STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G060	A. BUILDING _____ B. WING _____	C 06/07/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEVERLY FARM FOUNDATION	6301 HUMBERT ROAD GODFREY, IL 62035

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W9999	Continued From page 8 LICENSURE VIOLATION 350.620a) 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 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Requirements are not met as follows: Based on interview and record review, the facility failed to implement policies and procedures to prevent neglect when 1 of 3 individuals in the sample (R1) was left on the day training bus from approximately 8:45am to 2:30pm. Following the incident, the facility failed to have supervisory oversight to ensure that staff completed the bus monitor form accurately. In addition, the facility failed to ensure a communication system in which day training staff are aware when an individual will be or will not be in attendance. Findings include: According to R1's Individual Habilitation Plan (IHP) of 10/17/06, R1 is a 61 year old ambulatory male who functions in the profound range of	W9999		

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mental retardation with additional diagnosis of seizure disorder, visual impairment, schizo affective disorder, obsessive compulsive disorder and autistic disorder. Per review of R1's SIB (Scales of Independent Behavior) of 11/21/06, R1 has an overall age equivalent of 1 year and 10 months.

Per interview with E3 (R1's group leader), on 6/5/07 at 9:30am, E3 was assisting another resident outside while loading the day training bus on 5/24/07. R1 is able to ambulate independently and walked out in front of E3. R1 held the rail as he climbed aboard the bus. E3 stated there was one bus monitor at the top of the stairs (E5) and one monitor (E11) outside the bus by the door. E3 stated that when the building residents go on community outings and use a bus for transportation, he has observed R1 slump down in the seat with his knees pressed against the seat in front of him.

Per interview with E5 (bus monitor) on 6/4/07 at 2:00pm, the bus stopped at the side of R1's building on 5/24/07 at approximately 8:30am. E5 was at the top of the stairs inside the bus, assisting with the clients entering the bus. E5 stated that she never saw R1 get on the bus and did not see him all day at the workshop. E5 asked the building staff that morning whether R1 was coming to workshop and she heard the staff reply that due to a pre-medication the day before (for dental work) R1 would not be attending workshop that day. When the bus arrived at the workshop, E5 assisted in unloading the bus. E5 stated she walked through the bus before going into the workshop. E5 said she never saw E1 leave the bus.

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Surveyor tried several times to contact E11 (the second bus monitor on R1's bus) but was unable to make contact.

Per interview with E1(bus monitor) on 6/4/07 at 9:00am, E1 loaded up a group of female clients on the bus on the afternoon of 5/24/07 for the trip back to residential. E1 stated she is responsible for monitoring the same group of clients for the morning and afternoon bus ride. The bus arrived at the residential building and at that time she saw R1 trying to get off the bus by pushing through the girls. E1 had never seen R1 before and asked the other bus monitor (R2) the identity of the client. E1 stated that R1 looked liked he had been on the bus for a long time. R1 was covered in sweat and urine. R1 was placed back on the bus and taken back to day training.

Per interview with E2 (the second bus monitor with E1) on 6/4/07 at 8:45am, E2 and E1 loaded a group of female clients to be taken back to the residential facility on the afternoon of 5/24/07. E2 stated the bus monitors are responsible for completing the attendance chart prior to the bus moving. E2 was sitting toward the back of the bus and E1 was sitting at the front of the bus to monitor all activity on the bus. E2 stated she was shocked when she saw R1 pushing his way toward the front the bus. E2 said there was no possible way that R1 could have gotten on the bus in the afternoon with the other clients. E2 also stated that the bus monitors are responsible for walking through the bus after all the clients have exited the bus. E2 indicated that when a client is absent from her day training classroom, the supervisor will call the building to verify that the client will not be attending day training that day.

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Per interview with E12 (R1's day trainer) on 6/4/07 at 8:30am, when the bus arrived at day training on 5/24/07 she asked E5 if R1 was on the bus. E5 indicated that she was told from the building staff that R1 was staying home that day. E12 stated that she asked E5 four times that morning about R1's whereabouts. When she saw R1 that afternoon, his face was white and cheeks were red. R1's shirt smelled of sweat. R1 was taken to the bathroom and then seen by the day training nurse to be assessed. E12 stated she then went to E6's office (Assistant Day Training Administrator) to inform her of the situation.

Per interview with E6 on 6/4//07 at 8:00am, after she was informed by E12 that R1 had been left on the bus, a call was made to the facility abuse/neglect investigator and an investigation began immediately. E5 and E11 were asked to write a statement and were placed on leave during the investigation.

When reviewed, nursing note on 5/24/07 at 2:55pm stated, "Staff from Rm1 came and got me and said that R1 had been left on the bus all day, they said they were told he wasn't coming today. R1 was using the toilet when I came into the room, he was very sweaty, but seemed to be his usual self. His temp was 98.8-ax B/P 127/72, Pulse 65, respirations 18. We hydrated him slowly. I contacted the doctor by phone, he received report and said that the increased temp was probably due being on the hot bus we should monitor for changes in his behavior or vitals. Bldg nurse was notified and Bldg. Supervisor, also ADON and DON notified Bldg to start 72 hour Health Watch."

A second nursing note was made by DON at

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3:20pm "Guardian was notified at 4:00pm of above situation and doctor's orders to monitor."

Review of the bus monitoring job description last revision date 3/06:
-Participate with building staff in helping individuals to the bus
-aid individuals on the bus stairs and onto the wheelchair lift
-seat individuals and/or lock wheels into clips
-ensure the safety of all individuals boarding the bus and seated on the bus
-have knowledge of individuals not attending or boarding bus (i.e: attendance sheet, make note of any special needs)
-be informed and understand all safety and emergency policy and procedures. (Knowledge of use of the safety door, seat belts, and wheelchair locks,etc)
-Do a final walk through before leaving bus to ensure all individuals have exited the bus.

Per interview with E6 about any changes in the policy/procedures that were made after the incident, she said that all the day-training coordinators were responsible for re-inservicing all their staff.

Per interview with E13 (Day-Training Coordinator) on 6/4/07, E13 confirmed that his staff were re-trained on the job description of the bus monitor to make sure they are checking the bus. There were no changes made to the procedures on monitoring the buses.There is no evidence that the supervisory staff were over-seeing the monitors and making sure they were carrying out their responsibilities following the incident. Per review of the attendance sheet, at the bottom of the page, the monitors are to check/initial that the

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W9999	Continued From page 13 bus is empty. As of 6/1/07, the sheet for R1's bus is blank. Per interview with E14 on 6/4/07, the staff are to turn in the bus monitor reports at the end of the week to the office. The office uses the reports to verify attendance for the day training. The reports are not checked to make sure the bus monitors are completing them correctly. E14 stated the bus monitors are to report to the classroom trainer and inform them when a client is absent. The day training does not call the residential building to verify an absence. As of 6/4/07, this procedure had not been revised. Facility policy on neglect: No individual receiving services from Beverly Farm Foundation will be abused or neglected by anyone, including, but not limited to staff, volunteers, contractors, family members, friends or guardians. Neglect means: The failure to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to a individual or in the deterioration of an individuals physical or mental condition shall include any allegation where: The alleged failure causing injury or deterioration is ongoing or repetitious: or an individual required medical treatment as a result of the alleged failure; or the failure is alleged to have caused a noticeable negative impact on an individual's health, behavior or activities for more than 24 hours. There is no evidence that the facility implemented the policy when R1 was left on the bus and facility failed to supervise monitors to ensure accurate monitoring. (A)	W9999		