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 02/08/2007

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COLONIAL PLAZA	**618 WEST GOODNER NASHVILLE, IL 62263**

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W 183	Continued From page 22 each defined residential living unit housing: (i) Clients for whom a physician has ordered a medical care plan; (ii) Clients who are aggressive, assaultive or security risks; (iii) More than 16 clients; or (iv) Fewer than 16 clients within a multi-unit building. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to have a responsible direct care staff awake during the midnight shift(12:00-8:00) to care for the 4 individuals(R1-R4) who reside at the facility. Findings Include: According to the resident roster, R4 is a 33 year old female who functions in the moderate range of mental retardation. R4 was interviewed on 1/24/07 at 10:30am at the workshop. R4 stated that when E7 worked the midnight shift on 1/22/07, E7 was asleep on the couch. R4 then demonstrated to surveyor how E7 snores. Per interview with R3 on 1/24/07 at 10:45am, at the the workshop, she also saw E7 sleeping on the couch and said to E7 "get up E7". Per interview with E8 on 1/24/07 at approximately 9:30am both R4 and R3 had told her earlier that week that they had seen E7 sleeping while working the midnight shift. The facility failed to have direct care awake during all shift in order to care for the individuals residing in the facility	W 183		
W9999	FINAL OBSERVATIONS	W9999		

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W9999	Continued From page 23	W9999		

LICENSURE VIOLATIONS

350.620a)
350.1060a)g)
350.3240a)b)
350.3240a)b)c)d)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 350.1060 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.
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 350.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.
b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility

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W9999	Continued From page 24 administrator. (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. 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. e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of 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 These requirements were not met as evidenced by: Based on interview and record review, the facility failed to implement their written policies and procedures to prohibit mistreatment, abuse and neglect when R1 was guided through the commons areas of the facility naked from the waist down affecting 1of 3 (R1) individuals in the sample. The facility failed to ensure immediate administrative notification, failed to take immediate action resulting in the staff working the remainder of the shift, failed to complete a thorough investigation, failed to notify the guardian, and failed to notify Illinois Department of Public Health. Findings Include: According to the resident roster, R1 is a 56 year	W9999		

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W9999	Continued From page 25	W9999		

old female who functions in the moderate range of mental retardation. Per review of R1's ICAP of 7/5/06, R1 has an overall age equivalent of 2 years and 9 Months.

Per interview with E2 on 2/5/07 at 2:30pm, R1 does have incidents on incontinence although she will use the bathroom independently. R1 does not have a formal toileting schedule and will close the bathroom door for privacy.

Per review of an Incontinence Record of 1/07, 35/39 times R1 used the bathroom R1 needed assistance.

On 1/23/07 at approximately 10:30am, surveyor requested from E1 information regarding any on-going investigations of abuse/neglect being conducted by the facility. E1 handed 3 documents to the surveyor consisting of 2 statements written by staff (E2 and E6) and a Notice of Termination written by E1 for E3. The documents described an incident concerning R1 on 1/14/07.

E2's statement: "R1 had a bowel movement all over herself and E3 had walked R1 from the bedroom thru the living room and kitchen naked, dropping BM on the floor to the shower room." (typed as written)

E6's statement: "R1 had an accident in the bathroom and needed a shower. E2 walked R1 to the bathroom naked w/o sheet." (typed as written)

E1's statement: Notice of Termination dated 1/15/07: "Violation of clients/unethical conduct. Walked resident from North hall through public

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W9999	Continued From page 26 areas of facility to South hall bathroom completely naked. This is a clear violation of clients' rights. QMRP called E3 and asked E3 to come in to discuss the situation and employee refused. Employee stated that she would not come in until it was time to get her check." (typed as written) Per interview with E2 on 1/23/07 at approximately 11:30am, on 1/14/07 around 4:30pm, E2 was located in the dining room with 3 other residents (R2, R3 and R4). E3 was assisting R1 in the north hall bathroom. R1 came from the north hallway with no clothes on from the waist down and walked through the living and dining room and dropping pieces of feces as she walked into the south hallway bathroom. E3 walked behind R1 telling her to "Hurry up and get to the bathroom, I felt this was verbal abuse." E2 stated that E3 cusses around the residents a lot. At no time did E3 try to stop R1 from walking down the hallway without clothes or provide some type of wrap to cover R1's private areas. E2 stated that she contacted E1 about the incident on 1/14/07 by telephone. Per interview with E6 on 1/23/07 at 1:45pm, E6 indicated that she had only been employed at the facility about a week when the incident occurred on 1/14/07. E6 was sitting in the dining with the other 3 residents, when R1 walked through the dining room naked from the waist down. E6 saw E3 walking behind her saying to R1 "Come on R1, Let's get to the bathroom." When interviewed on 1/23/07 at 2:30, E1 stated to surveyor that she was not aware of the incident until the next day when notified by E2. E1 requested that the staff that were on duty on	W9999		

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W9999	Continued From page 27 1/14/07 write out a statement on what occurred concerning R1. E3 continued to work the remainder of her shift on 1/14/07. E1 stated that E3 refused to come in the next day to talk about the incident and stated she would be in at the end of the week to pick her paycheck. E1 stated that before every new employee starts working at this facility, they are given a copy of the Rights of the Individuals. The employees must sign that they read and understood the individuals rights and a copy is placed into their personnel file. When reviewed, Rights statement includes the following: #7 of the Rights: You shall be provided with the opportunity for personal privacy and shall be insured privacy during treatment and care of personal needs. #20 You shall be treated with consideration and respect and with full recognition of your dignity and individuality. (Summary of Individual rights as stated in section 483.420 of the Medicaid Program: Condition for Intermediate Care Facilities for the Mentally Retarded: Final Rule effective October 3, 1988.) Upon review of the facility Abuse and Neglect Policy, it states, "It is the practice of this organization to implement strong policies and procedure to detect and prevent incidents of abuse and neglect through education of staff, individuals receiving services, guardians and family members. This policy defines a proactive approach to prevent incidents of abuse and neglect and promotes the quality of life of each individual." Reporting/Immediate Action Procedures:	W9999		

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W9999	Continued From page 28 -All allegations of abuse/neglect/mistreatment shall be documented on the facility "Incident Report Form" and made part of the individual's clinical record. There is no evidence that an incident report form was completed by the facility. -The "Initial Allegation of Abuse Report" form shall be completed by the QMRP and/or facility administrator. There is no evidence that this form was completed. -Documentation of interviews shall be completed on the "Investigative Interview Form" with signatures and time and date of the interview. -Written statements may be requested as part of the investigation process and will be documented on the "Written Statement" form. -The final report shall be compiled on the "Investigative Summary" form and forwarded to the Illinois Department of Public Health within five (5) days of the initial report. Per interview with E1 on 1/23/07, the facility did not send a notice of alleged abuse to the Department of Public Health. -The "Responsibility Sheet for Abuse/Neglect Investigation" will be completed by the administrator or his/her designee to ensure compliance with this policy. There is no evidence that the facility administrator followed the facility policy to complete an "Incident Report Form" or "Initial Allegation of Abuse Report" once an allegation of abuse was reported. In addition, there is no evidence of a final report and no evidence of notification of IDPH. E1 confirmed on 1/23/07 at 2:30pm that a thorough investigation was not completed concerning the incident with R1 and E3 and only staff statements were completed by the staff on	W9999		

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W9999	Continued From page 29	W9999		

duty on the afternoon shift of 1/14/07. There is no evidence E1 provided retraining to E2 and E6 regarding immediate notification. (She stated she did not know about the incident until the next day) During the 1/23/07 interview, surveyor told E1 about E2's allegation of verbal abuse by E3 when she was interviewed at approximately 11:30 on 1/23/07.

On 1/31/07 a fax letter was sent to the surveyor from E1 which stated, "While getting the requested information out of E3's file, I found the report you were talking about. (The Notice of Termination on E3 that was given to the surveyor on 1/23/07) I am not sure why that it was in the file. It should not have been. I must have picked it up off my desk with the other papers by accident. That document is not valid. I am faxing the valid document."

"After speaking to E12 (owner) and E11 (acting administrator) about the incident, and after asking the employees who were present at the time of the incident, it was my finding that E3 was not leading R1 down the hall, she was in fact following her and trying to catch up to her. As I said, I discussed this with E11 and E12 and we all agree that this was not a violation of R1's rights. R1 in fact had chosen to walk through the facility on her own."
(The statement in question is the Notice of Termination that E1 gave the surveyor at the beginning of the investigation on 1/23/07 with E2's and E6's statements).

There is no evidence of how this conclusion was reached and no evidence that E1 had addressed E2's allegation of verbal abuse.

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W9999	Continued From page 30 A letter was faxed to the Department by Z1 on 1/26/07. It is written from the prospective of E2 and E6 stating that E3 had been getting clothing and toiletries together following R1's incident of BM incontinence on 1/14/07. It further states that E2 and E6 asked E3 what had taken place to which she explained that R1 had left the bathroom by herself. Lastly it states that R1 "did not appear to be agitated or upset..." Again, there is no evidence that E2's allegation of verbal abuse was addressed. A 2nd Notice of Termination letter for E3 was written by E1 and is dated 1/15/07. It states, E3 followed R1 through the facility and E3 did not redirect R1 (even though the first termination states that E3 violated the rights of R1 by leading the individual through the facility naked). The 2nd Notice of Termination was faxed to the Department on 1/31/07. It does not address E2's allegation of verbal abuse. On 2/1/07 at 10:45am by phone, E6 was re-interviewed about the statement she made on 1/23/07. E6 again stated that on 1/14/07 she was sitting in the dining with 3 other residents. E6 saw R1 walking through the dining room naked from the waist down. E3 was walking behind R1 and said "Come on R1, Lets go to the bathroom." E6 said that E3 was holding something that looked like a sheet. E6 was interviewed for the 3rd time on 2/5/07 at 1:15pm concerning the incident. E6 confirmed what happened on 1/14/07, during all 3 interviews. E6 stated she did not have a conversation with E3 about why R1 was walking through the facility half naked.	W9999		

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W9999	Continued From page 31 On 2/1/07 at 2:30 pm by phone, E2 was also re-interviewed about her interview that was made on 1/23/07. E2 confirmed that R1, with E3 behind her all the way, walked from the north hallway into the living room through the dining room and into south hallway without any clothes on. E2 stated that she heard E3 say to R1, "Hurry up and get to the bathroom." E2 reiterated that is sounded like verbal abuse by the way E3 said it. E2 was interviewed for the third time on 2/5/07 at 2:30pm and again confirmed her statements. E2 stated she did not have a conversation with E3 after the incident with R1. Z2 was interviewed on 1/25/07 at approximately 3:00pm. Z2 stated that the facility had not contacted her to report the allegations of mistreatment and abuse on 1/14/07. (A)	W9999		