Fracture of Left Hip, Left Breast Cancer, Dementia and Depressive Disorder. The Minimum Data Set (MDS) dated 6/2/15 assesses R13 to be severely cognitively impaired, requires extensive assist with the assistance of one staff for bed mobility, transfers and toileting. The MDS documents R13's balance as unsteady and requires staff assistance to maintain balance.	S9999		

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S9999	Continued From page 2 R13's fall risk assessments dated 2/3/15, 4/15/15 and 6/4/15 documents R13 is at high risk for falls. The facility's form titled "Accident and Incident Log June 2015" documents R13 had an unobserved fall on 6/11/15. R13's Nurses Notes dated 6/11/15 at 3:30 PM states "Resident found on floor laying on left side with left side of head on floor approximately at 2:50 PM. Resident noted to have laceration on left brow with pool of blood under left side of head...Nurse Practitioner notified and gave new order to send (R13) to emergency room..." The facility's report dated 6/11/15 titled "Licensed Nurse Initial Incident Investigation" report states "(R13 attempting to get our to recliner"... "Alarm was on (R13) and not alarming when (R13) found on floor...." Facility form titled "Investigation Follow Up" dated 6/12/15 stated for root cause of the fall " (R13) tried to transfer self and fell alarm not sounding." The same form lists the new interventions as "Alarm checked and staff educated on the checking of alarms and that they should be checked at rounds..." R13's care plan dated 1/26/15 documents "The resident uses electronic alarm. Ensure the device is in place as needed. (Personal) alarm while in wheelchair and Pressure alarm when in bed...Educated staff that all alarms are to be checked at shift change during walking rounds to ensure they are in place and working. (Personal) alarm will be placed and activated when (R13) is up in chair at all times." E2, Director of Nurses (DON) stated on 7/10/15 at 12:57 PM "...The alarm was on (R13) but was not turned on."	S9999		

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S9999	Continued From page 3 R13's Nurses Note dated 6/11/15 at 7PM documents "(R13) returned from hospital approximately 5:30 PM. Report from ER (Emergency Room) Nurse stated 7 sutures to left brow...Sutures to be removed on 6/16/15." (B) 300.2010a)1) 300.330 Section 300.2010 Director of Food Services a) A full-time person, qualified by training and experience, shall be responsible for the total food and nutrition services of the facility. This person shall be on duty a minimum of 40 hours each week. 1) This person shall be either a dietitian or a dietetic service supervisor 300.330 Definitions - Dietetic Service Supervisor - a person who: is a dietitian; or is a graduate of a dietetic technician or dietetic assistant training program, corresponding or classroom, approved by the American Dietetic Association; or is a graduate, prior to July 1, 1990, of a Department-approved course that provided 90 or more hours of classroom instruction in food service supervision and has had experience as a supervisor in a health care institution which included consultation from a dietitian; or has successfully completed a Dietary Manager's Association approved dietary managers course; or is certified as a dietary manager by the Dietary Manager's Association; or has training and experience in food service supervision and management in a military service	S9999		

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S9999	Continued From page 4 equivalent in content to the programs in the second, third or fourth paragraph of this definition. This requirement is not met as evidenced by the following: Based on interview and record review the facility failed to have a qualified Dietetic Services Supervisor who has completed the required training and works 40 hours per week in the kitchen. This has the potential to affect all 59 residents. Findings include: On 7-7-15 at 11:30am E3, Dietary Manager stated "the first three lessons have been completed of the Dietary Managers (correspondence) Course and I'm working on the fourth lesson now. The course was started on 5-12-15 and I have until November 2016 to finish the class. (E4), the prior Dietary Manager's last day of work was in April 2015." According to records provided by E3, the start date of the Dietary Manager Training Program was on 5-12-15 with completion date of 11-12-16. On 7-7-15 at 11:30 am E3 stated "(Z1, Consultant Registered Dietitian) comes eight hours every month and we are to work on the lessons." On 7-9-15 at 8:50am E1, Administrator stated E4 left employment in April 2015 and E3 took over the duties of Dietary Manager at that same time with plans to begin the Dietary Managers Course.	S9999		

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S9999	Continued From page 5 The Resident Census and Conditions of Residents Report on 7-7-15 reflects a census of 59 residents. (AW) 300.690b)c) Section 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. These requirements are not met as evidenced by: Based on interview and record review the facility failed to report an incident for R13 who sustained a fall which resulted in R13 receiving a laceration on the left brow requiring sutures. R13 is one of eight residents reviewed for falls in a sample of 15 Findings include:	S9999		

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S9999	Continued From page 6 The Physician's Order Sheet dated July 2015 lists the following diagnoses for R13: Femoral Neck Fracture of Left Hip, Left Breast Cancer, Dementia and Depressive Disorder. The Minimum Data Set (MDS) dated 6/2/15 assesses R13 to be severely cognitively impaired, requires extensive assist with the assistance of one staff for bed mobility, transfers and toileting. The MDS documents R13's balance is unsteady and requires staff assistance to maintain balance. R13's fall risk assessments dated 2/3/15, 4/15/15 and 6/4/15 documents R13 is at high risk for falls. The facility's form titled "Accident and Incident Log June 2015" documents R13 had an unobserved fall on 6/11/15. R13's Nurses Notes dated 6/11/15 at 3:30 PM states "Resident found on floor laying on left side with left side of head on floor approximately at 2:50 PM. Resident noted to have laceration on left brow with pool of blood under left side of head...Nurse Practitioner notified and gave new order to send (R13) to emergency room..." The facility's report dated 6/11/15 titled "Licensed Nurse Initial Incident Investigation" report states "(R13 attempting to get our to recliner"... "Alarm was on (R13) and not alarming when (R13) found on floor...." Facility form titled "Investigation Follow Up" dated 6/12/15 stated for root cause of the fall " (R13) tried to transfer self and fell alarm not sounding." The same form lists the new interventions as "Alarm checked and staff educated on the checking of alarms and that they should be checked at rounds..." R13's care plan dated 1/26/15 documents "The resident uses electronic alarm. Ensure the device is in place as needed. (Personal) alarm while in wheelchair and Pressure alarm when in	S9999		

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S9999	Continued From page 7 bed...Educated staff that all alarms are to be checked at shift change during walking rounds to ensure they are in place and working. (Personal) alarm will be placed and activated when (R13) is up in chair at all times." E2, Director of Nurses (DON) stated on 7/10/15 at 12:57 PM "...The alarm was on (R13) but was not turned on and I did not report this incident to IDPH (Illinois Department of Public Health). R13's Nurses Note dated 6/11/15 at 7PM documents "(R13) returned from hospital approximately 5:30 PM. Report from ER (Emergency Room) Nurse stated 7 sutures to left brow...Sutures to be removed on 6/16/15." (B) 300.1230 k) Direct Staffing Effective September 12, 2012, a minimum of 25% of nursing and personal care time shall be provided by licensed nurses, with at least 10% of nursing and personal care time provided by registered nurses. Registered nurses and licensed practical nurses employed by a facility in excess of these requirements may be used to satisfy the remaining 75% of the nursing and personal care time requirements. This requirement is not met, Based on record review and interview the facility failed to meet staffing requirements for nursing and personal care for two of 14 consecutive days reviewed. This failure has the potential to affect	S9999		

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S9999	Continued From page 8 all 59 residents in the facility. Findings include: On 7/8/15 at 2:00 PM E2, Director of Nurses, provided a staffing spreadsheet dated 6/17/15 through 6/30/15. The spreadsheet documents the average daily census for that period of 7.71 skilled care residents and 50.86 intermediate care residents. The calculations totaled 156.44 hours of minimum direct care staff required per 24 hours. The staffing spreadsheets and working schedules document the following staffing failures: 6/21/15 153.75 hours of direct care staffing shortage of 2.69 hours 6/28/15 138.40 hours of direct care staffing shortage of 18.04 hours E2, Director of Nurses at 3:30 PM on 7/9/15 confirmed the staffing hours were accurate. The Resident Census and Conditions of Resident Form dated 7/7/15 documents that 59 residents reside in the facility. (AW) 300.3100d)2) Section 300.3100 General Building Requirements d) Doors and Windows 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	S9999		

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S9999	Continued From page 9	S9999		

device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required.

These requirements not met as evidenced by:

Based on observation, interview and record review the facility failed to equip an unsupervised exterior door with a signal to alert staff when the door is opened. This failure has the potential to affect seven residents (R1, R2, R7, R12, R16, R22, and R23) on the sample of fifteen and thirty residents (R4, R8, R9, R11, R17, and R30 through R54) on the supplemental sample.

Findings include:

On 7/8/15 at 9:00 AM, the exit (exterior) door egressing outdoors to the south end of a central courtyard had no signaling equipment to alert staff when the door was opened.

The courtyard is "L" shaped, consequently, the east end of the courtyard was not visible from this door. There were also recessed arches around the perimeter of the courtyard which would conceal residents from staff view. There was also a large bush 8 feet in diameter on the southwest corner of the courtyard which would conceal residents from staff view. An unwitnessed resident exit has the potential for resident injury and exposure to elements.

On 7/8/15 at 9:00 AM E6 Housekeeping Supervisor stated, "Residents do go out that door sometimes."

On 7/10/15 at 8:00 AM E7 Social Services Director stated, "We do have three residents with a high risk for elopement (leaving the building

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S9999	Continued From page 10 unnoticed), (R1, R12, R47)." The facility's undated High Risk Elopement list confirms (R1, R12, R47) are assessed as being at high risk for elopement. The facility's undated Current Smokers list documents (R8, R22, and R30 through R32) are unsupervised smokers who use this area. The facility's self-identified roster dated 7/9/15 documents thirty-six residents (R1, R2, R4, R7, R8, R9, R11, R16, R17, R22, R23, and R30 through R54) who are independently mobile either ambulatory or in a wheelchair. R12 was omitted from this listing. (B)	S9999		