STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G295	A. BUILDING _____ B. WING _____	C 08/01/2006

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ADLOFF PLACE	**50 ADLOFF LANE SPRINGFIELD, IL 62703**

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W 149	Continued From page 36 g) Provide regular on site and external monitoring and follow up by Lead Program Services Specialist and responsible officers @ DDMS. Although the Immediate Jeopardy was removed, non compliance continues at the time of the exit conference since the facility will need to review on a case by case basis, allegations of abuse, neglect, mistreatment and injuries of unknown origin as they arise, continue to implement, review and or revise their policy and procedures on an on going basis, and provide necessary training and retraining to staff in regards its abuse, neglect and mistreatment intervention procedures.	W 149		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATION 350.620a) 350.680b)1) 350.680b)2) 350.680b)3) 350.700a)1) 350.700a)2) 350.700b) 350.700c) 350.1060a) 350.1060d)	W9999		

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W9999	Continued From page 37 350.1060h) 350.1060b)3) 350.1060b)6) 350.1060b)7) 350.1060c) 350.1060d)1) 350.1060d)2) 350.1060d)3) 350.1060e) 350.3240a) 350.3240b) 350.3240c) 350.3240d) Section 350.620 Resident Care Policies a) 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. Section 350.680 Developmental Disabilities Aides b) Each of the facility's developmental disabilities aides shall comply with one of the following conditions no later than 45 days after the date of initial 1) Provide documentation of registration on the Department's Nurse Aide Registry. 2) Enroll in a Department approved developmental disabilities aide training program (see 77 Ill. Adm. Code 395). The program shall be successfully completed no later than 120 days after the date of initial employment. Programs approved in accordance with 77 Ill. Adm. Code 395.150(a)(2) may last longer than 120 days.	W9999		

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W9999	Continued From page 38 However, a developmental disabilities aide may be employed no more than 120 days prior to the successful completion of the program. 3) Submit documentation in accordance with Section 350.683 of this Part in order to be registered on the Nurse Aide Registry. Section 350.700 Serious Incidents and Accidents a) The facility shall notify the Department of any incident or accident which has, or is likely to have, a significant effect on the health, safety, or welfare of a resident or residents. Incidents and accidents requiring the services of a physician, hospital, police or fire department, coroner, or other service provider on an emergency basis shall be reported to the Department. 1) Notification shall be made by a phone call to the Regional Office within 24 hours of each serious incident or accident. If the facility is unable to contact the Regional Office, notification shall be made by a phone call to the Department's toll-free complaint registry number. 2) A narrative summary of each serious accident or incident occurrence shall be sent to the Department within seven days of the occurrence. b) A descriptive summary of each incident or accident shall be recorded in the progress notes or nurses' notes for each resident involved. c) The facility shall maintain a file of all written reports of serious incidents or accidents involving residents. Section 350.1060 Training and Habilitation Services a) The facility shall provide training and habilitation services to facilitate the intellectual, sensorimotor, and effective development of each resident in the facility. d) There shall be evidence of training and	W9999		

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W9999	Continued From page 39 habilitation services activities designed to meet the training and habilitation objectives set for every resident. h) There shall be available sufficient, appropriately qualified training and habilitation personnel, and necessary supporting staff, to carry out the training and habilitation program. Supervision of delivery of training and habilitation services shall be the responsibility of a person who is a Qualified Mental Retardation Professional. Section 350.1230 Nursing Services b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in: 3) Periodic reevaluation of the type, extent, and quality of services and programming. 6) Development of a written plan for each resident to provide for nursing services as part of the total habilitation program. 7) Modification of the resident care plan, in terms of the resident's daily needs, as needed. c) A registered nurse shall participate, as appropriate, in planning and implementing the training of facility personnel. d) Direct care personnel shall be trained in, but are not limited to, the following: 1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention. 2) Basic skills required to meet the health needs and problems of the residents. 3) First aid in the presence of accident or illness. e) Sufficient, appropriately qualified nursing staff shall be available, which may include licensed practical nurses and other supporting personnel,	W9999		

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W9999	Continued From page 40 to carry out the various nursing service activities. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) b) 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) c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act) d) 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) These regulations are not met by the following: Based on observation, interview and record review the facility neglected to implement its abuse and neglect policy for 15 of 15 individuals (R1--R15) as follows: 1) Facility failed to: a) do an investigation into the cause of R15's large right leg bruise injury of unknown origin discovered 7/8/06. R15 was hospitalized for this bruise's progression and deterioration as a potential recluse spider bite on 7/12/06; b) to ensure timely physician assessment when R15's injury increased in size, redness, and swelling;	W9999		

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W9999	Continued From page 41 c) have documentation of nursing assessment and monitoring of R15's injury. 2) Facility failed to: a) have staff complete Form 0:300.04.1-A Individual Unusual Incident Report of R15's laceration injury to eyebrow; b) do an investigation into the cause of R15's serious injury of unknown origin of a left eyebrow laceration discovered at 6AM on 7/3/06 (This injury required the emergency room (ER) treatment of 5 sutures); c) notify R15's guardian of injury; d) have evidence of a system of monitoring R15 and the residents during the night. 3) Facility failed to: a) have evidence of a thorough investigation of R15's quarter size right cheek bruise injury of unknown origin discovered at 6:15 AM on 6/29/06 (This injury required an emergency room evaluation on 6/29/06 and was diagnosed as a right cheek contusion); b) obtain staff interviews/written statements for the investigation into the cause of R15's injury; c) have evidence of a system of monitoring R15 and the other residents during the night; d) have documentation of a timely nursing assessment of R15's injury. 4) Facility failed to:	W9999		

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W9999	Continued From page 42 a) provide medical services, as needed in a timely manner, that include evaluation, diagnosis and treatment for R12's forehead hematoma of unknown origin of 7/7/06; b) have staff notify the administrator immediately of R12's forehead hematoma injury; c) have evidence of a thorough investigation of R12's hematoma injury in a timely manner; d) notify R12's guardian of forehead hematoma injury. 5) Facility failed to: a) notify the administrator immediately of a neglect allegation; b) complete a thorough investigation of R13's lack of hygiene/oral care in a timely manner; c) meet the basic bathing and/or oral hygiene health care needs all individuals R1-- R15; d) train and encourage individuals to maintain good hygiene practices; e) have staff E11 follow Center for Disease Control (CDC) guidelines for universal precautions; f) ensure that all individuals' hygiene baskets are clean and contain basic hygiene items. 6) Facility failed to: a) have trained staff to document R14's knee	W9999		

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W9999	Continued From page 43 injury; b) have staff notify the on duty nurse of R14's knee injury for assessment and treatment; c) have staff complete an incident report of R14's knee injury of a 2 by 2 bloody abrasion from a fall while getting off the Day Training (DT) bus on 7/17/06. 7) Facility failed to: a) have staff assess R14 for injury after fall; b) have staff notify the PM nurse of R14's fall; c) have staff complete an incident report identifying the fall; when on 7/17/06 at 5:23PM, R14 was observed to walk into the dining room and fall down, directly in front of the surveyor, hitting the left side of face and left knee on the floor. Findings include: 1. By review of Physician Order Sheet (POS), R15 is a 35 year old female with the diagnosis of Profound Mental Retardation (MR), Schizoaffective disorder and Tourette Syndrome. According to Individual Unusual Incident Report of 7/8/06 completed by E20 and witnessed by E5, R15 was discovered with a large bruise on right leg when she was giving her a shower. The second entry on this report states: "6PM noted redness around middle of bruise like area, diameter size of 3-31/2 Inches wd+ lgth will continue to monitor."	W9999		

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W9999	Continued From page 44 Nursing assessment of bruise on Individual Unusual Incident Report (IR) completed the next day, 7/9/06 states: "The back of resident's R lower leg has black dot inside reddened area; the area is hard and hot to touch of area approximately 3-4 inches in diameter. B/P 122/73, Temp.97.8, Pulse 63, Resp. 16." Per 11:00 AM Nursing Note (N.N.) and IR, R15 was sent to emergency room (ER) on 7/9/06 for evaluation and returned with the diagnosis of cellulitis. PM N.N. by E19 of 7/9/06 documents "the redness enlarged" to R15's right leg and the physician Z4 given call at home several times, but unable to contact to inform of increase redness and swelling. There is no further evidence of physician contact. N.N. of 7/10/06 at 5:00 PM indicates that R15 was seen by physician, Z4, for suture removal (from previous injury of 7/3/06 eyebrow laceration of unknown origin) but neglected to have the physician assess R15's right leg. This N.N. states that staff E3 is going to make another appointment so it can be assessed. N.N. further states area on right lower leg same as on 7/9/06. There is no evidence of physician contact of the increase redness and swelling to R15's leg injury. N.N. of 7/11/06 6:00 PM indicates that R15 is afebrile and on antibiotic therapy. There is no documentation of ongoing assessment of bruise injury or evidence of physician contact. N.N. of 7/11/06 6:10 (PM) documents "V.S. (Vital Signs) 138/72--78--22" There is no documentation of assessing the bruise injury and R15's temperature, nor is there documentation of	W9999		

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W9999	Continued From page 45 physician contact. On 7/12/06 at 8:20AM, LPN E2 documents, per 7:30AM assessment of R15's leg injury, that "R leg hard Red HOT a necrotic area of abt (about) 3 1/2 by 3 in et (and) 1 sm (small) dot." This note further indicates that E2 spoke with a nurse, who had worked in her absence, who stated that R15 's injury much worse than yesterday. E2 documents sending R15 to ER on 7/12/06 for a possible recluse spider bite. N.N. of 7/12/06 10:45AM indicates that the local ER called to notify of admission and of a surgeon being called in for possible recluse bite. The facility's ABUSE AND NEGLECT policy and procedure 0-300.04.2, defines a serious injury as "An injury requiring medical treatment beyond first aid, which can only be administered by a physician, nurse practitioner, or physician assistant." This policy further states under it's procedure the following: An employee suspecting or witnessing an incident, which may be defined as mistreatment, corporal punishment, threat, exploitation, neglect, abuse or as a serious injury, shall, according to state statues and facility policy: A.Take immediate action to protect the individual served. B. Preserve any evidence. C. Immediately report the incident to the supervisor, who shall immediately inform the	W9999		

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W9999	Continued From page 46 Administrator or designee of the incident. D. Complete Form 0:300.04.1-A Individual Unusual Incident Report, in accordance with 0:300.04.1, Reporting Individual Unusual Incident. This policy also states under procedure 2.D. that the administrator will "initiate a formal in-house investigation into the allegations, per 0:300.04.3, Investigation of Possible Abuse and Neglect." upon being notified of any incident involving injuries of unknown source and insure that the family or guardian is promptly informed of the incident. Per 7/25/06 11:15AM phone interview with administrator E1, the facility did not investigate R15's large bruise injury of unknown origin discovered 7/8/06 while being given a shower. 2. By review of Physician Order Sheet (POS), R15 is a 35 year old female with the diagnosis of Profound Mental Retardation (MR), Schizoaffective disorder and Tourette Syndrome. Per 7/3/04 Emergency Department After Care Instructions and 7/3/06 AM Nursing Notes (N.N.), it was determined that R15 sustained a left eyebrow laceration requiring 5 sutures (N.N.7/4/06 9:00 AM) Direct care staff E11 and E12, stated, during 7/19/06 10:10AM interview, that they found R15 with the laceration when they came in to work the morning of 7/3/06 (6AM-2PM). E11 and E12 indicated that R15 had fallen, but not sure how. E11 and E12 stated they cleaned the injury up and told the nurse. R15 was then taken to the	W9999		

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W9999	Continued From page 47 emergency room (ER). E11 further stated that night shift wrote about the cut on a yellow piece of paper because there were no incident report forms available. The facility's ABUSE AND NEGLECT policy and procedure 0-300.04.2, defines a serious injury as "An injury requiring medical treatment beyond first aid, which can only be administered by a physician, nurse practitioner, or physician assistant." This policy further states under it's procedure the following: 1. An employee suspecting or witnessing an incident, which may be defined as mistreatment, corporal punishment, threat, exploitation, neglect, abuse or as a serious injury, shall, according to state statues and facility policy: A.Take immediate action to protect the individual served. B. Preserve any evidence. C. Immediately report the incident to the supervisor, who shall immediately inform the Administrator or designee of the incident. D. Complete Form 0:300.04.1-A Individual Unusual Incident Report, in accordance with 0:300.04.1, Reporting Individual Unusual Incident. The policy further states that "2 . Upon being notified of any incident involving injuries of unknown source, mistreatment, misappropriation of individual's property, corporal punishment,	W9999		

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W9999	Continued From page 48 threat, exploitation, neglect, abuse, Unauthorized Absence/Missing Individual/Elopement, or is a serious injury; the Administrator or designee shall: A. Take immediate action to protect the individual served, including immediately placing the alleged employee on Administrative Leave, pending the outcome of the facility's investigation." This policy also states under procedure 2.D. the administrator will "initiate a formal in-house investigation into the allegations, per 0:300.04.3, Investigation of Possible Abuse and Neglect." upon being notified of any incident involving injuries of unknown source and insure that the family or guardian is promptly informed of the incident. The Administrator E1, per 7/19/06 9:07AM interview, stated that he did not know whether or not R15's eyebrow laceration had been investigated. The License Practical Nurse (LPN), per 7/19/06 10:15AM interview, stated that no incident report or investigation was completed on R15's laceration. There is no evidence of guardian notification of this injury. There is no evidence of night time monitoring of any of the 15 residents. E3 confirmed, per 7/19/06 9AM interview, that there is no specific night time bed check documentation.	W9999		

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W9999	Continued From page 49 3. By review of Physician Order Sheet (POS), R15 is a 35 year old female with the diagnosis of Profound Mental Retardation (MR), Schizoaffective disorder and Tourette Syndrome. According to Individual Unusual Incident Report of 6/29/06 completed by staff E9, R15 was discovered with a slightly swollen bruise on right cheek at 6:15AM by staff E7 who informed the nurse. Confirmed by written statement by LPN E2, review of Nursing Notes (N.N.) of 6/29/06 and the incident report, it was determined that there was no documentation of a nursing assessment of the injury until the PM LPN, E19, at 5:00 PM. E19 documents on the incident report that the Agency nurse did not complete assessment of injury. On the next day's N.Ns. of 6/30/06 7:30 PM, E19 documents that R15 was sent to emergency room (ER) on 6/29/06, that R15's injury has increased bruising that included the corner of right eye/face being puffy, cool to touch and that R19 had been diagnosed with contusion of right cheek. The facility's ABUSE AND NEGLECT policy and procedure 0-300.04.2, defines a serious injury as "An injury requiring medical treatment beyond first aid, which can only be administered by a physician, nurse practitioner, or physician assistant." This policy further states under it's procedure the following: 1. An employee suspecting or witnessing an incident, which may be defined as mistreatment,	W9999		

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W9999	Continued From page 50 corporal punishment, threat, exploitation, neglect, abuse or as a serious injury, shall, according to state statues and facility policy: A.Take immediate action to protect the individual served. B. Preserve any evidence. C. Immediately report the incident to the supervisor, who shall immediately inform the Administrator or designee of the incident. D. Complete Form 0:300.04.1-A Individual Unusual Incident Report, in accordance with 0:300.04.1, Reporting Individual Unusual Incident. The policy further states that "2. Upon being notified of any incident involving injuries of unknown source, mistreatment, misappropriation of individual's property, corporal punishment, threat, exploitation, neglect, abuse, Unauthorized Absence/Missing Individual/Elopement, or is a serious injury; the Administrator or designee shall: A. Take immediate action to protect the individual served, including immediately placing the alleged employee on Administrative Leave, pending the outcome of the facility's investigation." This policy also states under procedure 2.D. that the administrator will "initiate a formal in-house investigation into the allegations, per 0:300.04.3, Investigation of Possible Abuse and Neglect."; upon being notified of any incident involving injuries of unknown source and insure that the	W9999		

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	14G295	A. BUILDING _____ B. WING _____	C 08/01/2006

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W9999	Continued From page 51 family or guardian is promptly informed of the incident. Per review of facility investigation there was only one written staff statement obtained from E12, who was one of the day shift staff finding the injury. Facility's Investigation of abuse and neglect policy 0-300.04.3 states under procedure 2.B., the investigator shall "Conduct interviews of all parties involved, asking "what", "who", "where", "when", "why" and "how" beginning with : 1. the person making the report" etc. No evidence was available of other staff interviews. There is no evidence of night time monitoring of R15 and or any of the 15 residents. E3 confirmed, per 7/19/06 9AM interview, that there is no specific night time bed check documentation. 4. R12, per observation and POS, is a 46 year old ambulatory female with limited verbal skills. R12's diagnosis, in part, includes Severe MR with behavior disturbance and non-insulin dependent Diabetes Mellitus. On 7/17/06 at 2:15 PM R12 was home from DT in the dining room with staff E5. R12 was observed to have a deep purple/yellow forehead and two prominent black eyes. Staff E5 stated, at that time when asked by the surveyor what had happen to R12, that "when she came home from DT she had a knot on forehead, then she went to sleep and the next day the coloration was there. The only nursing documentation for R12's 7/7/06 head trauma, per record review, is the incident	W9999		

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W9999	Continued From page 52 report and N.N., and in this documentation there is no assessment of neurological status, or blood pressure monitoring. N.N. by E19 on 7/7/06 at 5:30 PM states: "Tech Told Writer that Above Forehead + R side face-Lg Hematoma Which occurred @ DT Today. DT stated She was on floor When found per tech." The next day the N.N. 9:00 AM of 7/8/06 states: " Res. R eye has purple and black bruising around it. Res. denies any pain. B/P 122/70, Temp 96' ax, Pulse 64, Resp.22, Cooperative, quiet." N.N. by E19 on 7/8/06 at 6:00 PM states "V/S 166/105 P96 R12--would do puzzle after (symbol) supper--Bruising to R side face and forehead more noticeable this PM--does not want you to mess with (symbol) area acts as if in pain Tyl 2 (symbol) given." N.N. on 7/9/06 at 8:30 AM states: "B/P 170/100, Temp 96ax, Pulse 93, R20, Res. ambulating well throughout the building, ate breakfast well, now sitting in Activity room playing with puzzle. R eye remains purple in color around eye socket. bump on R temple/head area-approx. 2 inches in size in diameter, skin and hair intact, No open area. res moved head to touch to the area. res cooperative, quiet." N.N. by E19 on 7/9/06 at 6:00 PM states: "Several attempts made to call Dr. Z4 @ Home per Answering Service Request--unable to contact phone Busy. Reason is (noted more Bruising and swelling to L side of face--still refuse to keep Ice on areas, need to get permission for X-ray + Dr. Appt. to see Her. Will continue to monitor + ADD Comment to IR."	W9999		

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W9999	Continued From page 53 Day supervisor shift lead E3 stated, per 7/18/06 11:00 AM interview that she did not know whether or not the administrator had been notified of R12's injuries. E3 stated that on Monday (7/10/06) she had called E2 (LPN). E2 stated that I (E3) needed to immediately notified IDPH (Illinois Department of Public Health) and start an investigation. Staff E3 further stated that she did not know this because she's new at this and still learning. The first physician contact made by the facility of R12's head injury is documented in N.N. of 7/10/06 written at 5:00 PM and it states: "Res. went to see Dr. Z4 for Facial/Head bruises and bumps--new order written for Xray of facial bones--E3 (first name)/staff to schedule Xray." Xray of Facial Bones obtained 7/11/06 states: "History provided is bruising about the eyes. Please note that the patient is unable to cooperate and there is significant motion artifact. A definite fracture is not seen. However the study is essentially nondiagnostic. IMPRESSION: Grossly negative for fracture. If there is clinical concern for fracture, consideration may be given to sedation and CT. The facility's ABUSE AND NEGLECT policy and procedure 0-300.04.2, defines a serious injury as "An injury requiring medical treatment beyond first aid, which can only be administered by a physician, nurse practitioner, or physician assistant."	W9999		

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W9999	Continued From page 54 This policy further states under it's procedure the following: 1. An employee suspecting or witnessing an incident, which may be defined as mistreatment, corporal punishment, threat, exploitation, neglect, abuse or as a serious injury, shall, according to state statues and facility policy: A.Take immediate action to protect the individual served. B. Preserve any evidence. C. Immediately report the incident to the supervisor, who shall immediately inform the Administrator or designee of the incident. D. Complete Form 0:300.04.1-A Individual Unusual Incident Report, in accordance with 0:300.04.1, Reporting Individual Unusual Incident. The policy further states that "2. Upon being notified of any incident involving injuries of unknown source, mistreatment, misappropriation of individual's property, corporal punishment, threat, exploitation, neglect, abuse, Unauthorized Absence/Missing Individual/Elopement, or is a serious injury; the Administrator or designee shall: A. Take immediate action to protect the individual served, including immediately placing the alleged employee on Administrative Leave, pending the outcome of the facility's investigation." This policy also states under procedure 2.D. that	W9999		

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W9999	Continued From page 55 the administrator will "initiate a formal in-house investigation into the allegations, per 0:300.04.3, Investigation of Possible Abuse and Neglect." upon being notified of any incident involving injuries of unknown source and insure that the family or guardian is promptly informed of the incident. The facility neglected to implement its "ABUSE AND NEGLECT" policy/procedure number P-300.04.2 by their failure to have the administrator available for employees to report to and therefore failing to ensure that immediate action could be taken to protect R12 from further harm. The day supervisor shift lead E3 stated, on 7/18/06 at 11:00 AM, that the Administrator (Adm.), E1, doesn't have a cell phone or a pager. E1 is at the facility Monday through Friday from 8:30 AM till whenever about 5:30-6:00 PM. E3 further stated that only 3 staff have his home phone number and those staff are myself (E3), E4 PM shift lead and E2 the Licensed Practical Nurse (LPN) who works day shift. There is no evidence that staff including the night staff have a way to immediately contact the administrator to report suspected abuse/neglect. E3, day supervisor shift indicated, per 7/18/06 10:00 AM interview, that E12 was not sent to the ER sooner because she was told that you have to have an order for everything we do. E3 further stated that she did not know why the investigation was started so late (7/11) or how long one has to complete them because the administrator or the QMRP (Qualified Mental Retardation Professional) should be doing them.	W9999		

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W9999	Continued From page 56 Facility's Investigation of abuse and neglect policy 0-300.04.3 states under procedure 2.B., the investigator shall "Conduct interviews of all parties involved, asking "what", "who", "where", "when", "why" and "how" beginning with : 1. the person making the report" etc. Per review of facility's investigation of R12's (7/7) injury initiated 7/11/06 and completed 7/14/06 by E1 and E2, there were no interviews from the staff who stated R12 was found on floor at DT as identified in initial N.N. of incident. Only 2 interviews (Z5,Z6) of DT staff were obtained. Per review of 7/7/06 incident report, N.Ns. from 7/7---7/18/06 10:30AM and confirmed by LPN E2's 7/19/06 9:25 AM interview, R12's guardian had not been notified of R12's serious head injury. 5. Based on review of Physician Order Sheet (POS) and 5/16/06 Individual Support Plan (ISP), R13 is a 36 year old ambulatory verbal female with the diagnosis of Moderate Mental Retardation (MR), Psychosis, Hypothyroidism and Atrial Fibrillation who was admitted to this facility 4/13/03. R13 takes the medications Lanoxin, Toprol XL and Aspirin for Atrial Fibrillation diagnosed in January 2004, Clonazepam and Risperdal for her Psychosis, and Levothyroxine for Hypothyroidism diagnosis. This ISP states that R13 is able to dress, bathe and toilet herself with staff assistance limited to reminders. According to 1/4/04 psychological test and 7/17/06 interview with Z1, R13 is unable to	W9999		

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W9999	Continued From page 57 remain attentive and on task and has to be directed throughout the task. Examples given per Z1 are: R13 take the washcloth, R13 wash your arm, R13 wash your leg. Z1 further stated that if you lay her clothes out, she will put them on. Per ISP, R13 has very poor oral hygiene with severe periodontal disease, mobile teeth which may require extractions, may need multiple restorations with the dental recommendations to have a full work up in the hospital. On 6/19/06, R13 had dental treatment under general anesthesia by dentist Z3. According to Z1, the dental work was more extensive than originally thought and the dentist wanted to catheterize R13. Z1 stated that the dentist pulled her and the staff aside and asked them when was the last time R13 took a bath? E3, AM supervisor shift lead stated, during 7/19/06 1:13 PM interview, that the dentist Z3 called her and Z1 aside at the hospital prior to the dental surgery because they had to put a catheter in R13. E3 stated that the dentist said "R13 was so nasty and corroded in her peri area, that they literally had to scrape it out in order to get a catheter in." E3 further stated that Z1 "was absolutely off the wall. I thought I would have to take her to the ER for a heart attack." The dentist Z3 further stated, according to E3, R13's "oral care was horrible and that they had to do more dental then expected." Based on 7/17/06 interview with Z1 and 6/20/06 Dental statement of services rendered, E13 required 6 hours and $4741.00 of dental treatment. This treatment included 2 Acrylic Sealants, 2 one surface Amalgams, 2, two	W9999		

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W9999	Continued From page 58 surface Amalgams, 4, three surfaces Amalgams, 1, four surfaces Amalgams, 3 one surface Composites, 1 , three surface Composite, Composite Posterior 1 surface and the extraction of 2 teeth. Z1 stated, per 7/17/06 8:53 AM interview, that if they treat R13 who is higher functioning than the other residents, how are they treating the others? The following information was obtained from residents R10, R6 and R2's current Physician Order Sheets (POS) and their last dental assessments. It is an example of the basic health needs for oral care of some of the individuals. R10 was admitted on 1/1/93 and is a 44 year old male with a diagnosis of Profound MR. Dental Summary of 5/24/06 states the condition of teeth is poor, severe gingivitis, periodontitis: severe caries. Dental recommendation are that "Pt. needs Outpatient Hospitalization; NOW!!" Note on report states appointment pending approval for fees. R6 was admitted on 7/15/96 and is a 34 year old male with a diagnosis of Profound MR. Dental Summary of 9/13/06 indicates that he needs dental rehabilitation under general anesthesia due the very poor condition of his teeth. The dentist commented on the report that, "No oral hygiene taking place." R2 was admitted on 8/21/95 and is a 28 year old female with a diagnosis of Profound MR. Dental Summary of 9/19/06 states: "No oral hygiene is taking place, R2 (first name) needs her teeth brushed thoroughly twice a day, every AM+ every PM."	W9999		

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W9999	Continued From page 59 Observation made at 8:00 AM on 7/18/06 revealed that staff E11 neglected to follow Center for Disease Control (CDC) guidelines for universal precautions and did not train and encourag individuals R11 and R12 to maintain good oral hygiene practices. At 8:00 AM on 7/18/06, E11 was observed to verbally prompt R11 and R12 to brush their teeth. E11 then took an unlabeled toothbrush from R15's hygiene basket and applied toothpaste and handed it to R12. R12 put the brush in her mouth twice and essentially walked out of the bathroom. Surveyor asked E11 why she gave R12 the toothbrush from R15's basket. E11 stated that she knew that the toothbrush was R12's because it had blood on it and R12 has gingivitis and somebody just put it in the wrong box. R11 independently and briefly brushed her teeth and left the bathroom. Both R11 and R12 have dental recommendations for staff to assist the individuals with toothbrushing twice a day. For the most part, per observation, all 14 of 14 individuals present on 7/18/06 AM, did not get their teeth adequately brushed or receive oral care prior to leaving the facility for the day. Staff did not ensure that all the individuals hygiene baskets are clean and contain basic hygiene items. Based on AM observations of 7/18/06 and confirmed by 9:17 AM interview with LPN E2, all 15 residents hygiene baskets were not properly stocked (e.g had toilet paper roll, old light fixture, markers, toys, no toothbrush, no toothpaste) soiled and in need of cleaning. Observations of 7/17/06 from 3:35-6:30 PM and 7/18/06 from 6:13-8:03AM revealed that the	W9999		

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W9999	Continued From page 60 residents appeared not groomed, most of the individuals had oily hair, the men (R4,R7, R10,) were unshaven. Interviews with the AM staff E11, E12, E14, E15, at 6:32 AM of 7/18/06, revealed that only 4 residents were given baths (R1, R10, R3 and R12) prior to being dressed for the day. E3, the day supervisor shift lead indicated, per 7/19/06 9AM interview, that the facility has no specific bath schedules or hygiene monitoring sheets for R1 through R15. The staff just has a list of general responsibilities. The facility neglected to implement its "ABUSE AND NEGLECT" policy/procedure number P-300.04.2 This policy states under procedure the following: 1. An employee suspecting or witnessing an incident, which may be defined as mistreatment, corporal punishment, threat, exploitation, neglect, abuse or a serious injury, shall, according to state statues and facility policy: A. Take immediate action to protect the individual served. B. Preserve any evidence. C. Immediately report the incident to the supervisor, who shall immediately inform the Administrator or designee of the incident. Should the incident involve the facility Administrator, the staff shall immediately notify the Supervisor and the Chief Operating Officer at DDMS of the allegation.	W9999		

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W9999	Continued From page 61 Staff E3 failed to immediately report the neglect to the administrator, even though E3 was present at time of allegation by Z3 and participated in the neglect investigation. There is no evidence that the administrator was immediately notified nor does E3 identify the dentist Z3's allegation of neglect on the investigative report. Per Investigative Report completed by E2 and E3 under "D. Name of person reporting the incident including person's title:" the investigators wrote a date (6-21-06) and does not identify Z1 or Z3. The facility neglected to complete a thorough investigation into Z1 and Z3's neglect allegation regarding R13's hygiene and oral care. Per review of the facility's Investigative Report, of R13's guardian 's complaint of 6/19/06 of neglecting R13's hygiene/oral care it was determined that: a) the investigation was initiated on 6/21/06 and completed on 6/26/06 and not in the 5 day required time frame. b) The investigation report was incomplete. Examples are: A. Date and time incident occurred: the investigators E2 and E3 wrote the date 6/19/06. C. Date and time incident was reported to agency investigator: staff wrote the date 6/21/06. D. Name of person reporting the incident including person's title: staff wrote the date 6/21/06.	W9999		

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W9999	Continued From page 62 The conclusion of E2 and E3's investigative report states: "Neglect at some point but very vague on who to directly speak with or who is directly responsible." Facility's Investigation of abuse and neglect policy 0-300.04.3 states under procedure 2.B., that the investigator shall "Conduct interviews of all parties involved, asking "what", "who", "where", "when", "why" and "how" beginning with : 1. the person making the report" etc. E2 and E3 obtained the staff schedule identifying staff who cared for R13 from 6/15--6/19, but obtained no interviews from them. The facility did not take any corrective action even though the report states that "Management instituted a sign off for oral care + showering (assisting) resident." E3, the day supervisor shift lead indicated, per 7/19/06 9:00 AM interview, that the facility has no specific bath schedules or hygiene monitoring sheets for R1 through R15. The staff just has a list of general responsibilities. 6) R14, per POS and observation is an ambulatory nonverbal female with diagnosis of Profound MR and Cerebral Palsy. On 7/17/06 at 4:09 PM, R14 showed the surveyor a two by two inch bloody abrasion to her knee. Staff E10 was asked by the surveyor about the knee injury and was told that it just happened outside when the guy was getting her off the bus. E10 further stated that staff E16, E4, E6, and E7 all saw the incident saying that R14 lost her balance. E10 then stated that she did not know if anybody told the LPN, E2. At 4:13 PM on 7/17/06 the surveyor was informed by PM shift	W9999		

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W9999	Continued From page 63 lead staff, E4, that she called LPN E2 and was instructed to clean R14's knee using the first aid kit, do an incident report and have the nurse who comes in at 5:00 PM assess the injury. E2, per 7/18/06 9:17 AM interview, stated "No one informed me of R14's knee injury and I was here!" 7. By general observations of 7/17 and 7/18, and per POS, R14 is a 28 year old deaf nonverbal ambulatory female whose diagnosis, in part, is Profound MR and Cerebral Palsy. On 7/17/06 at 5:23 PM, R14 was observed to walk into the dining room for supper carrying a large filled purse and wearing rainbow plastic type sandals that were for too large for her feet. R14 fell down directly in front of the surveyor hitting the left side of face and left knee on the floor. R14 independently got up and went to her dining table and sat down. Staff E10 commented from her seat in the dining room that R14 tripped because she's carrying that large heavy purse. Staff did not notify the PM nurse of R14's fall, they did not assess her for injury or complete an incident report. (A)	W9999		