STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G129	A. BUILDING _____ B. WING _____	C 07/25/2006

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W 331	Continued From page 42 suds enema if no bowel movement within 72 hours of being checked for fecal impaction. However, per interviews with E3 and E4 (DSPs) on 7/13/06 at 12:50 P.M., both staff stated that R 6 is not on a nursing plan for constipation and that there was no protocol identified at the inservice on 5/9/06 for when staff are to call the consulting nurse. E3 and E4 said that they thought that the nurse was to do a rectal exam to check for impaction if R6 has not had a bowel movement in 72 hours. E3 confirmed that the last soap suds enema given to R6 was on 4/12/06. Per interview with E7 (DSP - night shift) on 7/13/06 at 1:30 P.M., E7 said that she doesn't call the consulting nurse daily with status reports on R6. E7 stated that it is her understanding that staff are to call the nurse if R6 has not had a bowel movement for 72 hours. E7 said that this is the protocol she follows. Per physician's orders, dated 3/17/06, R6 was to be given a soap suds enema "as needed for no BM in 48 hours after checking for fecal impaction ". According to the physician's order sheet, these instructions were in place until 6/29/06 as noted on July's physician orders.	W 331		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.510a) 350.620a) 350.700a)1) 350.700a)2) 350.700b) 350.700c)	W9999		

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W9999	Continued From page 43 350.1060a) 350.1060b)1) 350.1060b)2) 350.1060c)1) 350.1060c)2) 350.1060d) 350.1060e) 350.1060h) 350.1070 350.1230d)1) 350.123d)2) 350.1230d)3) 350.3240a) 350.3240b) 350.3240c) 350.3240d) Section 350.510 Administrator a) There shall be an administrator licensed under the Nursing Home Administrators Licensing and Disciplinary Act (Ill. Rev. Stat. 1987, ch. 111, par. 3651 et seq.) full-time for each licensed facility. The licensee will report any change in administrator to the Department, within five days. 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 350.700 Serious Incidents and Accidents a) The facility shall notify the Department of any incident or accident which has, or is likely to	W9999		

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W9999	Continued From page 44 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. b) Each resident shall have individual evaluations which shall: 1) Be based upon the use of empirically reliable and valid instruments whenever such tools are available. 2) Provide the basis for prescribing an	W9999		

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W9999	Continued From page 45 appropriate program of training experiences for the resident. c) There shall be written training and habilitation objectives for each resident that are: 1) Based upon complete and relevant diagnostic and prognostic data. 2) Stated in specific behavioral terms that permit the progress of the individual to be assessed. d) There shall be evidence of training and habilitation services activities designed to meet the training and habilitation objectives set for every resident. e) An appropriate, effective and individualized program that manages residents' behaviors shall be developed and implemented for residents with aggressive or self-abusive behavior. Adequate, properly trained and supervised staff shall be available to administer these programs. 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 350.1070 Training and Habilitation Staff Appropriately qualified staff shall be provided in sufficient numbers to meet the training and habilitation needs of the residents. At a minimum, staffing shall be provided as described in Section 350.810(b) of this Part.	W9999		

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W9999	Continued From page 46 Section 350.1230 Nursing Services 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. Section 350.510 Administrator a) There shall be an administrator licensed under the Nursing Home Administrators Licensing and Disciplinary Act (Ill. Rev. Stat. 1987, ch. 111, par. 3651 et seq.) full-time for each licensed facility. The licensee will report any change in administrator to the Department, within five days. 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)	W9999		

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W9999	Continued From page 47 These requirements are not met as evidenced by the following: Based on interview and record review, the facility failed to follow its policy to prevent neglect when the facility failed: 1) to notify the administrator of injuries of unknown origin and failed to investigate bruises of unknown etiology for R2, R6, R8, 2) failed to notify the administrator and other authorities of an elopement by R4 on 5/12/06, failed to investigate the circumstances surrounding the elopement, and failed to take corrective action to prevent further occurrences, and 3) failed to investigate how R4 accessed contraband prohibited by his behavior plan on 7/9 /06 and 7/12/06. Findings include: Bruises of unknown origin not addressed 1) According to the facility roster, R6 is a 54 year old female who functions at the Moderate level of Mental Retardation. Additional diagnoses include Psychosis, Schizophrenia, Depression and Anxiety. Per review of staff/nurse communication logs, R6 was noted to have sustained the following injuries of unknown origin since 6/1/06: 6/9/06 - Bruise to right wrist, 1" x 1", purple in color	W9999		

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W9999	Continued From page 48 6/15/06 - Bruises x 2, scratches x 5, right thigh. Bruises purple in color. First bruise is 1" x 1", second bruise is 1" x 1/2". 6/18/06 - Left forearm scratches 7/6/06 - Bruise to right arm 1 1/2" x 1" 7/7/06 - Bruise to right hand by knuckles - purple in color - 1 1/2" x 1." 2) The facility roster states that R8 is a 54 year old female who functions at the Moderate level of Mental Retardation. During observations on 7/11 /06 from 2:30 P.M. to 5:00 P.M., R8 was noted to have a large bruise, deep purple in color above R 8's left elbow, approximately 2" x 1 1/2" in size. Surveyor asked R8 how she got her bruise. R8 shook her head and said "don't know." Per review of the staff/nurse communication sheet, the bruise was noticed at 2:50 P.M. on 7/6/ 06 and was documented as being purple, 1" x 1" in size. 3) No investigations were found regarding the above bruises for R6 or R8. Interview with E3/ DSP (Direct Support Person) on 7/11/06 at 4:00 P.M. confirmed that the current procedure for injuries, known or unknown, is for facility staff to complete a staff/nurse communication sheet, to notify the nurse and to leave the communication sheet for the nurse to sign when she comes to the facility. E3 explained that the nurse looks them over, the QMRP (Qualified Mental Retardation Professional) reviews them when she comes in, then they are filed. E3 stated that the nurse comes in as needed and that the	W9999		

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W9999	Continued From page 49 QMRP is also on an "as-needed" basis. E3 said that no one checks the communication sheets, they "just sit there until the nurse comes." E3 also confirmed that she was not aware that they were supposed to call the administrator about bruises of unknown origin, nor was she aware that they were to be investigated. E3 also confirmed that nothing had been sent to the Illinois Department of Public Health for the past few months. E3 gave surveyor the facility's policy of abuse and neglect (dated 6/04) on 7/11/06 at approximately 11:00 A.M. which she said she had gotten from the facility's policy/procedure manual. No procedural guidelines or protocol regarding injuries of unknown origin were included in this policy. Interview with E4, DSP/day shift, on 7/13/06 at 9:00 A.M. confirmed that she did not know they are supposed to investigate injuries of unknown origin and that as far as she knows no one contacted the administrator or the owner about them. E4 said that normally the QMRP (E2) would take care of this but E2 is only working on a part time basis now. Per telephone interview with E12, administrator, on 7/19/06 at 12:53 P.M., E12 said that she was not notified about the bruises of unknown origin. E12 explained that she has not been able to come to the facility since 6/12/06 due to health issues but staff "know that they can reach me by phone" when needed. E12 also stated that had she been notified of the bruises of unknown origin, she "would have advised them to investigate."	W9999		

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W9999	Continued From page 50 Interview with E1 (owner) on 7/13/06 at 9:40 A.M. confirmed that he was not sure if the administrator was contacted about the injuries of unknown origin. E1 said that he "can't say that the administrator is called on everything." E1 also said that the facility did not have evidence of staff training regarding injuries of unknown origin, nor did the facility track patterns and trends of unknown injuries. E1 also said that he would check to see if the facility had a more current policy regarding abuse/neglect issues which he subsequently presented to the surveyor after receiving it by fax from the business office. According to the latter (undated) policy, signs and symptoms of potential abuse and neglect include bruises and imprint injuries. The policy also defines injuries of an unknown origin as "any physical injury, whether serious or non-serious, that an individual sustains without credible evidence or witness as to the nature of the injury ." The policy also states that "injuries of unknown origin will be reported to the administrator or designated representative, or to other officials in accordance with state and federal regulations within five (5) working days of the incident". Interview with E3 on 7/13/06 at 10:45 A.M. confirmed that E3 had not seen the new abuse/ neglect policy nor had staff been trained on this policy. Review of the facility's inservices also confirmed that the last documented training for staff regarding abuse/neglect issues was conducted on 2/17/06. Additional examples of injuries of unknown origins not having been reported to the	W9999		

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W9999	Continued From page 51 administrator and not having been investigated includes R2 who was noted to have bruises of unknown etiology on 6/5/06, 6/6/06, and 6/12/06. Failure to address R4's elopement 4) Per review of facility records, R4 has diagnoses of Moderate Mental Retardation, Depression, Mood Disorder and Sexual Inappropriateness. According to the behavior notes for R4 dated 5/ 12/06, R4 told E5 (DSP/Direct Support Person) at 5:10 P.M. that he "was going uptown. Staff told him he was not supposed to w/o (without) somebody with him, but he left anyway. Staff was alone at this time, and could not go after him". Per interview with E5 on 7/12/06 at 2:05 P.M., E5 stated that at the time of the incident with R4, she was by herself, was passing meds and was also trying to fix supper. E5 said that she had heard R 4 threaten to leave the facility, but they talked about it and R4 calmed down. E5 said she wasn't sure when R4 actually took off. E5 stated that while she was passing the afternoon medications, "some of the other residents told her he left." E5 said she called another DSP (E2) who told her to call the owner (E1). When E5 called E1, E 5 was instructed to call in another staff. E5 said she was able to get hold of E6 (DSP) who found R4 at a convenience store approximately 1/2 mile from the facility. According to E5, R4 was gone about 20 minutes. Per review of the facility's documentation, the only notation of R4's elopement was found by	W9999		

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W9999	Continued From page 52 surveyor on the behavior notes written by E5 on 5/12/06. No incident report and no investigation of R4's elopement was found. Review of R4's Behavioral Assessment dated 5/21/06 states that if R4 "is upset, he will leave the facility, unsupervised. At this time, (R4) is not safe in the community by himself." The assessment also confirms that R4's history of elopement "goes back several years" with a behavioral intensity of "medium to high depending on his challenge. He has stayed gone and in bad weather for several hours." In addition, per review of behavioral notes, R4 had previously left the facility without staff knowing where he was on12/6/05 and at least two times on 1/10/06 when the police escorted him back to the facility. Behavioral documentation also confirmed that R4 left the facility twice during the evening of 6/26/06 with staff having to follow him and, required telephone calls from his family to get R4 to come back to the facility. Behavioral documentation also noted that R4 threatened to leave the facility on 4/1/06, 4/14/06, 4/17/06 and again on 6/21/06. However, per interview with E3 on 7/12/06 at 10:45 A.M., when asked if R4 was on a behavior plan for elopement, E3 said that R4 has behavioral intervention plans for anger and sexual inappropriateness, but not for elopement. E3 also stated that R4 "hasn't eloped for a long time." Per review of R4's behavior plans, dated 2/8/06, R4 exhibits "Angry aggressive behavior defined as yelling, pushing, kicking or hitting others" and "	W9999		

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W9999	Continued From page 53 Sexual inappropriateness defined as placing objects in penis/rectum." No mention of R4's history of elopement nor R4 threatening to leave the facility was found in either plan's definition of R4's maladaptive behaviors. However, both plans' methodology state that "should (R4) leave the facility due to being angry, staff should follow him if he leaves the facility grounds to insure his safety." According to interview with E1, Owner, on 7/13/06 at 9:40 A.M., E1 stated that when he received the call about R4's elopement on 5/12/06, he instructed staff (E5) to call in another staff (E6) to help look for R4, and if she couldn't get hold of E 6 to then call the police. E1 also said that R4's incident was not really an elopement, more of a behavior that R4 exhibits when he is angry. Per facility policy titled Wandering or Missing Resident, dated 4/1/04, "WHENEVER A RESIDENT LEAVES FACILITY PROPERTY, UNACCOMPANIED BY STAFF OR FAMILY MEMBERS, WITHOUT NOTIFYING FACILITY STAFF, AN ELOPEMENT HAS OCCURRED." The policy also states that "WHEN IT HAS BEEN DETERMINED THAT THE RESIDENT HAS LEFT THE IMMEDIATE AREA...: FAMILY, AND POLICE ARE NOTIFIED IMMEDIATELY." Per on-going interviews with E1, E5 and E6, the police were not contacted and no indication was given that the family was notified. E1 confirmed that the facility did not have documentation that the administrator was called about R4's elopement. E1 said that he "can't say the administrator is called on everything."	W9999		

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W9999	Continued From page 54 E1 also confirmed that the facility did not have any evidence of staff training regarding R4's elopement nor had R4's behavior plans been reviewed for appropriateness. Interview with E3 on 7/13/06 at 9:00 A.M. confirmed that the R4's elopement had not been reported to the administrator or to the Illinois Department of Public Health because staff were not aware that they were supposed to and also did not know that they should investigate elopements. Per telephone interview with E2 (QMRP/Qualified Mental Retardation Professional) on 7/12/06 at 10:50 A.M., E2 said that she was not at R4's recent Interdisciplinary Team meeting held 6/1/06 but did write R4's plan prior to the meeting. E2 stated that she was not sure what R4's community access status was and did not include what R4's level of supervision is since she was not certain what the ID Team wanted to do. E2 explained that she was only working part-time and was considered as "on-call status." Incidents of contraband not investigated 5) Review of R4's behavior plan of 2/8/06 which addressed the maladaptive behavior of sexual inappropriateness, "defined as placing objects in penis/rectum" states that staff are to conduct 15 minute visual checks on R4 and also a "room search during the day while (R4) is out on programming; either at workshop, activity or home visit." The methodology also states that if R 4 "goes outside to the dumpster, staff will keep him in sight, either through the window or door or by going outside.....at the workshop, (R4) will be	W9999		

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W9999	Continued From page 55 monitored in the bathroom and grooming room." The plan also notes that staff are to keep sight of R4 while out shopping to "insure what he buys is safe as possible and is not an item of preference for sexual inappropriateness" which includes balloons or anything with a straw. According to behavior notes for R4 dated 7/9/06, staff "found a drinking straw in (R4's) laundry basket while sorting clothes to do laundry." Another entry dated 7/12/06 states that staff " found a rubber glove in (R4's) bed." No indication that an investigation was conducted to determine how R4 got access to the contraband was found by surveyor. Interviews with E1 and E3 on 7/13/06 confirmed that the facility had not investigated how R4 accessed a drinking straw and the rubber glove. (A)	W9999		