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	14G216	A. BUILDING ______ B. WING ______	C 01/11/2008

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MAPLE TERRACE	**1510 NORTH FOURTH STREET QUINCY, IL 62301**

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W9999	Continued From page 56 LICENSURE VIOLATIONS 350.620a) 350.700a)1)2) 350.1230b)3)6)7) 350.1230c) 350.1230d)1)2)3) 350.1230e) 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 350.700 Serious Incidents and Accidents a) The facility shall notify the Department of any incident or accident which has, or is likely to 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.	W9999		

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W9999	Continued From page 57 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: The DON shall participate in: 3) Periodic reevaluation of the type, extent, and quality of services and programming. 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. 3) First aid in the presence of accident or illness. 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. 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 were not met as evidenced by: Based on observation, record review and interview the facility has failed to provide nursing care in accordance to the needs of one of three	W9999		

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W9999	Continued From page 58 residents in the sample, R3, when they failed to ensure nurse involvement in assessment, evaluation and recommendations. R3 developed a pattern and trend of increaased falls and injuries of unknown origin. Findings include: In review of the Individual Service Plan (ISP) of January 23. 2007 belonging to R3 it validates that R3 is a 62 year old female who functions in the profound range of mental retardation. Additional diagnoses are Downs Syndrome, Alzheimer, Osteoporosis, Dementia and Raynaud Syndrome. Review of Quarterly Health Status Review reveals that R3 experienced a cervical fracture following a fall in May of 2007. R3 is 4 feet 6 inches in height and weighs 104 pounds. Per observation conducted on December 26, 2007 at 4:10 PM, R3 has an unsteady gait, leans to the left with a wide stance and has a dark area under right eye. The facility policy 5.57 C in summary states that direct care staff can only call the RN for consultation if they are unable to reach the house Manager, QMRP or Administrator. Per interview with E3, RN on 12/28/07 at 1:00 PM, it was stated that E3 is "notified only if it warrants medical attention, it is up to the Q to notify me. I wasn't the one that put that into play, that was the company that took away the staff's right to call me, I don't agree with it but that's the way it is."	W9999		

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W9999	Continued From page 59 Per review of the Progress Notes (GP-15) written by direct care staff for R3, it is verified that on the following dates R3 was experiencing the noted injuries/incidents. August 16, 2007 7:00 AM fell in the living room, no staff were present, though the note states that vital signs were taken, the actual numbers are not included. In addition there is no evidence of follow up of R3's health status following the fall. There is no documentation to verify the notification of, or assessment by, an RN. August 20, 2007 staff documented finding bruise on the right buttock "golf ball sized." There is no noted documentation to verify the notification of an RN. No follow up to R3's health status is noted. September 1, 2007 staff documented a fall off of a bench resulting in "bruised, scrapped (sic) swollen" right knee. Also documented is injury to right eye, "black and blue." A follow-up is written on September 2, 2007 at 8:00 AM by E1, the Residential Service Director (RSD)/QMRP stating that R3 was seen by a Registered Nurse (RN) who stated that the black eye R3 was experiencing may have been "due to a burst blood vessel," however there is no documentation by the nurse to verify treatment or follow up recommendations. September 10, 2007 at 6:45 PM it is documented that direct care staff found a bruise 3 inches by 1/2 inch on the inside of R3's left knee. A followup was written on September 11, 2007 at 9:15 AM by E1, RSD/QMRP stating that R3 "has developed a tendency to back up to the dining room chairs and them plopping down on them.	W9999		

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Bruise is consistent with striking the edge of the seat." There is no follow up or explanation of how "plopping down" would case a bruise to the inside of the left knee. There is no documented notification of, or assessment by, an RN.

September 19, 2007 at 8:14 PM it is documented that R3 slipped of the edge of the chair and landed on the floor. There is no evidence of vital signs being taken or follow up being recommended. There is no documentation to verify notification of, or assessment by, an RN.

September 20, 2007 at 4:45 AM R3 fell while getting out of bed landing on left side with knees bent upwards and a peers walker over R3. There is no evidence of vital signs being taken or follow up being recommended. No noted documentation to verify notification of, or assessment by, an RN.

September 23, 2007 at 10:50 AM it is documented that R3 fell in the living room. It is documented that R3 has an old bruise on the right aspect of her buttocks. There is no evidence of vital signs being taken or follow up being recommended. There is no documentation to verify notification of, or assessment by, an RN.

September 26, 2007 at 5:05 PM it is documented that R3 fell in the dining area. There is no evidence of vital signs being taken or follow up being recommended. There is no documentation to verify notification of, or assessment by, an RN.

October 2, 2007 it is documented that R3 had scratches on the top of the head, neck and back of the head, there is also report of a "knot back

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W9999	Continued From page 61	W9999		

Continued From page 61

there." Follow up on this was written on October 2, 2007 at 4:30 PM by E1, QMRP who reported that R3 had long finger nails that staff were unable to trim but that R3's nails had been trimmed at this time. There is no follow up to the knot on the back of R3's head and no evidence of vital signs being taken. There is no documentation to verify the notification of, or assessment by, an RN.

On October 3, 2007 E1, documented that the RN had been notified of the injuries to R3 that occurred on October 2, 2007. According to the documentation, E1, QMRP/RSD, asked E3, RN, to evaluate the noted areas. There is no documentation to verify that the RN completed an evaluation on R3.

October 16, 2007 at 12:45 AM it is documented that R3, has scratches on the back of the neck on the right side. Follow up by E1, QMRP states that R3 has night clothes with a stiff and rough tag and that the scratches are consistent with the tag rubbing on the back of the neck. There is no evidence that tag was assessed for removal or how a tag could cause scratches. There is no documentation to verifty notification of, or assessment by, an RN.

October 16, 2007, no documentation of the time, it is noted that R3 has three scratches on her right breast approximately 1 inch long with minor skin tears. The QMRP was notified and antibiotic ointment was applied. There is no evidence of a nail care program to address this. There is no documentation to verify notification of, or assessment by, an RN.

October 21, 2007 at 1:45 AM R3 was noted to

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W9999	Continued From page 62 have a bruise on the right side of the forehead and on the lower aspect of the right forearm. Follow up by E1, QMRP states that E3 constantly wanders through the living room, dining room and kitchen. E3 also turns to the left and re-enters rooms that were just exited often running into the door frames. E1 states that R3's bruises are consistent with this. There is no evidence of vital signs being taken. There is no documentation to verify notification of, or assessment by, an RN. October 30, 2007 at 1:50 AM it is documented that R3 has a bruise on the right aspect of the forehead and the right eye. There is no documentation to verify the notification of, or the assessment by, an RN. November 17, 2007 at 6:00 PM it is documented that R3 has a bruise on the left thigh from thigh to knee. There is no documentation to verify the notification of, or assessment by, an RN. November 18, 2007 at 12:35 AM R3 was found on the floor of the bedroom with a large "goose egg" above the right eye. There is no documentation to verify the notification of, or the assessment by, an RN. There is no evidence of neurological checks or vital signs being taken. November 21, 2007 it is documented that R3 has a bruise to the right corner of the lip. There is no evidence of vital signs being taken. There is no documentation to verify the notification of, or assessment by, an RN. November 22, 2007 it is documented that R3 has a bruise to the left upper lip and also to the calf of the left leg. There is no evidence of vitals being taken or follow up recommendation for care.	W9999		

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W9999	Continued From page 63 There is no documentation to verify notification of, or assessment by, an RN. November 26, 2007 it is documented that R3 has bumped the left and right sides of the head and the left foot is swollen with ice applied. There is no documentation to verify the notification of, or assessment by, an RN. There is no evidence of neurological checks being ordered or completed, recommendations for follow up or vital signs being taken. November 28, 2007 at 8:20 PM it is documented that R3 bumped the right side of the head on a door frame when unattended by staff. There is no documentation to verify the notification of, or assessment by, an RN. There is no evidence of neurological checks being ordered or completed or follow up for recommendation for care or vital signs being taken. November 30, 2007 at 3:55 AM it is documented that R3 fell getting out of bed landing on the buttocks, while being assisted by staff . There is no evidence for vital signs being taken or recommendation for follow up. There is no documentation to verify the notification of, or assessment by, an RN. December 2, 2007 at 1:45 AM it is documented that R3 has two bruises to the top of the left leg above the left knee, also documented is that E1, QMRP was present and related the two bruises to the fall on November 30, 2007. There is no mention of how bruises to the top of the left leg above the knee were associated with the fall to the buttocks. There is no documentation to verify the notification of, or assessment by, an RN.	W9999		

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W9999	Continued From page 64 December 2, 2007 at 8:15 AM it is documented that E3 has an abrasion to the nose and the left side of the neck. No documentation to verify notification of, or assessment by, an RN. December 7, 2007 at 7:00 AM it is documented that E3 fell to floor landing on buttocks. There is no evidence of vital signs being taken. There is no documentation to verify the notification of, or assessment by, an RN. December 8, 2007 at 11:40 AM R3 fell while getting on the van. R3 landed on buttocks and bumped the right knee. No documentation to verify the notification of, or assessment by, an RN. December 11, 2007 at 8:45 PM R3 fell while being assisted to bed by staff. No evidence of recommendations for follow up care. No documentation to verify the notification of, or assessment by, an RN. December 13, 2007 at 9:50 AM it is documented that R3 had a bruise on the posterior aspect of the right thigh, "deep purple" in color, approximately 6 inches by 6 inches." There is no evidence of recommendation for follow up of care. Follow up was documented on December 17, 2007 by E1 in which it is stated that the bruise is consistent with the last three falls dating back to December, 7, 8, 11, 2007. There is no documentation to verify notification of, or assessment by, an RN. December 14, 2007 at 3:05 PM it is documented that R3 has a light purple bruise 2 inches in length on the tailbone. Follow up is documented on December 17, 2007 referring back to previous	W9999		

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W9999	Continued From page 65 three falls dating back to December, 7, 8, 11, 2007. However, there is no recommendations for care. There is no documentation to verify notification of, or assessment by, an RN. December 25, 2007 it is documented that R3 has a bruise under the right eye. There is no documentation to verify notification of, or assessment by, an RN. Per interview with Z1, Physician on December 27, 2007 at 11:55 AM when asked if Z1 was aware of the falls of R3, Z1 replied "no I haven't heard of those." When asked about the bruising Z1 stated "I haven't seen her since last July." Per review of commmunication log to day training, R3 fell on 12/17/07, "sat down on floor" and on 12/19/07, R3 was "unstable on feet" and fell while getting on the bus to go home . There is no evidence of facility review assessment or recommendation and no evidence of RN notification. When reviewing R3's record there is no evidence that the facility QMRP notified the facility RN of the increase in falls that R3 was experiencing. There is no evidence that professional sensory motor assessments were recommended and no evidence of health or medical intervention. In review of the Individual Service Plan (ISP) dated January 23, 2007, of R3 it validates that R3 is a 62 year old female who functions in the profound range of mental retardation. Additional diagnoses are Downs Syndrome, Alzheimer, Osteoporosis, Dementia and Raynaud Syndrome.	W9999		

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W9999	Continued From page 66 Per review of the Progress Notes dated from 8/16/07 to 12/25/07, R3 has fallen on 11 occasions, has 14 documented bruises to various areas of the body, 6 abrasions, an edematous left ankle and two hematomas, one to the top of R3's head and one to right eye area. Per observation of R3 on 12/26/07 beginning at 10:40 AM, R3 leans to the left at the waist while sitting and standing, R3 has a wide, stiff legged gait that is unsteady. Per interview with E1, Residential Services Director/Qualified Mental Retardation Professional (RSD/QMRP) on 12/26/07 at 3:20 PM. E1 was asked if the R3's guardian was notified of the recent falls, E1 stated "I don't notify him unless she goes to the E.R.(emergency room). We do communicate by e-mail once in a while and I tell him about how she is doing." There was no evidence presented to verify notification of guardian. Per interview with Z5 guardian of R3 on January 8, 2008 at 10:50 AM Z5 initially related that he was aware of the falls and bruises. When surveyor asked if the compiled list could be read to Z5 for confirmation Z5 agreed. Upon completion of the reading of the list, Z5 stated "I am aware of about 1/2 of those. They keep telling me that they see opportunity to challenge her mentally and physically. Something has to be worked out with the falls and bruises. I will be there for the meeting this month, my wife and my son who is a social worker will be with me. I am going to insist that they report these things to me." There is no evidence that the facility notified Z5	W9999		

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W9999	Continued From page 67 of R3's patterns and trends of increased falls and bruises. (A)	W9999		