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	14G050	A. BUILDING _____ B. WING _____	C 07/19/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APOS CHRISTIAN TIMBER RIDGE	2125 VETERANS ROAD MORTON, IL 61550

(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
W9999	Continued From page 16 LICENSURE VIOLATIONS LICENSURE VIOLATIONS 350.620a) 350.1210b) 350.1230b)3) 350.1230c) 350.1230d) 350.1230e) 350.1230f) 350.1230g) 350.3240a) 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 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following: (A, B) b) Nursing services to provide immediate supervision of the health needs of each resident by a registered professional nurse or a licensed practical nurse, or the equivalent. (B) 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:	W9999		

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W9999	Continued From page 17 3) Periodic reevaluation of the type, extent, and quality of services and programming. 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, to carry out the various nursing service activities. f) The individual responsible for providing nursing services shall have knowledge and experience in the field of developmental disabilities. g) Nursing service personnel at all levels of competence and experience shall be assigned responsibilities in accordance with their qualifications. 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) These regulations were not met as evidencied by the following:	W9999		

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W9999	Continued From page 18 Based on observations, interviews, and record review, the facility failed to set up a structure which protected R2 from neglect by failing to develop and implement written procedures that prohibit neglect, in that: 1) The facility failed to provide adequate supervision for R2, who was known to get out of bed. 2) The facility failed to provide a safe method of fall protection for R2. 3) The facility failed to provide thorough training to nursing staff regarding the use of emergency monitoring equipment. Findings include: Per review of the facility's Investigation Report of an incident dated June 25, 2006 at 10:16a.m., R2 was found unresponsive in her room and subsequently pronounced dead by the Deputy Coroner who was summoned to the scene. 1) The facility failed to provide adequate supervision for R2, who was known to get out of bed. R2 was a 23 year old female who functioned in the mild range of mental retardation according to her Admission and Discharge Record (face sheet). However, her psychological evaluation using the Stanford-Binet Fifth Edition scored R2 as 10, and R2's ICAP (Inventory for Client and Agency Planning) adaptive behavior score was zero years-seven months, both placing R2 in the profound range of mental retardation.	W9999		

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W9999	Continued From page 19 During an interview on 07-12-06 at 3:24p.m. with E2, D.O.N. (Director of Nursing), and E9, Occupational Therapy and Physical Therapy Director, both acknowledged that R2 had a history of climbing out of bed at her previous placement, and that R2's mother had also mentioned this behavior. In an interview on 07-12-06 at 8:34a.m., E15, direct care staff, stated she had put R2 to bed at approximately 8:45a.m., and had last seen her at approximately 9:05a.m. when E15 had finished putting R3, R2's roommate, to bed. E15 stated she left the room and left the door halfway open. E15 added that R2 was laying straight in her bed, awake and calm. During an interview on 07-11-06 at 11:40a.m., E 16, direct care staff, was asked what she observed on the morning of 06-25-06 regarding R 2. E16 stated, "When I came in the door was closed. I knocked and then went in." E16 was asked what time she went in, and replied, "At 10: 05, it was time to get them up. I was just coming off break." E8, direct care staff also working the morning of 06-25-06, was interviewed and stated she last saw R2 in the living room at about 7:00a.m., waiting to be put down. E8 stated that she did not go on 600 wing that morning, so she did not know if the door was open or closed. E8 added that E16 was on 600 wing that day. In an interview on 07-13-06 at 3:20p.m., E2, D.O. N. was asked, since R2 had her new bed for less than three weeks, was any monitoring being done to determine if the new bed was meeting R 2's needs. E2 stated that the aides had been	W9999		

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W9999	Continued From page 20	W9999		

asked if R2 had been climbing out of the new bed . E2 added that R2 hadn't climbed out until the day before the incident, when she crawled out of the bed and into the hallway. E2 also stated the doors are supposed to be left open when residents are in bed.

E2 was asked if R2 had a specific level of supervision assigned, and replied, "Not more than any other resident."

Interviews with staff failed to find anyone who had seen R2 from the time she was placed in bed until she was discovered face down in a bean bag chair.

2) The facility failed to provide a safe method of fall protection for R2.

In an interview on 07-12-06 at 8:34a.m., E15 stated she had put R2 to bed at approximately 8: 45a.m. E15 described this as, "I repositioned her straight in the bed, put up the two side rails, then the blue rail pad, then put the bed down to the lowest level, and then put the beanbag on the floor between the side rails. E15 was asked if there was an order for the beanbag to be placed there, and replied, "I don't know, it's just there to use."

In an interview on 07-12-06 at 3:24p.m., E2 and E9 were asked if there was an order or recommendation for the use of the beanbags as bedside safety devices, and replied, "We inherited that. We've always used them."

During an interview on 07-11-06 at 11:40a.m., E 16, direct care staff, described what she saw upon entering R2's bedroom. "(R2) was face

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W9999	Continued From page 21 down in the beanbag with her legs on the bed with her knees bent and feet up in the air. E16 stated she didn't want to touch R2 without the nurse, so she called for the nurse who ran to the room and pulled R2 out of the beanbag and turned her over to assess her. E16 added that R 3, R2's roommate, was also out of bed on the floor hanging onto the beanbag chair on which R 2 was lying. E17, Licensed Practical Nurse (L.P.N.), stated when she was called to the room, she observed R2's upper body between the side rail gap and under the side rail pad on a beanbag with her face down in it. E17 stated that she pulled R2 out by her arms with E16 assisting with R2's legs. Observations of the bed were that is was positioned very low to the floor with approximately 12" from the top of the mattress to the floor. Observations of the bean bag chair were made on 07-11-06 at 12:07p.m. The chair was made of a thin, soft, very pliable vinyl material. The bag was not fully filled, allowing for molding to any shape. E16, direct care staff, demonstrated where R2's face and head were located on the bean bag and stated, "She was really way down in there like this" and pushed her fist into the top of the bean bag approximately 12 - 14 inches. E16 added, "I don't think she could have got herself out of there with her legs caught like that." The U.S. Consumer Product Safety Commission homepage refers to an April 30, 1990 release stating, "The Commission has received 19 reports that an infant was found dead lying face-down on an infant bean bag cushion."	W9999		

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W9999	Continued From page 22 3) The facility failed to provide thorough training to nursing staff regarding the use of emergency monitoring equipment. During an interview on 07-11-06 at 12:16p.m. E 17, L.P.N., stated when she arrived in R2's bedroom and assessed R2, she was not breathing, was very pale, skin dry but a little clammy, not diaphoretic, not blue, and had a faint radial and carotid pulse. E17 stated she paged E 18, North wing nurse, told E19, Agency L.P.N. to take the crash cart to R2's bedroom and called 911. When E17 returned to R2's bedroom, E18 was putting the AED on R2, and that the AED advised no shock, just CPR (Cardio-Pulmonary Resuscitation). The AED went through three or four cycles before the paramedics arrived and advised no shocks, just CPR each time. E17 stated, "We did just rescue breathing because we thought she still had a pulse." E17 was asked, " Even though the AED recommended CPR?" E17 replied, "Yes, because the pulse ox said she still had a pulse." In an interview on 07-12-06 at 9:25a.m., E18, North wing nurse, stated when she entered R2's bedroom, R2 was on her back with the upper part of her body on the beanbag. E18 continued that she knew we'd need her (R2) flat, so she called for a mat and put R2 on the mat. E18's impression was that R2 was not breathing, but had a pulse of 36 or 38 on the pulse oximeter, and didn't look normal, not blue, but something was wrong. E18 didn't remember if R2's eyes were open or closed. E18 stated she started rescue breathing and then put the AED on which stated, "No shock indicated", so E18 continued rescue breathing	W9999		

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W9999	Continued From page 23 until E17 came in and relieved her. E18 was asked what R2's pulse registered when the paramedics arrived, and replied that she didn't know because they had taken the pulse oximeter off when they applied the AED, because they didn't know if it would interfere with the AED. In an interview on 07-12-06 at 10:20a.m., Z3, Paramedic, stated when they arrived on the scene, (R2) was on the floor and staff had an AED in place not advising shock. Z3 stated the AED did not have a monitoring screen as it was a model generally sold for home use by the public. Z3 stated that his impression was that R2 "had been down at least 10 minutes." Z3 described R 2 as cold, very pale, no vital signs, no cyanosis, and no rigor. By disconnecting the pulse oximeter to monitor pulse, the facility staff was unaware R2's heart had stopped beating, and that CPR should have been administered. (A)	W9999		