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	14G240	A. BUILDING _____ B. WING _____	C 04/25/2008

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BETHESDA LUTHERAN-AURORA	**1480 RECKINGER ROAD AURORA, IL 60505**

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W 331	Continued From page 17 E2 was asked if she was made aware of the day training staff's concerns of R2 having a urinary tract infection in February (2/14/08) - as documented in the communication log. E2 left the interview and returned within a few minutes. E2 then stated in February she talked to staff (at facility) and no one noted any concerns (e.g.. foul smelling or concentrated urine). E2 also verified there was no documentation in R2's nursing notes regarding the day training staff's concerns of foul smelling and concentrated urine for R2.	W 331		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1230b)3)4)5)6)7) 350.1230d)1)2) 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 350.1230 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:	W9999		

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W9999	Continued From page 18 The DON shall participate in: 3) Periodic reevaluation of the type, extent, and quality of services and programming 5) Training in habits in personal hygiene and activities of daily living. 6) Development of a written plan for each resident to provide for nursing services as part of the total habilitation program. 7) Modification of the resident care plan, in terms of the resident's daily needs, as needed. 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. 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	W9999		

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W9999	Continued From page 19 or agent of a facility shall not abuse or neglect a resident. These Requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to: 1. Ensure a system is in place, for 1 of 1 clients in the sample (R1), to prevent and treat decubitus ulcers acquired at the facility - and to include nursing care in accordance with his health needs. 2. Obtain a follow up CT (computerized tomography) to chest for 1 of 1 clients (R1) for further evaluation and exclusion of right pulmonary nodule. 3. Ensure nursing staff assessed 1 of 1 clients (R2) after being notified client had foul smelling and concentrated urine. Findings include: 1) R1, per review of his current POS (Physician's Orders Sheet) dated April 2008, is a 48 year old male whose diagnoses include Profound Mental Retardation, Down Syndrome, Chronic Constipation, Scoliosis, Adjustment Disorder with Anxious Mood, Osteoporosis and Seizure Disorder. R1 was observed 4/17/08 at approximately 10:15am at his day training program. R1 was in his wheelchair in his classroom. R1 is essentially non-verbal and is non-ambulatory. E2 (DON - Director of Nursing) stated per interview 4/16/08 at 2:35pm, R1 is non-ambulatory and at times can bear a little bit of weight. R1 is essentially non-verbal.	W9999		

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W9999	Continued From page 20 Review of R1's adaptive behavior assessment, dated 2/15/07, noted R1 obtained a score of 1 year 5 months. On 4/16/08 at 2:05pm E2 was interviewed regarding any clients at the facility who currently have a decubitus/pressure ulcer. E2 identified 2 clients with decubitus ulcers (R1 and R4). E2 explained that R4's decubitus ulcer is from self-injurious behavior. E2 stated R1 developed the decubitus ulcer after he came home from the hospital. E2 stated R1's decubitus ulcer also spread to his scrotum. E2 said the scrotal area is currently healed, the decubitus ulcer is now just on R1's buttocks. E2 classified R1's decubitus ulcer on his buttock as a Stage I. R1's buttocks were observed at his day training program 4/22/08 at 11:16am. R1 had an open area on his left buttock. The open area measured approximately 1cm wide by 1 inch in length. R1 also had an open area on the left side of his scrotum. The open area was approximately 1/4 inch. R1's nursing notes from 7/13/07 through 4/16/08 (12pm) were reviewed. On 7/13/07 R1 was transported and then admitted to the hospital with diagnoses of aspiration pneumonia, seizures and leukocytosis. R1 returned to the facility 8/6/07. There was no documentation in R1's nursing notes that R1 had any skin breakdown at this time. On 8/12/07 nursing staff documented R1 had redness around groin area with no open areas noted. On 8/15/07 nursing staff documented, "7am L (left inner buttock skin raw and bleeding sm. (small) amt (amount), approx 2" X 4" (inch) area open. Tx (treatment) cream applied. Area tender to touch." On 8/16/07	W9999		

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W9999	Continued From page 21 nursing staff documented "7am L buttock - inner area remains raw (no) bleeding this shift. Tx done." Further review of nursing notes through 4/16/08, revealed nursing staff documented on average twice per day. During the past 8 months nursing staff identified R1's decubitus ulcer as a Stage I. Nursing staff charted approximately 15 times over this 8 month period R1 had a Stage I decubitus ulcer. Nursing staff documented approximately 30 times over the past 8 months measurements of R1's decubitus ulcer either to his buttocks or scrotum. Nursing measurements included the following: - 8/15/07 2 inch by 4 inch open area to left inner buttock - October 2007 measurements were taken approximately 10 times with largest open area noted 10/23/07. 3 inch by 1/2 inch sore was noted to left buttock with a moderate amount of bleeding. Two open sores were also documented to scrotum. One sore was documented to measure 1.5cm by 2cm (centimeter). -November 2007 measurements were taken approximately 7 times with largest sore noted 11/21/07. "Sore is larger with base approx. 15cm and then a jaggered cut approx. 2" (inches) long." - December 2007 measurements were taken approximately 4 times with largest area noted 12/22/07. "Left scrotum with 2 inch area open with whitish/red area."	W9999		

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W9999	Continued From page 22 - January 2008 measurements were taken approximately twice. - February 2008 measurements were taken approximately 4 times. - March 2008 measurements were taken approximately 3 times. Nursing staff failed to consistently assess R1's decubitus ulcer to his buttocks and scrotum. Nursing staff failed to consistently describe R1's decubitus ulcer including location, measurements and staging. E2 (DON - Director of Nursing) was interviewed 4/16/08 at 2:35pm. E2 was asked if nursing staff document anywhere besides nursing notes regarding R1's decubitus ulcer. E2 stated nurses only chart in R1's nursing progress notes. E2 was asked if R1 had a specific positioning schedule. E2 stated R1 did not. Review of R1's physician's notes, dated 8/25/07, contains a drawing and identifies R1 has a 3 X 3 cm Stage III decubitus ulcer to his left buttock. Nursing notes prior to 8/25/07 and post 8/25/07 do not reflect R1 has a Stage III decubitus ulcer to his left buttock. E9 (physician) was interviewed via phone call 4/22/08 at 2:55pm. E9 was asked to explain the varying Stages used to identify a decubitus ulcer. E9 explained the following: - Stage I = redness to the skin, either newly formed or in the healing stage - Stage II = break down of the skin - Stage III = open areas of the skin	W9999		

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W9999	Continued From page 23 - Stage IV = open areas to the bone Surveyor explained to E9 observations of R1 from 4/22/08 at at 11:16am when R1 was observed to have an open area on his left buttock. The open area measured approximately 1cm wide by 1 inch in length. R1 also had an open area on the left side of his scrotum. The open area was approximately 1/4 inch. Surveyor asked E9 what Stage R1's decubitus ulcer would be considered. E9 stated probably a Stage II, however he would need to observe the decubitus ulcer to verify that. E9 was asked about his last physician progress noted dated 4/14/08 that appears to read "ulcer on the buttock is stable." E9 stated he did not actually observe R1's decubitus ulcer on 4/14/08. E9 explained that he relies on nursing staff's assessment. E9 stated R1 usually has a brief (adult incontinence brief) on with cream on so he did not observed R1 on 4/14/08. E9 stated that stable means - no better and no worse. E9 stated he thought a wound care agency was taking care of R1. Surveyor told E9 that a wound care agency has seen R1 twice in the past 8 months. E9 stated he was unaware of that. E9 was asked about the medication Calmoseptine ointment that was ordered, per the POS (Physician's Order Sheet) dated 12/31/08 (12/31/07). E9 stated the Calmoseptine ointment was probably recommended by someone from the wound care agency. E9 was asked if it was appropriate to continue to use the Calmoseptine ointment since it was ordered approximately 3 1/2 months ago. E9 stated, "Probably not appropriate for a 3 month use." Literature (obtained from Drugs.com / Drug Information Online) regarding the use of Calmoseptine ointment notes: "Stop using this	W9999		

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W9999	Continued From page 24 medication and call your doctor if your condition does not improve within 7 days of treatment." On 4/17/08 E4, E5 and E6 (direct care staff) were interviewed at 9:30am. E4 and E5 stated that R1 is non-ambulatory and is "dead weight." E4 and E5 stated R1 is either a 2 person transfer or staff must use a mechanical lift with R1. E4 and E5 were asked about R1's morning routine. E4 and E5 stated R1 usually gets up around 6:30am and is put in his wheelchair. After breakfast, at approximately 8:00am, R1 is seated in his recliner chair. R1 stays in the recliner until lunchtime, approximately 11:30am. At approximately 11:30am R1 is put back in his wheelchair until lunch is complete. After lunch R1 may be be put in his bed - supine position. E4 and E5 were asked if R1 has any positioning schedule to identify how often and how to reposition R1. E4 and E5 stated R1 does not have a positioning schedule. E6 was asked if R1 has any open areas to his buttocks and scrotum. E6 stated R1's buttocks are "clearing up a lot," however his "skin is still broken." E6 was asked if R1 wears an incontinence brief at night. E6 stated R1, "wears a diaper at night." E6 stated that every morning R1 is soiled (from bowel movement), so he is usually cleaned up and changed last. On 4/16/08 E2 (DON) was asked if R1 wears an adult incontinence brief at night. E2 stated she was not sure, however she believed he did. Review of R1's physicians's orders noted a telephone order, taken by E2 on 2/4/08. The order reads: "2/4/08 - Adaptive Equipment - disposable brief during day only et. (and) soaker pad at noc (night) due to incontinence."	W9999		

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W9999	Continued From page 25 Z1 was interviewed 4/17/08 at 10:22am at R1's day training program. Z1 was asked if R1 had any positioning schedule to be implemented at his day training program. Z1 stated he did not. Z1 explained that R1 usually arrives in his wheelchair at approximately 9:30am. Z1 stated R1 is then changed and then put in a recliner chair. R1 stays in the recliner chair until after lunch, at which time he is again changed. At approximately 12:30pm R1 is again seated in his wheelchair. R1 usually leaves the day training program between 2:15pm and 3:00pm, depending if he is riding the early or late bus. R1's 2/26/08 IPP (Individual Program Plan) was reviewed. The IPP identifies that nursing staff completed an assessment titled, "Patient Assessment for Potential for Skin Breakdown." The assessment, completed by E2 is not dated. The assessment does note that R1 is a "High Risk," with a score of 36, for potential for skin breakdown. The assessment and R1's IPP do not identify any preventative measures to prevent skin breakdown. R1's 2/26/08 IPP does not identify any treatment measures since he acquired a decubitus ulcer to his buttock and scrotum starting 8/15/07. 2) R1's chart was reviewed on 4/17/08. R1 had a chest X-ray on 8/15/07 (post hospitalization due to aspiration pneumonia). The results of the 8/15/07 chest X-ray note: "Equivocal nodule projected over the lateral thoracic spine on one of the two lateral views presented. I would simply recommend a follow-up lateral view of the chest in about one months' time for further evaluation." Approximately 4 months later R1 had a follow up chest X-ray that noted the following: "The	W9999		

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W9999	Continued From page 26	W9999		

posterior nodule previous discussed is not well reassessed because of the basilar changes. I would recommend further follow-up chest radiography. CT may be necessary for further evaluation and exclusion right pulmonary nodule." R1's physician (E9) documented (no date) on the X-ray report the following: "CT (computerized tomography) - chest - with contrast - sedation."

E2 (DON) was interviewed 4/17/08 at 9:45am regarding the follow up chest CT as ordered by R1's physician. E2 stated it was done - she just needs to find it. At 11:10am on 4/17/08 E2 stated the chest CT for R1 was scheduled for January 2008, however it was cancelled. E2 stated it has been rescheduled for 4/18/08.

3) R2, per review of her current POS (Physician's Orders Sheet) is a 51 year old female whose diagnoses include Profound Mental Retardation, Epilepsy, Unspecified Hypothyroidism, Unspecified Hearing / Vision Deficit, Sclerosis and Undersocialized Conduct Disorder (Aggressive Type). R2, per interview of E1 (Director of Operations) and E2 (DON) on 4/22/08 at 1:45pm, is non-ambulatory and requires a mechanical lift for transfers. R2 will "mimic" words and can communicate some of her needs (e.g.. pain).

R2's nursing notes were reviewed 4/17/08. On 3/14/08 nursing staff documented, "7am She slept all night. No problems - urine sample taken from her by straight cath (catheter)." Additional nursing notes are as follows:

- 3/17/08 "2p UA C&S (urinalysis and culture and sensitivity) results faxed to MD (Medical Doctor)."

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W9999	Continued From page 27 - 3/18/08 "12p UA C&S results called into MD - orders rec'd " - 3/19/08 "6am started on ABT (anti-biotic therapy) for UTI (Urinary Tract Infection) (no) c/o (complaint) or distress noticed." - 3/29/08 "7a ABT completed last noc (night) no S/E (side effects) noted. Closing out F/U (follow-up) charting." - 4/5/08 "10a UA C&S results obtained - WNL (with in normal limits)." On 4/17/08 at 12:05pm E2 was interviewed. E2 was asked why nursing staff obtained a urine specimen, via straight catheter, on 3/14/08 for R2. E2 stated staff at R2's day training program reported R2's urine was foul smelling and concentrated. E2 was asked when did the staff - at the day training program report this. E2 stated probably around 3/12/08 or 3/13/08. E2 was asked if there was any documentation regarding the staff's report. E2 stated if there was nothing in the nurses notes, then there was no documentation. E2 stated after she was made aware of staff's report she then told nursing staff to get a urine specimen from R2. E2 verified R2 was diagnosed with a urinary tract infection, via lab reports, and received a course of anti-biotics. On 4/22/08 surveyor observed R2 at her day training program at 11:25am. Z2 told surveyor 4/22/08 at 11:30am, that staff at R2's day training program had concerns 2/14/08 that R2 may have a urinary tract infection. Z2 stated she called E2 2/14/08 and left a phone message regarding the staff's concerns. Z2 stated Z4 also	W9999		

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W9999	Continued From page 28 documented in the communication log about staff's concerns. Z2 provided surveyor a copy of the entry in the communication log. Z2 also explained the communication log is a book that staff at the day training program document in regarding any concerns or needs they may have for clients attending their program from R2's residence. Z2 showed surveyor an entry, made by Z4, that notes, "(R2) - concern about UTI (urinary tract infection) - could she be tested." Z2 also showed surveyor an entry, dated 3/10/08, that notes "(R2) continues with very foul smelling urine. We have been giving her (increased) fluids, but (no) change. Perhaps a UA (urinalysis) would be helpful?" Z3 was interviewed 4/22/08 at 11:37am. Z3 stated the day training program communicates with E2, via the communication log. Z3 stated, sometimes they (day training) will also E-mail E2 regarding concerns. Z3 stated the nurse at R2's residence is responsible for reviewing the communication/log book. Z3 stated R2 has had foul smelling concentrated urine, until recently treated, for approximately 6 weeks. On 4/22/08 at 12:20pm E1 (Director of Operations), E2 and E10 (Area Director) were interviewed. E2 stated the communication/log book is sent back and forth between the facility and the day training program. The log is reviewed daily by the nurse on duty. E2 was asked if she was made aware of the day training staff's concerns of R2 having a urinary tract infection in February (2/14/08) - as documented in the communication log. E2 left the interview and returned within a few minutes. E2 then stated in February she talked to staff (at	W9999		