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	14G099	A. BUILDING _____ B. WING _____	07/18/2006

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TURNER MANOR	P.O.BOX 303, 901 OGLESBY ROAD HARRISBURG, IL 62946

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W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, interview and record verification the facility has failed to ensure that all medications are administered without error for 1 of 6 residents observed to receive medications on 06-14-06. (R11) Findings Include: Per review of R11's Physician's Order Sheet R11 is a 55 year old male who functions at a Profound level of mental retardation. Other diagnoses' include: Epilepsy, Hypothyroidism, Congestive Heart Failure, Gastritis and Impulse Control Disorder. Per review of R11's Medication Administration Record on 06-14-06, R11 is to receive Gabitril 12 milligrams at 3:30 P.M. and Gabitril 8 milligrams at 9:00 P.M for seizure control. Per observation of the 3:00 P.M. medication pass on 06-14-06 R11 was administered Oyster Calcium 500 milligrams, Micro K 20 millequivalients, Buspar 15 milligrams, Dilantin 125 milligrams and Depakote ER 1500 milligrams . Per review of R11's Physician's Orders, R11 was also to receive Gabitril 12 milligrams. Per interview with E7 (Licensed Practical Nurse) on 06-14-06 at 4:35 P.M., E7 stated that R11's	W 369		7/19/06

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W 369	Continued From page 92 Gabitril was not available and was not given as ordered at 3:00 P.M..	W 369		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.750b)1) 350.1060a)e) 350.1084c)d)e) 350.3240a)b)e) 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 350.750 Contacting Local Law Enforcement b) The facility shall immediately contact local law enforcement authorities (e.g., telephoning 911 where available) in the following situations: 1) Physical abuse involving physical injury inflicted on a resident by a staff member or visitor; 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.	W9999		

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W9999	Continued From page 93 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. Section 350.1084 Emergency Use of Physical Restraints c) If a resident needs emergency care and other less restrictive interventions have proven ineffective, a physical restraint may be used briefly to permit treatment to proceed. The attending physician shall be contacted immediately for orders. If the attending physician is not available, the facility's advisory physician or Medical Director shall be contacted. If a physician is not immediately available, a nurse or QMRP with supervisory responsibility may approve, in writing, the use of physical restraints. A confirming order, which may be obtained by telephone, shall be obtained from the physician as soon as possible, but no later than within eight hours. The effectiveness of the physical restraint in treating medical symptoms or as a therapeutic intervention and any negative impact on the resident shall be assessed by the facility throughout the period of time the physical restraint is used. The resident must be in view of a staff person at all times until either the resident has been examined by a physician or the physical restraint has been removed. The resident's needs for toileting, ambulation, hydration, nutrition, repositioning, and skin care must be met while the physical restraint is being used.	W9999		

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W9999	Continued From page 94 d) The emergency use of a physical restraint must be documented in the resident's record, including: 1) the behavior incident that prompted the use of the physical restraint; 2) the date and times the physical restraint was applied and released; 3) the name and title of the person responsible for the application and supervision of the physical restraint; 4) the action by the resident's physician upon notification of the physical restraint use; 5) the new or revised orders issued by the physician; 6) the effectiveness of the physical restraint in treating medical symptoms or as a therapeutic intervention and any negative impact on the resident; and 7) the date of the scheduled care planning conference or the reason a care planning conference is not needed, in light of the resident's emergency need for physical restraint. e) The facility's emergency use of physical restraints shall comply with Sections 350.1082(e) , (f), (g), and (j). 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) e) Employee as perpetrator of abuse. When an	W9999		

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W9999	Continued From page 95 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. (Section 3-611 of the Act) These regulations are not met as evidenced by the following: Based on interview and file review, the facility failed to implement their policies and procedures prohibiting abuse and neglect for 2 of 2 individuals of the facility, as evidenced by: 1) The facility failed to implement their own policies and procedures prohibiting abuse, neglect and mistreatment for 1 of 1 individual in the sample (R6) who sustained a fractured right clavicle and an AC (Acetabular) separation of her right shoulder after being placed in a "child basket hold" by staff on 12/10/05. After this incident, the facility did not thoroughly investigate the use of this crisis intervention procedure and take corrective action to prevent further potential injury. Twenty four individuals have been identified by the facility as having a behavior program (R1, R3, R4, R8, R9, R10, R11, R12, R 13, R14, R15, R16, R17, R19, R20, R22, R23, R 24, R26, R28, R29, R30, R31 and R32) and may potentially be restrained during a behavioral incident; and 2) The facility failed to implement their own policies and procedures prohibiting abuse, neglect and mistreatment for 1 of 1 individual	W9999		

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W9999	Continued From page 96 outside the sample (R15) who allegedly was physically abused by E6 (direct care staff) on 02/ 28/06. The facility began an investigation on 03 /01/06 but did not thoroughly investigate this incident. At the request of the facility, R15 was examined by the nurse at Day Training on 03/01/ 06 and was found to have redness and swelling of his left eye. This information was not included in the facility's investigation. After this incident, the facility failed to thoroughly investigate an allegation of staff abuse, failed to notify local police authorities, and failed to take corrective action whereby jeopardizing the safety of all thirty two individuals of the facility (R1 - R32). Findings include: Per review of the facility's policy entitled "Client Protections Subject: Abuse and Neglect" documentation identified that the facility is committed to ensuring that clients of the facility are not subjected to physical, verbal, sexual, or psychological abuse of punishment. Review of the procedures identified within this policy identified: " * In the event a staff member observes injury to or mistreatment of clients of any nature a verbal report will immediately be made to the QMRP (Qualified Mental Retardation Professional) DON (Director of Nursing) or other supervisor on duty followed by a written incident report. The nurse on duty must be immediately notified of any injury and entry made into the nursing record. * The supervisor will immediately initiate an investigation and notify the Administrator, DON and the RSD / Human Rights Officer who will ensure notification of the guardian, physician or	W9999		

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W9999	Continued From page 97 other relevant professionals... * As per the procedure noted under "Serious Incidents and Accidents" and Investigation of Incident" in this section, local law enforcement will be notified. When a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee is the perpetrator of the abuse, the QMRP of Charge Supervisor will ensure that employee is immediately barred from contact with facility consumers pending the outcome of any further investigation, prosecution or disciplinary action against the employee... * A nursing assessment will be performed at the time of notification and any injuries noted there in... Per review of the facility's policy entitled "Client Protections Subject: Investigation of Incident" documentation identified, " * Investigations are required as a result of an allegation of abuse or neglect or for serious Incidents and Accidents or or incidents of unknown origin as indications in those respective policies. * The team will interview available witnesses, obtain written statements, review results and make decisions based on the outcome of the investigation... * Results of investigations will be sent to the Human Rights Committee for review. * Results of investigations will be forwarded to the department as required.	W9999		

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W9999	Continued From page 98 * Notification will be made by QMRP to local law enforcement in situations regarding physical abuse resulting in physical injury by a staff member or a visitor..." Based on review of the Behavior Development Plan for R6, dated 02/09/05, R6 is a 66 year old female who functions at a profound level of mental retardation. Further documentation identified that R6 has targeted behaviors of yelling, kicking and pushing furniture, kicking people, throwing objects to the floor, spitting and slapping at people. Methods identify that if R6 becomes a threat to herself or others, staff should use least to most restrictive behavior management techniques as lightly as possible until she is calm. Further documentation identified a hand written entry of "Child form." Review of the Incident/Accident Report dated 12/10/05 documentation identified that at 7:30 A.M. R6 got up and fell hit head and shoulder. Cause of the incident was identified as "Resident Behavior." No documentation was noted on file to reflect that a behavioral incident occurred on 12/10/05 at 7:30 A.M.. A Universal Note for R6, dated 12/10/05 was provided to the surveyor on 06/16/06 as part of the facility's investigation. Documentation identified, "R6 was hitting and kicking staff and herself and other consumers. We removed the other consumers from her area of active treatment. She continued to hit and kick staff. She then head butted a staff member and was then held in a CPI (Crisis Prevention Institute) child restraint form. The CPI method was used from 9:30 A.M. until 9:32 A.M., approximately 2	W9999		

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W9999	Continued From page 99 min. (minutes). She was released and assisted back to there active treatment area." This Universal Note entry was signed by E11 (Direct Care Staff). Nurses Notes for 12/10/05 for R6 did not identify the use of CPI restraint, nor notification of R6's physician. Review of the Schedule for the Silver Room and Employee Time cards identified that E11, E12 and E13 worked the morning shift on 12/10/05 when R6 was restrained. No documentation was provided by the facility that would identify the staff member who placed R6 in a basket hold. Nurses Notes for 12/11/05 for R6 at 8:30 A.M. identified, "Consumer was noted to have significant bruising to right shoulder et (and) chest. MD (Medical Director) on call notified. Order to send to ER (Emergency Room) for eval. (evaluation)..." Further documentation for 12/11/05 identified that R6 returned from the emergency room at 10:35 A.M. Nursing notes identified that R6 had an "AC (Acetabular) separation." Day Training documentation for 12/12/05 identified: R6 bruised from head to toe. Rt (Right) shoulder, chest, Rt neck and Rt cheek. Long bruise on right thigh. Reported that her right shoulder is dislocated. Laceration on left side of back of head. In review of the facility's summary of the investigation regarding R6's injuries of unknown origin discovered on 12/11/05, the facility concluded that, "... the pattern of bruising, as assessed by nursing staff, appeared consistent	W9999		

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W9999	Continued From page 100 with a basket hold, a CPI technique used to intervene with aggressive behavior. R6 is on a behavior program that includes CPI technique..." Further documentation identified that CPI would no longer be used on R6. Per record review, no documentation was noted that R6 had sustained a fractured clavicle on 12/ 10/05 until 01/16/06 when R6's clavicle was X-rayed during hospitalization for other medical reasons. The radiology report for 01/16/06 identified, 1/16/2006 Right Clavicle Five Views History: Rule out dislocation. Findings: Fracture involving the mid right clavicle is seen. The fracture is most likely recent. No dislocation of the right shoulder is identified. Impression: Fracture, mid right clavicle. Addendum: Report called to the 3rd floor nursing service 01/17/06 0930 hours. Per interview with E2 (Resident Services Director - RSD) on 06/16/06 at 12:30 P.M., E2 stated, " We did not investigate this incident because we knew how it happened. It happened in December. During this interview, E2 confirmed that the facility did not have the radiology report for 12/11/05 on file for R6. E2 also confirmed that the facility did not use information from the radiology report of 12/11/05 as part of the facility's investigation. On 06/16/06 at 1:30 P.M., the facility provided the surveyor with a facsimile copy of the radiology	W9999		

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W9999	Continued From page 101 report for R6 which identified, "Right Shoulder: 12 /11/05. Two views are obtained. Identified is a 100% inferior displaced comminuted oblique fracture involving the mid right clavicle. In addition, there is a widening of the AC joint consistent with a type II AC separation. There are no additional acute fractures seen. No gross bone destruction..." In review of the facility's investigation, the facility failed to identify the person who had restrained R 6 in a child form basket hold on 12/10/05; failed to include the information from the radiology report for 12/11/05 during the facility's investigation and failed to retrain and inservice all staff on the use of crisis intervention procedures to prevent further potential injuries. Interview with E3 (QMRP - Qualified Mental Retardation Professional) on 06/23/06 at 9:35 A.M. confirmed that everyone on a behavior program may potentially be restrained during a behavior. E3 stated, "Everyone that is on a behavior program has CPI listed. We use the least restrictive first prior to CPI. Everyone that has a behavior program is listed on the facility roster." 2) The facility failed to implement their own policies and procedures prohibiting abuse, neglect and mistreatment of the individual for R 15 who allegedly was physically abused by E6 (Direct Care Staff) on 02/28/06. After this incident, the facility failed to thoroughly investigate an allegation of staff abuse, failed to notify local police authorities, and failed to take corrective action to protect the safety of R15 and other individuals of the facility. Per review of the Initial Report of Incident dated " May 23, 2002," (typographical error)	W9999		

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W9999	Continued From page 102 documentation identified that on 03/01/06, "E5 reported to the QMRP (Qualified Mental Retardation Professional - E3) that while getting ready to leave for workshop DSP (Direct Support Personnel) E6 was smacked by R15 and that E6 responded by slapping the consumer with her left hand making contact with R15's right jaw. E5 did intervene and an investigation is being conducted during which E6 will not have contact with facility residents..." Per interview with E5 on 06/14/06 at 2:55 P.M., E 5 confirmed that he was present and on duty on the day of the alleged incident. E6 stated, "I was working with E6. I think it was on a Wednesday because they were having IDT (Interdisciplinary Team meetings) in the Red Room. I saw her (E6) slap him so hard his head turned. I couldn't leave the room to report it because every one else was changing people and getting them ready to go to work. This happened about 7:45 A .M. because we were done feeding." When asked by the surveyor when he reported the abuse, E6 stated, " I told E8 (Safety Director) and E9 (Direct Care Staff) and E9 called E3 (QMRP). Per telephone interview with E8 on 06/14/06 at 11:15 A.M., E8 confirmed that E5 had informed him of the abuse a day after the alleged abuse occurred. E8 stated, "I remember hearing E5 talking and I called him to put a sign on the coke machine because it wasn't working. He told me that E6 had slapped R15. I caught her (E6) when she was coming through the front door for work and told her she would have to wait for Management." When E8 was questioned by the surveyor as to why E6 was arriving to work if she was already at work, E8 stated, "It had to be the day after the incident. I was working in the room	W9999		

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W9999	Continued From page 103 with the time cards and I did not allow her to start work. It had to be the next day." Review of E6's time card for 03/01/06 identified that a hand written entry had been made on her time card which stated, "Per E8 off floor at 7:30 A .M. waiting on management." Further review of E6's time card identified that E6 had worked the day prior to 03/01/06. Documentation identified that E6 worked from 6:07 A.M. - 10:25 A.M. on 02/28/06. Review of the witness statements included within the facility's investigation identified an initial date of 02/28/06. Further review of these statement sheets identified that this date had been marked out and a date of 03/01/06 had been added. No names or initials were noted that would identify who had made the date changes on the statement sheets. Per review of the facility's investigation, no documentation was noted to identify what date or time E5 informed administration of the allegation of abuse. Interview with E3 (QMRP) on 06/14/06 at 3:15 P. M. confirmed that E5 had reported the allegation to him. E3 stated, "E6 reported to me then E1 (Administrator) took over the investigation. During this interview, E3 could not provide documentation as to when he was informed of the allegation of abuse. Per interview with E1 (Administrator) on 06/14/06 at 3:20 P.M., E1 confirmed that she began an investigation on 03/01/06. E1 stated, "I started an investigation and had E6 removed from contact with any of the consumers. I talked with	W9999		

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W9999	Continued From page 104 everyone to see what happened and did my interviews." E1 confirmed that the facility did not have documentation of the staff interviews completed during the investigation. E1 also confirmed that the police had not been notified as per the facility's policy. Review of the outside Day Training Incident Report dated 03/01/06, documentation identified, "E1 (Administrator) from **** *** (name of facility) called this nurse (Z5) et (and) voiced it has been reported to me that R15 was slapped by either client or staff yesterday or today at our home. Would you check for any bruising areas? This nurse voiced, "yes I will..." Further review identified the description of R15 injuries as found by Z5 on 03/01/06 at 11:20 A.M.. Documentation identified: Describe Injury: L (left) eye with (symbol for with used) red swollen lid Rt (right) shoulder blade with 2" long scratch et (and) 1" long scratch to L of the first scratch. Further review of the Incident Report dated 03/01 /06 identified that a 24 follow up had been completed by Z5 and that R15 continued to have swelling to his left eye and that his scratched areas had begun scabbing. Per telephone interview with E1 (Administrator) on 07/11/06, E1 stated that she was not aware of day training incident report for 03/01/06 which identified injury to R15's left eye. Review of the facility's 24 Hour Follow Up sheet for R15 dated 03/01/06 identified that R15 had no signs of injury when checked by nursing staff at the facility even though day training had identified	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G099	A. BUILDING _____ B. WING _____	07/18/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TURNER MANOR	**P.O.BOX 303, 901 OGLESBY ROAD HARRISBURG, IL 62946**

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W9999	Continued From page 105 injuries. Documentation identified: "Initial Note: I was called to report an incident involving a consumer and a DSP. I checked R15 over and saw no s/s of injury redness, scratches or bruising. Follow Up 11 A.M. Checked with DT (Day Training) Nurse reported that they found no s/s of injury. 8 Hour Post 3 P.M. Returned from DT site a body check No s/s of bruising or redness noted. 16 Hour Post (No time specified) No s/s pain or distress noted 24 Hour Post 03/02/06 No s/s of bruising or injury noted..." Review of the facility's investigation dated 03/06/06 identified, "E5 indicated that he and E6 were the only two staff members present at the time and he did observed E6 slap the consumer with her left hand making contact with R15's right jaw in response to being hit by the consumer. No employee working the shift could verify that they saw E6 strike or in any way abuse any resident. Consumer R15 functions within the profound level of mental retardation and does not have any function communication skills. E6 was requested to complete a witness report form and left the facility grounds before being interviewed as the incident occurred at shift end. E6 did not answer phone calls from the investigative team. When she next reported to work, she was not allowed to clock in, at which time she was instructed to	W9999		