STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145967	A. BUILDING _____ B. WING _____	12/14/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCALLISTER NURSING & REHAB	18300 S. LAVERGNE AVE POB 367 TINLEY PARK, IL 60477

(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 520	Continued From page 167 2007 at the facility. F224, F226, F323, F501, F520 and F490 were discussed in detail. Meetings have been scheduled in advance for the next six months, monthly. The facility's QA policies and procedures were revised to include a method of reporting to the QA committee as well as a method for following up on reported concerns. The facility has developed several QA tools to monitor and attempt to ensure that alleged deficiencies do not recur. These tools include: **A comprehensive compliance rounds sheet. The tool was imitated on November 29, 2007 by E2 and E12 (Maintenance Supervisor) who will monitor for compliance. **A pressure ulcer tool was initiated on November 29, 2007 by E2 and E4 who will monitor for compliance. **An accident/incident tool. The tool was initiated on November 29, 2007 by E2 and E4 will monitor for compliance. **Dining supervision tools. The tool was initiated on November 29, 2007 by E2 who will monitor for compliance. Completion Date: December 3, 2007	F 520		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS LICENSURE VIOLATIONS 300.610a) 300.3240a)	F9999		

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F9999	Continued From page 168 300.3240e) 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. These REGULATIONS are not met as evidenced by: Based on observations, record review, interviews	F9999		

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F9999	Continued From page 169	F9999		

and review of policy, the facility failed to protect residents and ensure they are free from abuse by not following the abuse prevention policy to ensure that allegations of abuse and injuries of unknown origin are investigated and reported to the state agency, for 2 of 15 residents in the sample (R10 and R11), and by failing to remove employees accused of abuse from resident contact pending the outcome of an abuse investigation.

Findings include:

1. R11 is an 80 year old resident who was admitted to the facility with diagnoses including multiple dislocations of the left hip, history of left hip replacement with prosthesis, aortic aneurysm, cerebral vascular accident and hypertension. According to the most recent resident assessment instrument (Minimum Data Set) dated 9/10/07, facility staff identified that R11 has no difficulties with memory recall. Facility staff also identified that R11 has modified independence with cognitive skills for decision making. R11 was identified by facility staff to have limitations in range of motion of the upper and lower extremities. R11 who is non-ambulatory uses a wheelchair and requires staff assistance with bed mobility and transfers. R11 also requires staff assistance with all activities of daily living. R11 is dependent on facility staff for all of his care needs.

On review of the allegations of abuse presented by the facility, it was documented that R11 informed facility staff of an allegation of physical abuse. On 11/19/07, R11 reported to E10 (Registered Nurse) that he had been kicked in the knee by a certified nursing assistant. E10 did

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F9999	Continued From page 170 not provide any assistance and instructed the resident to notify the nursing supervisor (E6) of the allegation of abuse himself. During an interview on 11/28/07, E6 confirmed that R11 reported an allegation of physical abuse. E6 stated that the resident reported that while he was seated in his wheelchair, he was kicked in the knee by a certified nursing assistant (CNA). E6 stated that R11 was reluctant to answer questions regarding the alleged abuse and stated, "oh just forget it you are one of them." E6 did not document the allegation of abuse and did not initiated an abuse investigation. E6 reported the allegation of abuse to E3 (Abuse Coordinator) on the following day. On 11/20/07, E3 completed the Preliminary 24 hour Incident Investigation Report. According to the report, on 11/19/07, R11 "complained that they (certified nursing assistants) kicked him in the knee." R11 identified that E27, E31 and E36 (certified nursing assistants) were present during the alleged abuse, but could not identify which certified nursing assistant kicked him. According to the documentation, R11 informed facility staff that E20 (Admissions Director)) witnessed the alleged abuse. During an interview on 11/28/07, E3 stated that she was informed of the allegation of abuse on 11/20/07. E3 stated that she initiated an abuse investigation when she was informed of the allegation of abuse. E3 confirmed during the interview, that R11 identified that E27, E31 and E36 were present when he was kicked in the knee. E3 also confirmed during the interview that E27, E31 or E36 were not sent home or suspended pending completion of the	F9999		

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F9999	Continued From page 171 investigation. According to the facility Abuse Prevention Program Facility Procedures, the facility has a responsibility to protect a resident with allegations of employee-to-resident abuse. The policy states, "employees of this facility who have been accused of mistreatment will be removed from resident contact immediately until the results of the investigation have been reviewed by the administrator or designee. Employees accused of possible mistreatment shall not complete the shift as a direct care provider to residents." The facility failed to follow the policy for abuse prevention. This resulted in the facility's failure to protect R11 from abuse. 2. R10 is an 85 year old resident with diagnoses including hypertension, chronic obstructive pulmonary disease, anxiety and dementia. According to the most recent resident assessment instrument (Minimum Data Set) dated 9/9/07, facility staff identified that R10 has difficulties with short term memory recall and moderately impaired cognitive skills for decision making. R10 is totally dependent on facility staff for bed mobility and transfers. Facility staff have also identified that R10 is dependent on facility staff for all activities of daily living. R10 has limitation in range of motion of the left upper and lower extremities. On 11/26/07 at approximately 11:40 AM, R10 was observed lying in bed with both side rails in the up position. The head of the bed was at a 45 degree angle and the resident was observed to have slid down towards the foot of the bed. The resident's left foot was wedged between the	F9999		

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F9999	Continued From page 172	F9999		

footboard and the mattress. R10 was yelling out in pain and screaming for staff assistance. Facility staff did not respond to the resident's cry for help until prompted by the surveyors. E34 and E16 (certified nursing assistants) responded and stated that they would inform the nurse of the resident's complaints of pain. R10 was observed to have a swollen left knee and an outward rotation of the left extremity. On review of the clinical record, there was no documentation of the resident's complaints of pain.

Again on 11/28/07 at approximately 10:20 AM, R10 was observed lying in bed screaming out in pain. The resident complained of left hip pain. R10 was observed to have a soiled dressing to the left lower leg. E7 (licensed practical nurse) removed the dressing to reveal a wound to the left lower anterior leg. R10 was observed to have a large skin tear that measured 3.5 cm x 3.0 cm. The wound was observed to have an irregular shape with an attached skin flap. The wound and surrounding area was red, swollen and tender to touch. There was a small amount pink color drainage at wound area.

On review of the clinical record, there was no documentation of the injury to R10's left lower leg. On review of the allegations of abuse presented by the facility, there was no documentation of any incidents that resulted in the injury to R10's left leg. During an interview on 11/28/07, E3 confirmed that an abuse investigation had not been initiated.

According to the Abuse Prevention Program Facility Procedures, facility staff are required to identify and report injuries of unknown origin. The facility policy states that, "the nursing staff is