STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G109	A. BUILDING _____ B. WING _____	C 07/01/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL LIVING CENTER, INC	200 SOUTH 9TH STREET NEW BADEN, IL 62265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 156	Continued From page 35 Phone interview on 5/14/08 at 8:00am. E2 made an allegation against E1 for R3 down in a dining room chair. E2 also alleged that during the week of 4/20/08, E1 put R2's wheelchair in the hallway, leaving R2 stranded on his bed. On 5/14/08 at 5:00pm, E3 (facility administrator) became aware of these allegation. As of 6/4/08, the complete report of the facility investigation(staff members/clients interviewed & summary of facility investigation) results regarding the allegation of abuse has not been reported to the Department. b) Review of an alleged abuse investigation that allegedly occurred on 6/1/08, E8(cook) started her first day of employment at the facility as the weekend cook. E8 was alleged to verbally abuse the resident's 6/1/08. It was reported that there were several episodes that E8 had negative affect on clients(R3,8 & 12) during her shift. Interview with E3 on 6/18/08 at 11:00am, E3 became aware of the allegation against E8 on the morning of 6/2/08. E3 completed interviews with the staff who worked on 6/1/08 (E9, E10 and E11) with E8. R3,R12 and R8 were also interviewed by E3. E3 stated that she failed to conclude her investigative summary and report to the department within five working days.	W 156		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.681 350.700a)1)2)	W9999		

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W9999	Continued From page 36 350.700b) 350.700c) 350.1060a)d)e)h)j) 350.1640a)b)c) 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 350.681 Health Care Worker Background Check A facility shall comply with the Health Care Worker Background Check Act [225 ILCS 46] and the Health Care Worker Background Check Code (77 Ill. Adm. Code 955). 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	W9999		

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W9999	Continued From page 37 or incident occurrence shall be sent to the Department within seven days of the occurrence. b) A descriptive summary of each incident or accident shall be recorded in the progress notes or nurses' notes for each resident involved. c) The facility shall maintain a file of all written reports of serious incidents or accidents involving residents. 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. d) There shall be evidence of training and habilitation services activities designed to meet the training and habilitation objectives set for every resident. 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. 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. j) Appropriate records shall be maintained for each resident functioning in these programs. These shall show appropriateness of the program for the individual, resident's response to the program and any other pertinent observations	W9999		

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W9999	Continued From page 38 and shall become a part of the resident's record. Section 350.1640 Records Pertaining to Residents' Property a) The facility shall maintain a record of any resident's belongings, including money, valuables and personal property, accepted by the facility for safekeeping. This record shall be initiated at the time of admission and shall be updated on an ongoing basis and made part of the resident's record. b) When purchases are made for a resident from the resident's personal monies, receipts shall be obtained and retained that verify the date, amount, and items purchased. c) A separate bookkeeping system shall be maintained by the facility which accounts for all transactions affecting each resident's account. Each individual resident, or the individual resident's representative, shall have access to the record of that individual resident's account. 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 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	W9999		

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W9999	Continued From page 39 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: 1. Based on interview and record review, the facility failed to implement their written policies and procedures to prohibit mistreatment and abuse/neglect when the facility: a) failed to take immediate administrative action concerning an allegation of abuse/neglect. b)failed to gather the appropriate evidence to facilitate an alleged abuse investigation. c)failed to report an alleged abuse investigation results within 5 working days. d)failed to train new employees regarding abuse/neglect and emergency procedures. e)failed to supervise new employees. f)failed to prohibit financial exploitation of clients. 2. Based on interview and record review, the facility failed to implement their policy for abuse and neglect when staff failed to immediately report an allegation of verbal abuse. In addition, the administrator failed to take steps to supervise/train new staff members and failed to	W9999		

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W9999	Continued From page 40 have evidence that all allegations are investigated and reported to the Department in a timely manner. 3. Based on interview and record review, the facility failed to establish a system that precludes any commingling of client funds without maintaining accounting of accrued interest in the funds for 4 of 4 in the sample (R1,R2,R3,R4) and ten individuals(R5,R6,R7,R8,R9,R10,R13,R14,R16 & R17) outside the sample. Findings Include: 1. According to the facility roster on 5/21/08, R2 is a verbal non-ambulatory male who functions in the profound range of mental retardation. R2 has an overall age equivalent of 2 years and 0 months. Review of R2's IPP (Individual Program Plan) of 5/17/07, "R2 uses a wheelchair. R2 is mobile with the use of the special one hand guidance. R2's left hand is unable to help him propel the wheelchair but once he gets moving he moves right along. R2 can, if he wants, transfer from wheelchair to bed and bed to wheelchair. Staff is present at all transfers." According to the facility roster on 5/21/08, R3 is a verbal ambulatory female who functions in the moderate range of mental retardation. R3 has an overall age equivalent of 5 years and 2 months. During phone interview on 5/14/08 at 8:00am, E2 made an allegation against E1 (QMRP). E2 stated she "witnessed E1 push R3 down in a dining room chair. E2 also stated that during the	W9999		

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W9999	Continued From page 41 week of 4/20/08, E1 took R2's wheelchair away from him. E1 placed R2's wheelchair in the hallway, leaving R2 stranded on his bed." Phone interview with E5 (Hab Staff) on 6/4/08 at 3:30pm, E5 stated that he has witnessed E1 placing R2's wheelchair in the hallway and leaving R2 stranded on his bed. E5 stated that E1 uses this as a punishment for R2. E5 also stated that he had never reported this to E3 (Administrator). Interview with E6 (Hab Staff) on 5/22/08 at 3:00pm, E6 stated she has never seen E1 push R3 down in her chair but she has seen E1 take R2 out of his wheelchair and place the wheelchair in the hallway. E6 stated she was afraid of retaliation from E1 so she did not report to E3. Interview with R2 on 5/21/08 at approximately 10:30am, R2 stated, "that E1 took my wheelchair away from me and placed it in the hallway." R2 thought it happened about 2 months ago. R2 stated, "I guess I wasn't behaving that day." Interview with R3 on 5/21/08 at approximately 10:45am, R3 stated that "E1 has never pushed me down into a chair but she does get upset when the clients act out." Review of the facility policy/procedure on 5/22/08: "In the event that any abuses occur or suspected, the staff witnessing the situation must immediately contact the RSD and the Administrator. If the resident was abused by a staff person, that staff will be placed on immediate suspension pending the outcome of an investigation. The staff that witnessed the	W9999		

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W9999	Continued From page 42 incident or told of the incident by the resident must write a full report. The administrator and RSD will complete the investigation through interview and gathering of all materials deemed necessary. Depending upon the outcome of the investigation appropriate action will be taken. The facility will follow the recommendation of the particular agency doing the investigation. A full report of their findings will be in the facility and forwarded to IDPH". Upon entering the facility on 5/21/08 at 10:00am, E3 (Administrator) and E1 (QMRP) had been asked whether the facility had investigated any allegations of abuse/neglect within the last year or had any open investigation at the time. E1 responded she was not aware of any abuse/neglect at the facility. E3 (Administrator) was called on 5/21/08 at 5:00pm at home by surveyor and made aware of allegations of abuse against E1. E1 was alleged to have pushed R3 down in a dining room chair and had removed R2's wheelchair and placing it in the hallway leaving R2 stranded on his bed. E1 stated that, "these allegation were made by a disgruntle former employee E2." E3 repeatedly defended E1 saying, "E1 would never abuse these individuals and just tell me what you want me to do about it." Per phone interview with E3 on the same evening at 5:05pm, Z7 re-informed E3 regarding the allegation of abuse against E1. E1 was verbally distraught stating, "this is not true and E1 did not hurt anyone. You should be investigating Z2." Z7 asked E3 what her plan was regarding this allegation. E3 responded that "she would talk to	W9999		

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W9999	Continued From page 43 E1" and "she is the one who handles this." When Z7 asked her what she would do when E1 is the alleged perpetrator, E3 said again that "E1 wouldn't hurt anyone and did not do this." E3 repeatedly stated that "she would have to ask E1 what she should do." E3 refused to listen to what Z7 was trying to tell her, that since E1 was the alleged perpetrator that E1 could not investigate the allegations. Per interview that evening at approximately 5:30, Z6 attempted to explained to E3 about the requirements when an allegation of abuse is made and the allegation is made against the QMRP (Qualified Mental Retardation Professional). E3 thought the allegation was"totally wrong" and "didn't happen." Z6 explained the regulations under client protections. E3 again stated that "E1 would have to take care of it." E3 asked Z6, "What do you want me to do about it?" Z6 asked E1 what the facility policy was regarding allegations of abuse/neglect or mistreatment. E3 again responded, "I don't know, E1 does that." Z6 reiterated that E1 is the alleged perpetrator and she again loudly stated, "But she didn't do anything!" Z6 then told her that the regulation requires safeguarding during the investigation of allegations and asked what safeguards she had put in place. E3 stated, "I don't know." At approximately 6:15pm, E3 returned a phone call to Z6 and told her that she had asked E1 to go home and work only when the residents were not in the facility. Review of E1's statement of 5/23/08 relating to the allegation for R2, "R2 had not been changed before supper. R2 was soiled with urine and BM	W9999		

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W9999	Continued From page 44 and it was now close to supper. At that time, R2 was told he had to changed before he ate, he headed for his room after several prompts, but then could not get on his bed. R2 was unhappy about missing the first group of dinner. I helped R2 onto his bed, and then placed the wheelchair outside of his room because the bed was moved to close to the door and R2 could not get onto the bed from the side he usually transfers on. R2 uses his right arm for leverage from the side of the bed. R2 has little use of his left arm and while it provides support he was not on the side for correct support. R2 was now on the left side of the bed which is the wrong side for him to transfer. R2's wheelchair was placed outside of the room because at that point it could not get into the room because of the bed. R2 was changed by staff and he joined the second group for dinner. While R2 was eating, I moved the bed to its proper spot. since then the wheelchair moves around the bed and there is no issue of space." (typed as written) Review of E1's statement of 5/23/08 relating to the allegation for R3, "The residents were coming in from workshop and preparing to have their drink after work. R3 was standing on the side of the table by the office/bathroom area which is also the hallway. R3 was holding a pitcher with hot water or apple cider in it. R13 was coming down the hallway with her arms swinging. R6 was moving down the hallway very quickly. To prevent R3 from getting burnt by the hot liquid with all the swinging arms and movement, my first instinct was to get her seated and put the pitcher down to prevent R3 from being burnt by the hot liquid." E1 did not recall the date of this incident. (typed as written)	W9999		

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W9999	Continued From page 45 2. Review of the staff time cards, E8 worked on 6/1/08 (Sunday) from 10:00am-6:00pm. Per review of E9's statement on 6/18/08, this was E8's first day of employment. E8 was hired as weekend cook. E9 was to show E8 around the kitchen and get her familiar with the area, how things were done, where the kitchen items are kept, talk about the menu, etc. E9 documented, "before I had the chance to do anything immediately E8 got loud and said I'm the cook. I ran a place like this I know what I'm doing." E8 questioned the therapy of the individuals and where was the house monitor and why there wasn't one on duty. E9 continued to explained that E8 "told everyone this was her kitchen now and asked everyone to leave the area, rather ordered everyone out." I was not welcome, and certainly the residents were not. Every time a resident walked in the kitchen E8 would say, cooks here now, this is my kitchen out. E8 would even stand in the doorway telling them to go away. E8 was very loud, the woman acted like she was really going off. Staff, as well as residents, could say nothing, it was very quiet. Everyone in the building I don't think, could believe what was going on, we just all sort of looked at one another. E8, I'm sure scared many of the residents." Review of E10's statement concerning E8: "The new staff in the kitchen was ordering everyone out of the kitchen including other staff and saying it was her kitchen and they don't belong in there." Review of E11's (afternoon direct care staff) statement: "I came to work at 3:15pm on 6/1/08, the lady in the kitchen was saying how she	W9999		

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W9999	Continued From page 46 stopped everyone from coming in the kitchen, she was not use to a lot of people being in the kitchen. E8 stated that there was no one to tell her what to do in the kitchen, she had to look for everything on her own, no one even told her where the time clock was. E8 told E11 that she was not coming back it was too much for her to deal with and the residents came in and telling me what all she said. E8 told R3 to stay out of the kitchen and R3 said she told her this was her home." Review of R8's statement: "E8 was here over the weekend and would not let the residents in the kitchen and she said it was her kitchen and they could not cross the line. E8 told the residents they were not allowed to sit down until R13 (takes R13 little time to sit down) did and that E8 cussed at them." Review of R3's statement: "The new cook this weekend would not make coffee for the residents and told the residents they were not allowed in the kitchen." Interview with E4 on 6/18/08 at 11:00am, E4 (day team leader) was informed by E10 concerning E8's behavior on 6/1/08. E4 informed E3 when she arrived at the facility on 6/2/08. Interview with E3 on 6/18/08, she was informed about E8's behavior of 6/1/08 when she arrived at the facility on 6/2/08. E3 continued to state, "there is no oversight by the facility for new employees. New staff are trained by the staff that are currently working the same shift." E8 would have been trained on 61/08 by E9, E10 and E11. E3 was asked by surveyor the first date of E8's employment, E3 responded that "E8 had just	W9999		

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W9999	Continued From page 47 started working at the facility at the beginning of May." E3 also stated that the nurse aide registry was not checked due to the fact E8 was hired to cook and the paperwork had not been completed for the background check before E8 was hired. A final report was completed by the facility on 6/18/08 after the Department contacted the facility regarding their final investigation (17 days after the incident). 3. A. Per review of individual client financial statements from 01/01/08-05/30/08 for(R1,R2,R3,R4,R5,R6,R7,R8,R9,R10,R11,R12, R13,R14,R15,R16 & R17) and client receipts, clients have been charged as follows: a. 2/10/08- The following clients were charged $9.50 each for a chicken dinner: (no receipt) R2,R3,R4,R5,R6,R7,R8,R9,R10,R11,R12,R13,R 14,R15,R16 & R17 for a total account expenditure of $152.00. b. 3/9/08-The following clients were charged $10.00 each for a chicken dinner: (no receipt) R2,R3,R4,R5,R6,R7,R8,R9,R10,R11,R12,R13,R 14,R15 & R16 for a total account expenditure of $150.00. c. 3/15/08-The following clients were charged $8.00 each for a chicken dinner: (no receipt) R3,R4,R5,R6,R7,R9,R10,R11,R12,R13,R14,R15 & R16 for a total account expenditure of $104.00. d. 5/14/08-out to eat $30.00 for each client: R6,R7,R13,R14 & R15 (no receipt) for a total account expenditure of $150.00.	W9999		

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	14G109	A. BUILDING _____ B. WING _____	C 07/01/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL LIVING CENTER, INC	200 SOUTH 9TH STREET NEW BADEN, IL 62265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W9999	Continued From page 48 e. 5/19/08-out to eat $30.00 for each client: R1,R2,R3,R4,R5,R8,R9,R10,R11&R12 for a total account expenditure of $300.00. f. 5/27/08 receipt $69.08-seven meals ordered: R1,R2,R3,R5 & R10's names written on receipt. g. 5/30/08 receipt $108.35-eight meals ordered: R4,R8,R9,R11 & R12's names written on receipt. h. 1/7/08-out to eat $30.00: R3 (receipt $29.46-three meals ordered). i. 1/30/08-out to eat (Bob Evans) R6 charged $26.50 (no receipt). j. 1/30/08-out to eat (Bob Evans) R9 charged $26.50 (no receipt). k. 4/23/08-out to eat (Bob Evans) R6 charged $20.77(no receipt). l. 4/23/08-out to eat (Bob Evans) R9 charged $20.77(no receipt). B. Financial statements from 1/1/08-5/21/08 for R1,R2,R3,R4,R5,R6,R7,R8,R9,R10,R13,R14 & R16 were reviewed. There are no ledger entries to address accrued interest during the 2008 fiscal year. All clients had various positive account balances from 1/1/08-5/21/08. Per review of R17's discharge plan of 3/12/08, R17 was discharged from the facility on 3/12/08. R17's 2008 financial statement stated that a "$296.10 cashiers check was made out to R17's guardian" to close R17's account on 3/19/08. Per review of R17's 3/12/08 discharge plan, it did not	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G109	A. BUILDING _____ B. WING _____	C 07/01/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL LIVING CENTER, INC	200 SOUTH 9TH STREET NEW BADEN, IL 62265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W9999	Continued From page 49 address R17's financial net worth at the time of discharge, did not address any accrued interest and did not address any outstanding credits or debits. C. Per review of client financial statements from 01/01/08-05/19/08, R10 and R11 were charged by the facility for medical equipment/adaptive equipment. a. R10-01/28/2008 wheel chair part $102.00. b. R11-02/15/08 adaptive shoes $432.64. R10's & R11's Individual Program Plans (IPP's) had no evidence of billing R10 and R11 for the medical equipment and no explanation for charges incurred for medical equipment. In addition there was no evidence in current financial statements for R10 and R11 that reimbursement was forthcoming. E4 stated that R10 & R11 were charged for medical equipment as per policy of the facility. E4 was unable to provide documentation to support the policy of client payments towards medical equipment and/or adaptive equipment. D. Per review of facility policy and procedures there was no evidence as of 6/4/08 of any policies governing client funds. E4 (Facility Home Manager) was interviewed on 6/04/08 at 11:00AM and confirmed reviewing client financial statements. E4 stated that it is a facility practice that the clients pay a portion of staff meals when on an outing or appointment. E4 stated that E1(Residential Service Director) informed her that all facilities in the area charge clients for staff meals on outings and/or	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G109	A. BUILDING _____ B. WING _____	C 07/01/2008

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W9999	Continued From page 50 appointments. E4 was unsure of the date of information from E1. E4 stated that R1,R2,R3,R4,R5,R6,R7,R8,R9,R10,R13,R14 & R16 have one account at a local financial institution. E4 confirmed that this account is a interest bearing account and the clients share the account due to small account balances for several of the clients in the past. E4 stated that she maintains the financial statements by making weekly entries for each client for expenses and any income received by individual clients. E4 confirmed receiving quarterly financial reports from the local financial institution with interest accrued stated on the statement. E4 stated that she has not added any interest payments for 2007 and 2008 to the clients' individual financial statements. E4 confirmed the discharge of R17 and the payout of $296.10 to close out R17's account. E4 stated that R17's interest for 2007 & 2008 was not added to his account upon discharge. E4 stated she would have to go back to financial records for 2007 & 2008 to calculate and then send the interest payment to R17's guardian. (A)	W9999		