STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION

MARKLUND CHILDREN'S HOME — Facility Name
0011288 — I.D. Number

164 SOUTH PRAIRIE AVENUE, BLOOMINGDALE, ILLINOIS 60108 — Address

11/04/2004 — Date of Survey

ANNUAL — Type of Survey

As a result of a survey conducted by representative(s) of the Department, it has been determined the following violations occurred. Please respond to each violation. The response must include specific actions which have been or will be taken to correct each violation. The date by which each violation will be corrected must also be provided. Forms are to be submitted with the original signature.

IMPORTANT NOTICE: THE STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 83-1530. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THE FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

"A" VIOLATION(S):

350.620a)
350.3240a)b)c)d)e)

The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually.

AN OWNER, LICENSEE, ADMINISTRATOR, EMPLOYEE OR AGENT OF A FACILITY SHALL NOT ABUSE OR NEGLECT A RESIDENT. (Sections 2-107 of the Act)

A FACILITY EMPLOYEE OR AGENT WHO BECOMES AWARE OF ABUSE OR NEGLECT OF A RESIDENT SHALL IMMEDIATELY REPORT THE MATTER TO THE FACILITY ADMINISTRATOR. (SECTION 3-610 OF THE ACT)

A FACILITY ADMINISTRATOR WHO BECOMES AWARE OF ABUSE OF A RESIDENT SHALL IMMEDIATELY REPORT THE MATTER BY TELEPHONE AND IN WRITING TO THE RESIDENTS'S REPRESENTATIVE. (Section 3-610 of the Act)

A FACILITY ADMINISTRATOR, EMPLOYEE, OR AGENT WHO BECOMES AWARE OF ABUSE OR NEGLECT OF A RESIDENT SHALL ALSO REPORT THE MATTER TO THE DEPARTMENT. (Section 3-610 of the Act)

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 THE 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. (Section 3-611 of the Act)

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These regulations were not met as evidenced by the following:

A. Based on review of incident investigations, record verifications and interviews, the facility failed to implement their policy prohibiting abuse and neglect when they:

1) Failed to ensure that 1 of 1 allegation of abuse and neglect on 7/24/04 was immediately reported to the Administrator resulting in E6 (Certified Nursing Aide) working on 7/25/04 and 7/26/04.

2) Failed to prevent a delay in having an x-ray resulting in a delay in a diagnosis of Fractured Femur. The facility thus failed to address changes in activity needs for R9 during the delay in x-ray.

Findings include:

1.) R10, per his Physician's Orders Sheet, is a 17-year-old profoundly mentally retarded male who is non-verbal and non-ambulatory. R11, per his Physician's Orders Sheet, is a 5-year-old profoundly mentally retarded male who is non-verbal and non-ambulatory.

A review of incidents showed an incident dated 7/24/04. A letter (not dated) written by E4 is attached to the incident. This letter stated, "E5 (Certified Nursing Aide (CNA) was feeding R10 on Saturday afternoon (7/24/04). R10 wasn't eating so, E5 started shaking his head back and forth and hitting R10 on the back of the head telling R10 to wake up. E6 (CNA) was feeding R11. R11 was choking on his food and jolting in his chair and E6 didn't even look at him. R11 repeated coughing and choking and she never gave him the time of day. The aides sit in the dining room and ABSOLUTELY NEGLECT the clients. This was not a one time incident. This is how they have behaved every weekend that I have worked. I just wanted to let you know this. I wasn't sure who to express this to because I didn't recognize the nurses that were working and so I was told to write a letter to you."

E4's written statement stated under "What did you do?" "I made a phone call to E3 (Human Resource Director) to find out what to do because I didn't recognize any of the nurses that were on duty. She (E3) advised me to write a letter to E2, DON explaining everything so that's what I did."

Interview with E1, Administrator on 10/26/04 at 4:02PM stated, "No, E3 did not inform the facility when she was informed by E4. E3 is the Human Resources Director for the entire organization." E1 added, "No, we did not talk to E3 about this incident."

E3 was interviewed on 10/27/04 at 11:55AM. E3 stated, "I am fairly sure E4 told me (the 7/24/04 incident) when she got home that day. I asked E4 if she reported it to the nurse in charge and she said she didn't know who the nurse in charge was." E3 added, "I've been here a long time. I was using analytical skills to determine what to do - at that point I thought the best thing for E4 to do was to write it out and give it to E1 and E2 on Monday (7/26/04).In hindsight, maybe I should have paged E1 and had him make a call."

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A review of staff assignment sheets showed that E5 only worked on 7/24/04 from 7AM to 3PM. However, E6 worked 7AM to 3PM shift on 7/24/04, 7AM to 11PM shift on 7/25/04 and 3PM to 11PM shift on 7/26/04. Due to E3 and E4's failure to report the allegation of abuse and neglect immediately to the Administrator all 30 clients in the facility were at risk for potential abuse and neglect from E6 until she was suspended on 7/27/04.

The other allegations in E4's letter stating, "This was not a one time incident. This is how they have behaved every weekend that I have worked" has not been investigated by the facility. E4 per E3 was working from beginning of June until August 15th.

Per E1, E4 was verbally counseled about reporting. E2 then presented an in-service sheet dated 8/2/04 regarding the policy on Suspected Unusual Events wherein staff were reminded to immediately report it to the relevant supervisor on duty. This in-service was attended by the nurses and CNAs along with one of the three receptionists. The housekeeping, laundry and dietary staff were not included in this in-service.

Interview with E7, laundry assistant on 10/28/04 stated, "Yes, the facility trained me on abuse and neglect. I can't remember when the last time I was trained on abuse and neglect." E7 was asked what she would do if she would see abuse, E7 answered, "If I see a CNA hit a client, I would ask someone (another CNA) to help that CNA." E7 was asked if she would report this as abuse, E7 replied, "No, I will not report it (abuse)." E7 added, "As long as the kid is okay, I'm okay with it. I will not report it."

A review of the facility's General Policy and Procedure on Suspected Abuse, Neglect or Mistreatment of a client (Unusual Events) stated that "Any employee who suspects or witnesses an unusual event involving a client must report the incident to the supervisor on duty and provide the facility with a written statement signed and dated detailing the alleged event."

2. Per the Clinical Record R9 is a 29-year-old male whose diagnoses include, Profound Psychomotor Retardation, Seizure Disorder, Severe Levothoracic Scoliosis, Asthma, and Spastic Quadriparesis.

Review of the facility's accident incident report dated 10/01/04 states: "Client transported to (local hospital) via ambulance for x-ray of bilat hips & thighs per order of (Z1); this, (secondary) client (complaint of) discomfort when repositioned or moving legs." "Returned form (local hospital), 10/01/04 8p diagnosis: fx (left) femur."

Review of the facility's Occurrence Internal Investigation Report states: "Describe what occurred as provided by reporting individual: Client's guardian reported some facial grimacing and lower extremity tremors (with) extension of legs. Guardian stated she felt this was muscular in origin of discomfort. Refused x 24 hrs to have x-rays taken. Discomfort did not subside. Transported to ER for evaluation. Fracture of (left) femur discovered. Orthopedic surgeon (surgeon's name) consulted. Client is not a surgical candidate. Bed rest until 10/5/04, then (increase) activity tolerance."

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"Describe what occurred as provided by employee involved: By all accounts of witness statements, on 3-11 shift 9/29/04. Guardian first reported seeing client grimace and have leg tremors when legs extended. Guardian states he exhibits same behaviors (with) muscle spasms. Seen by attending MD 9/30/04 am, x-rays were ordered but allowed to be refused by guardian. Client continued (with) usual activities (with) no assessment of legs indicating any deficits. When discomfort had not subsided 10/1/04, guardian agreed to x-rays; x-rays + fracture of (left) femur. (No) surgical intervention (secondary) to (increased) risk."

"Describe your findings related to what occurred: This medically fragile client who is homebound and attends on-site DT programming participated in his usual activities up until the time the diagnosis of a (left) femur fracture was made. Guardian who is client's aunt, is very involved (with) clients direct care on a daily basis, approx 4pm until 1 or 2 am. Aunt reported signs of discomfort but stated to each nurse that she felt this was muscular in nature as clients behavior was similar to when he had muscle spasms. All nursing assessments indicate (no) redness, (no) swelling, equal warmth + pedal pulses to lower extremities."

"Recommendations/corrective action taken: The client is to have no physical therapy to increase activity as tolerated. Will be seen in ortho clinic on 10/12/04. Staff were in-serviced to use blanket/drool pad as an assist to reposition. He is to be a 2 man blanket transfer (with) pillow between legs until further MD orders. Client will be seen 10/7/04 by dietician for nutritional assessment. 10/8 addendum: client now requires a 3-man lift instead of 2 man blanket lift."

Review of the nursing progress notes confirm the narrative from the investigation summary. The initial notation indicating R9 was experiencing pain is dated 9/29/04 at 5:30 p.m. The Medication Administration Record prn medications lists Tylenol 15cc given for leg pain. All entries for Tylenol usage prior to this date note the medication given for discomfort.

During interview with Z1 on 10/28/04 he said, on 9/30/04 R9 experienced left hip thigh pain and x-ray was ordered. The guardian didn't want it done at that time so I ordered the delay in x-ray. If the area was painful I would have thought that they wouldn't have moved the area or protected it because it was suspicious. Usually the x-ray will be done that day for other clients, if the guardian said not that day it won't be done because they have legal rights. If the guardian had wanted it longer, I would have gently pushed on the guardian to get permission to get it done.

Per interview with Z2 on 10/27/04, ambulance rides upset R9 and there was no redness or temperature change which is why I didn't want him to go on (9/30/04). I thought it was something else. When asked about pain relief for R9, Z2 said he got Tylenol and has a standing order for Valium.

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Interview with E2, DON (Director of Nursing) on 10/27/04, confirmed that R9 initially complained of pain on 9/29/04 and was seen by Z1 on 9/30/04. Z1 ordered an x-ray, which was delayed until 10/01/04. R9 continued to receive Range of Motion (ROM) until the fracture was diagnosed. Upon return to the facility R9's activity was decreased, a pillow was placed between the legs at all times and stronger pain medication was ordered. R9's lift status was changed and all staff were in-serviced.

R9's normal activity status including ROM and usual medications continued until a fracture diagnosis was made approximately 48 hours after the initial complaints of pain were offered.