STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G204	A. BUILDING _____ B. WING _____	11/18/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARBROOK EAST	3802 SOUTH OLD WILKE ROAD ROLLING MEADOWS, IL 60008

(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 000	INITIAL COMMENTS ANNUAL CERTIFICATION SURVEY - FUNDAMENTAL ANNUAL LICENSURE SURVEY	W 000		
W 122	INSPECTION OF CARE 483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on interview and record review, the facility failed to: 1) Implement their policy to prevent neglect, for 1 of 1 clients (R5), when they failed to prevent R5 from falling and sustaining 2 fractured ribs on 10/30/08. 2) Develop and implement preventative measures, for fall prevention (R5), after a special IDT (Inter-Disciplinary Team) meeting was held 6/10/08. 3) Obtain a PT (Physical Therapy) evaluation as recommended by the IDT on 6/10/08 and as recommended by the neurologist on 7/23/08. 4) Fully develop their policy for neglect when they failed to describe what constitutes neglect with potential to affect 14 of 14 clients living in the facility (R#'s 1 thru 4 and 6 thru 15) 5) Thoroughly investigate 2 of 2 injuries of	W 122		12/15/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 122	Continued From page 1 unknown origin (R1 and R5) Refer to deficiencies cited under: W149 - The facility must develop and implement their written policies and procedures that prohibit mistreatment, neglect or abuse of the client W154 - The facility must have evidence that all alleged violations are thoroughly investigated	W 122		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to implement their policy to prevent neglect for 1 of 1 clients (R5) when they failed to prevent R5 from falling and sustaining 2 fractured ribs on 10/30/08. The facility failed to: 1. Develop and implement preventative measures after a special IDT (Inter-Disciplinary Team) meeting was held 6/10/08. 2. Obtain a PT (Physical Therapy) evaluation as recommended by the IDT on 6/10/08 and as recommended by the neurologist on 7/23/08. 3. Fully develop their policy for neglect when they failed to describe what constitutes neglect with potential to affect 14 of 14 clients living in the facility (R#'s 1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, 13,	W 149		12/15/08

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W 149	Continued From page 2 14, and 15). Findings include: R5, per review of her 11/2/08 POS (Physicians's Orders Sheet), is a 52 year old female whose diagnoses include Moderate Mental Retardation, Seizure Disorder and Hypothyroidism. E3 (QMRP), interviewed 11/7/08 at 9:45am, stated R5 is verbal but is not always reliable. R5 is ambulatory but uses a wheelchair any time she is outside of her residence. R5 also has a physician order to wear a helmet at all times when out of bed due to frequent seizures and drop attacks. E1 (Administrator), interviewed 11/7/08 at 3:20pm, stated R5 is currently residing in a nursing home. The facility's Incident Reports were reviewed, and R5 was noted to have the following falls: - 10/30/08 8:20pm: R5 sustained 2 fractured ribs as the result of a possible fall. - 10/5/08 8:45am: R5 was in the bathroom getting ready for a shower. R5 lost her balance, hitting her left arm on the sink and her back on the toilet seat. - 9/27/08 2:05pm: R5 lost her balance walking to to the van. R5 hit her head but had her helmet on. - 9/24/08 7:05am: R5 was getting dressed, had a seizure, and fell to her knee.	W 149		

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W 149	Continued From page 3 - 7/30/08 6:05pm: R5 was drying herself after bathing had a seizure and fell. - 7/29/08 7:30pm: R5 was in the bathroom and fell back hitting her head. R5 was wearing her helmet. - 7/23/08 7:15pm: R5 was walking to her bedroom - lost her balance and fell. - 6/1/08 9:20am: R5 appeared to have a seizure in her bedroom and fell. - 5/19/08 7:00am: R5 was in the bathroom appeared to have a seizure and fell backwards hitting her back against the toilet. - 5/13/08 8:20pm: R5 went into the bathroom to get a garbage bag and fell. - 5/5/08 11:10am: R5 showed day training staff a "large purple and pink discoloration, about 2" long by 1 1/2 " wide on the underside of her forearm just above her elbow." R5 stated she fell at home. R5 was sent to the emergency room later in the day and diagnosed with a left elbow contusion. - 5/2/08 7:25am: R5 had a seizure in the bathroom, fell and hit her back on the shower chair. - 5/1/08 9:30pm: R5 fell in the bathroom scraping left elbow. Review of R5's clinical record noted an Interim Staffing / Special IDT meeting was held 6/10/08.	W 149		

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W 149	Continued From page 4 The IDT documented the reason for the staffing as, "To discuss (R5's) recent falls and issues with staff." "Recommendations by the IDT: Follow up on any medical issues such as MRI, Thyroid issues prior to consulting with Psychiatrist to rule out medical concerns. In-service staff on working with (R5), how to motivate her to get up. Refer for counseling and Psychological, RN waiting for call from (neurologist). Next behavioral in-service will discuss (R5's) non-compliance and ways to motivate her." "Request for PT (Physical Therapy) referral" is also noted on the 6/10/08 IDT meeting notes. E1, interviewed 11/6/08 at 11:10am, verified the facility had 1 special IDT meeting on 6/10/08 regarding R5's falls. E3 (QMRP) was interviewed 11/5/08 at 2:10pm. E3 was asked if there were any follow up IDT meetings as a result of the 6/10/08 IDT meeting and recommendations. E3 stated there were not. E1 (Administrator) was interviewed 11/6/08 at 11:10am. E1 was asked to explain the facility's system for monitoring R5's 13 falls that occurred between 5/1/08 and 10/30/08. E1 stated the facility uses Incident Reports to document the falls. E1 stated he reviews the Incident Reports and then notifies the staff to conduct an IDT meeting. After a meeting is held the IDT should follow up on recommendations made. E1 stated he reviewed the Incident Reports, related to R5's falls and talked to staff. An IDT	W 149		

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W 149	Continued From page 5 meeting was held 6/10/08. E1 stated he noticed an increase in the number of falls R5 was having. E1 stated he thought a PT (Physical Therapy) evaluation was requested at the time of the IDT meeting (6/10/08). E1 was again interviewed 11/6/08 at 11:30am. E1 stated no further follow up IDT meetings were held for R5. E1 also stated R5 has no current PT evaluation as was recommended by the IDT. E1 did provide surveyor a copy of a PT Consultation, dated 6/23/08, regarding R5. The PT Consultation notes the following: " ... Her balance and stability are impaired due to her seizure disorder and therefore she requires close staff supervision for mobility. ... PT services are not indicated at this time. ... " E1 verified R5's PT Consultation was not a complete evaluation. E1 and E2 (nurse) were interviewed 11/6/08 at 1:10pm. E1 and E2 were asked what "close staff supervision for mobility" as recommenced by the PT consult entailed. E1 and E2 stated they did not know. E1 and E2 were asked what preventative measures were put in place after the IDT meeting of 6/10/08, to ensure R5's safety from falls. E1 stated that R5 was started on thyroid medicine due to her diagnosis of hypothyroidism. E1 stated R5 had a neurology consult dated 7/23/08. R5's neurology consult dated, 7/23/08, recommended the following: "Physical therapy - gait disorder - evaluate and treated - unconditioned." E2, per interview 11/6/08 at 1:10pm, was asked if	W 149		

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W 149	Continued From page 6 a PT evaluation was obtained based on the neurologists recommendation. E2 explained and showed surveyor an internal E-mail that documents the following: - 8/22/08 8:26am: E1 received the following, that notes in summary: Request for PT evaluation has been received, however the agency does not currently have a Physical Therapist. The E-mail questioned if it is an emergency or if their has been a change in R5's functioning. - 8/22/08 10:30am: E1 responded it is not an emergency (for R5) and whenever a PT evaluation can be scheduled will be fine. - 8/22/08 2:00pm: E1 received a follow up E-mail that notes the agency is planning on contracting with a Physical Therapist and annual evaluations, including looking at R5, will be started in October (2008). E1 verified R5 has not yet been evaluated by a Physical Therapist. Surveyor requested, from E1, the facility's policy regarding Abuse and Neglect. E1 provided to surveyor an undated policy titled, "Client Treatment Policy." This policy, in summary, notes the following: "Under no circumstances shall any abuse or neglect of a client be tolerated. ... Any person witnessing or observing evidence of abuse or neglect of a client must report it immediately to the Administrator or the Administrator's designee. ... Any report of abuse or neglect of a client shall be communicated to the Administrator for immediately and thorough investigation and	W 149		

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W 149	Continued From page 7 proper action. ... " E1 was interviewed 11/6/8 at 2:20pm. E1 was asked if the facility had any other policy that defined Neglect. E1 reviewed the "Client Treatment Policy" and verified this policy does not define Neglect. E1 also provided a policy titled "Incident and Accident Investigation Policy" dated 2/98. This policy includes a paragraph titled "Trend Analysis" that documents the following: " ... (The agency) has developed an agency-wide method for the analysis of trends. All unusual Incident reports will be forwarded to the Behavior Department. The Behavior Department will generate an Unusual Incident Report summary, listing the number of incidents, the type of incident, the time of the incidents, and the location of these incidents. These reports will be reviewed by the individual programs in their respective staff meetings on a monthly basis. The review will include discussion of whether or not there are any apparent trends. If there are such trends, the staff will develop strategies for incident reduction and/or elimination. These discussions will be documented in the staff meeting minutes." Based on review of R5's 13 falls, from the time period of 5/1/08 thru 10/30/08, the facility did not implement their policy and analyze the falls for trends. The facility did not develop a strategy for reduction and / or elimination of R5's falls.	W 149		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.	W 154		12/15/08

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W 154	Continued From page 8 This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to thoroughly investigate 2 of 2 injuries of unknown origin (R1 and R5) Findings include: 1) R1, per review of her 11/27/07 face sheet, is a 52 year old female whose diagnoses include Mild Mental Retardation , Cerebral Palsy and Depressive Disorder. R1, observed 11/5/08 at 4:40pm is non-ambulatory. R1 is verbal and able to express her needs. R1 requires total care regarding her ADL's (Activities of Daily Living - dressing, bathing, toileting). The facility's Incident Reports were reviewed 11/5/08. R1 was noted to have sustained the following injury of unknown origin on 9/29/08: - "Bruise above tailbone 5 inches wide by 5 inches long, deep purple in color. Bruise on right hip approximately 6 inches in length and 1 inch wide deep purple in color." R1 was observed to have this injury of unknown origin 9/29/08 at 12:35pm. R1's DT (Day Training) staff observed the bruises when toileting R1. DT staff documented that they asked R1 how the bruises occurred and R1 stated it happened last weekend at home. The facility's investigation of R1's injury of unknown origin concluded that the cause of R1's injury is unknown. The investigation noted,	W 154		

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W 154	Continued From page 9 however, it is possible R1 sustained the bruises 9/13/08 when she slid out of her wheelchair. The investigation also notes R1 may have sustained the bruises during a similar behavioral incident in recent weeks. The behavioral incident consisted of R1 attempting to throw herself out of her wheelchair. The facility's investigation is not thorough and does not include the following: - R1 initially stated the bruises occurred when she was home last weekend. E3 (QMRP) was interviewed 11/5/08 at 11am. E3 was asked if R1 goes on home visits. E3 stated R1 no longer goes on home visits due to health reasons of a family member. Therefore it is not possible for R1 to have been injured at home. The facility's investigation does not address R1's statement. - The facility's investigation does not identify which staff took care of R1 prior to her bruises being observed. There is no documentation as to who dressed R1 the morning of 9/29/08. There is no documentation as to who bathed and dressed R1 the evening of 9/28/08. E3 was interviewed 11/5/08 at 11am. E3 verified the facility's investigation does not address which staff cared for R1 the morning prior to her bruises being noted (9/29/08). E3 also verified the facility's investigation does not address which staff cared for R1 the evening prior (9/28/08). 2) R5, per review of her 11/2/08 POS (Physicians's Orders Sheet), is a 52 year old female whose diagnoses include Moderate Mental Retardation, Seizure Disorder and Hypothyroidism. E3 (QMRP), interviewed 11/7/08 at 9:45am, stated R5 is verbal but is not always reliable. R5	W 154		

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W 154	Continued From page 10 is ambulatory but uses a wheelchair any time she is outside of her residence. R5 also has a physician order to wear a helmet at all times when out of bed due to frequent seizures and drop attacks. E1 (Administrator), interviewed 11/7/08 at 3:20pm, stated R5 is currently residing in a nursing home. On 11/7/08 the facility provided surveyor with an Incident Report dated 5/5/08. The Incident Report involves R5 and notes the following: "5/5/08 11:10am, (R5) showed staff a large purple and pink discoloration, about 2 inches long by 1 1/2 inches wide on the underside of her forearm just above her elbow. When asked where she got it, she said she had fallen at home" A fax cover sheet, dated 5/6/08, notes R5 was sent to the emergency room and diagnosed with a left elbow contusion. The date of this incident was 5/5/08. E3 (QMRP) was interviewed 11/7/08 at 2:05pm. E3 was asked if the facility investigated R5's injury of unknown origin. E3 stated she saw no documentation of an investigation.	W 154		
W 317	483.450(e)(4)(ii) DRUG USAGE Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated. This STANDARD is not met as evidenced by: Based on record review, observation and	W 317		12/1/08

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W 317	Continued From page 11 interview, the facility failed to have a carefully monitored medication reduction program for 1 of 2 clients in the sample who are on psychotropic medications, R1. Findings include: R1, per review of face sheet dated 11/27/08, is a 52 year old female whose diagnoses include Mild Mental Retardation, Cerebral Palsy, and Depressive Disorder. R1, observed in the home on 11/5/08 at 4:40pm and 11/6/08 at 7:30am, is non-ambulatory and verbal. R1 is propelled by staff in a wheel chair. The Behavior Program for R1 with an implementation date of 5/1/08 was reviewed. Under functional analysis, it reads, "R1 exhibits depressive symptoms, suicidal ideation, screaming and delusional thinking which appears to be an outgrowth of her underlying psychiatric disorder." Under Restriction, it reads, "The use of psychotropic medications." On page two, three medications are listed that R1 currently receives. The list of psychotropic medications is as follows: 1. Seroquel 50mg(milligrams) per day 2. Paxil 40mg per day 3. Depakote Tablet 2000 mg per day The medication plan for Seroquel was reviewed. It reads, "0 incidents of psychotic symptoms for 8 consecutive months or by 11/08." The medication plan for Paxil was reviewed. It reads, "0 incidents of depressive symptoms for 9 consecutive months or by 4/09." The medication plan for Depakote Tablet was	W 317		

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W 317	Continued From page 12 reviewed. It reads, "0 incidents of depressive symptoms for 9 consecutive months or by 9/08." No mention of milligram dosage or percentage of reduction is mentioned for any of the above medications in the Behavior Program. During an interview with E3(Qualified Mental Retardation Professional) on 11/6/08 at 9:00am, this surveyor asked E3 if there was any medication reduction plan in place for R1 that specifically mentions a reduction in milligrams or percentage, once her goal is achieved, for any of the psychotropic medications R1 is currently receiving. E3 confirmed that there was not a specific program for R1 that addresses which medication will be reduced by what milligram dosage or percentage. E3 stated that she is scheduled to meet with her new psychiatrist in November, and will have him address this requirement, and add it to the Behavior Program.	W 317		
W 441	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to hold drills under varied conditions from the dates of January 1st, 2008 through November 1st, 2008, when they held their drills on a scheduled time rotation. Findings include: The fire drills were reviewed from January of 2008 through November of 2008. All of the fire drills were held on the first of every month. The	W 441		12/1/08

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W 441	Continued From page 13 time of the drills were in a rotation of 7:30am, 4:30pm and 12:30am. There were no other fire drills held at any other time except for those mentioned above. Varied drills, other than fire, were reviewed from January of 2008 through November of 2008. The varied drills were held on the 15th of every other months at the rotated times of 7:30am, 4:30pm, and 12:30am. There were no other varied drills held at any other time except for those mentioned above. During an interview with E1(Administrator) on 11/6/08 at 1:00pm, this surveyor asked E1 if there were any drills that were held at any other times. E1 stated that he used to schedule the drills at more varied times, but then the staff would be confused, and the drills were not getting done. E1 continued that with trying to ensure all of his facilities get there drills completed, he had to convert to some type of scheduled process.	W 441		
W 482	483.480(d)(1) DINING AREAS AND SERVICE The facility must serve meals for all clients, including persons with ambulation deficits, in dining areas, unless otherwise specified by the interdisciplinary team or a physician. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure all clients were served their meals in a dining area, when: 1. 1 of 1 client in sample, R1 and 1 of 1 client out of the sample, R7, ate their breakfast meal in the living room area on the morning of 11/6/08, and 2. 1 of 1 client in the sample, R1 and 1 of 1 client out of the sample, R8, ate their dinner meal in the	W 482		12/1/08

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W 482	Continued From page 14 living room area on the evening of 11/5/08. Findings include: R1, per review of face sheet dated 11/27/08, is a 52 year old female whose diagnoses include Mild Mental Retardation, Cerebral Palsy and Depressive Disorder. R1 was observed in the home on 11/6/08 at 7:30am to be non-ambulatory and verbal. R1 is propelled in her wheel chair by staff. R2, per review of face sheet dated 9/14/08, is a 67 year old female whose diagnoses include Mild Mental Retardation, Generalized Anxiety Disorder and Hypertension. R2 was observed in the home on 11/6/08 at 7:30am to be verbal and ambulatory. R6, per review of Inspection of Care record dated 5/7/07, is a 69 year old female whose diagnoses include Moderate Mental Retardation and Seizure Disorder. R6 was observed in the home on 11/6/08 at 7:30am, to be verbal and ambulatory. R7, per review of Inspection of Care record dated 5/7/07, is a 63 year old female whose diagnosis includes Profound Mental Retardation. R7 was observed in the home on 11/6/08 7:30am to be essentially non-verbal, and ambulatory with assistance of staff. R8, per review of Inspection of Care record dated 5/7/07, is a 69 year old female whose diagnosis includes Severe Mental Retardation. R8 was observed in the home on 11/5/08 at 5:10pm to be essentially non-verbal, and ambulatory.	W 482		

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W 482	Continued From page 15 1. During morning observations on 11/6/08 from 7:00am through 9:00am, breakfast was observed being served at 7:30am. A folding table was set up in the living room area with two place settings. Twelve other place settings were observed set for breakfast in the dining room area. R1 and R7 were observed being set up for breakfast by staff around the folding table in the living room area. R1 was sitting in her wheel chair, with her lap tray still in place, and R7 was ambulated to the folding table with assistance of staff. Both clients were observed being fed by assistance of staff. During an interview on 11/6/08 at 11:19am, surveyor asked E4 (Cook) who normally eats at the folding table in the living room area. E4 confirmed that R1 and R7 ate in the living room area this morning. E4 stated that normally R1, R2, R6, and R7 eat at the folding table. E4 continued that R1 and R7 eat out in the living room, because they need assistance eating, and R2 and R6 eat in the living room because they are neat eaters, and are not messy, and less likely to have spills in the living room area which happens to have carpet. E4 continued that the dining room area is just too small, and as the ladies are getting older, and require wheel chairs and walkers now, there just is not enough room for all of them to eat together in the dining room. 2. During evening observations on 11/5/08 at 5:20pm, R1 and R8 were observed eating at a folding table in the living room area. R1 was observed being fed by staff, and R8 was observed eating independently. The remaining twelve clients were observed eating together in the dining room area. During an interview with E5(Transportation/Direct	W 482		

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W 482	Continued From page 16 Service Personal) on 11/5/08 at 5:15, E5 was asked where R8 was going to eat, since there were not enough places set up in the dining room area for R8 to eat. E5 stated that R8 is going to eat in the living room area, at the folding table with R1. E5 stated R1 and R8 need to eat in the living room, because there is not enough room in the dining room area. During an interview with E3(Qualified Mental Retardation Professional) on 11/6/08 at 11:03am, E3 confirmed that R1 and R8 were who ate at the folding table in the living room during the evening meal on 11/5/08. E3 stated that normally R1, R2, R6 and R7 eat in the living room area, but occasionally they mix it up.	W 482		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.1210d) 350.1220h) 350.1230b)3)7) 350.3240a) Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following: d) Physical and occupational therapy services for purposes of initiating, monitoring and follow-up of individualized treatment programs rendered by or under the supervision of a physician with special training or experience in the specialty or a physical therapist or an occupational therapist.	W9999		

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W9999	Continued From page 17 Section 350.1220 Physician Services h) The facility shall maintain effective arrangements through which medical and remedial services required by the resident but not regularly provided within the facility can be obtained promptly when needed. 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 re-evaluation of the type, extent, and quality of services and programming. 7) Modification of the resident care plan, in terms of the resident's daily needs, as needed. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These REGULATIONS are not met as evidenced by: Based on interview and record review, the facility failed to implement their policy to prevent neglect for 1 of 1 clients (R5) when they failed to prevent R5 from falling and sustaining 2 fractured ribs on 10/30/08. The facility failed to:	W9999		

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W9999	Continued From page 18 1. Develop and implement preventative measures after a special IDT (Inter-Disciplinary Team) meeting was held 6/10/08. 2. Obtain a PT (Physical Therapy) evaluation as recommended by the IDT on 6/10/08 and as recommended by the neurologist on 7/23/08. 3. Fully develop their policy for neglect when they failed to describe what constitutes neglect with potential to affect 14 of 14 clients living in the facility (R#'s 1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, 13, 14, and 15). Findings include: R5, per review of her 11/2/08 POS (Physicians's Orders Sheet), is a 52 year old female whose diagnoses include Moderate Mental Retardation, Seizure Disorder and Hypothyroidism. E3 (QMRP), interviewed 11/7/08 at 9:45am, stated R5 is verbal but is not always reliable. R5 is ambulatory but uses a wheelchair any time she is outside of her residence. R5 also has a physician order to wear a helmet at all times when out of bed due to frequent seizures and drop attacks. E1 (Administrator), interviewed 11/7/08 at 3:20pm, stated R5 is currently residing in a nursing home. The facility's Incident Reports were reviewed, and R5 was noted to have the following falls: - 10/30/08 8:20pm: R5 sustained 2 fractured ribs as the result of a possible fall.	W9999		

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W9999	Continued From page 19 - 10/5/08 8:45am: R5 was in the bathroom getting ready for a shower. R5 lost her balance, hitting her left arm on the sink and her back on the toilet seat. - 9/27/08 2:05pm: R5 lost her balance walking to to the van. R5 hit her head but had her helmet on. - 9/24/08 7:05am: R5 was getting dressed, had a seizure, and fell to her knee. - 7/30/08 6:05pm: R5 was drying herself after bathing had a seizure and fell. - 7/29/08 7:30pm: R5 was in the bathroom and fell back hitting her head. R5 was wearing her helmet. - 7/23/08 7:15pm: R5 was walking to her bedroom - lost her balance and fell. - 6/1/08 9:20am: R5 appeared to have a seizure in her bedroom and fell. - 5/19/08 7:00am: R5 was in the bathroom appeared to have a seizure and fell backwards hitting her back against the toilet. - 5/13/08 8:20pm: R5 went into the bathroom to get a garbage bag and fell. - 5/5/08 11:10am: R5 showed day training staff a "large purple and pink discoloration, about 2" long by 1 1/2 " wide on the underside of her forearm just above her elbow." R5 stated she fell at home. R5 was sent to the emergency room later in the day and diagnosed with a left elbow contusion.	W9999		

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W9999	Continued From page 20 - 5/2/08 7:25am: R5 had a seizure in the bathroom, fell and hit her back on the shower chair. - 5/1/08 9:30pm: R5 fell in the bathroom scraping left elbow. Review of R5's clinical record noted an Interim Staffing/Special IDT meeting was held 6/10/08. The IDT documented the reason for the staffing as, "To discuss (R5's) recent falls and issues with staff." "Recommendations by the IDT: Follow up on any medical issues such as MRI, Thyroid issues prior to consulting with Psychiatrist to rule out medical concerns. In-service staff on working with (R5), how to motivate her to get up. Refer for counseling and Psychological, RN waiting for call from (neurologist). Next behavioral in-service will discuss (R5's) non-compliance and ways to motivate her." "Request for PT (Physical Therapy) referral" is also noted on the 6/10/08 IDT meeting notes. E1, interviewed 11/6/08 at 11:10am, verified the facility had 1 special IDT meeting on 6/10/08 regarding R5's falls. E3 (QMRP) was interviewed 11/5/08 at 2:10pm. E3 was asked if there were any follow up IDT meetings as a result of the 6/10/08 IDT meeting and recommendations. E3 stated there were not. E1 (Administrator) was interviewed 11/6/08 at 11:10am. E1 was asked to explain the facility's system for monitoring R5's 13 falls that occurred	W9999		

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W9999	Continued From page 21 between 5/1/08 and 10/30/08. E1 stated the facility uses Incident Reports to document the falls. E1 stated he reviews the Incident Reports and then notifies the staff to conduct an IDT meeting. After a meeting is held the IDT should follow up on recommendations made. E1 stated he reviewed the Incident Reports related to R5's falls and talked to staff. An IDT meeting was held 6/10/08. E1 stated he noticed an increase in the number of falls R5 was having. E1 stated he thought a PT (Physical Therapy) evaluation was requested at the time of the IDT meeting (6/10/08). E1 was again interviewed 11/6/08 at 11:30am. E1 stated no further follow up IDT meetings were held for R5. E1 also stated R5 has no current PT evaluation as was recommended by the IDT. E1 did provide surveyor a copy of a PT Consultation, dated 6/23/08, regarding R5. The PT Consultation notes the following: " ... Her balance and stability are impaired due to her seizure disorder and therefore she requires close staff supervision for mobility. ... PT services are not indicated at this time. ... " E1 verified R5's PT Consultation was not a complete evaluation. E1 and E2 (nurse) were interviewed 11/6/08 at 1:10pm. E1 and E2 were asked what "close staff supervision for mobility" as recommenced by the PT consult entailed. E1 and E2 stated they did not know. E1 and E2 were asked what preventative measures were put in place after the IDT meeting of 6/10/08 to ensure R5's safety from falls. E1 stated that R5 was started on	W9999		

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W9999	Continued From page 22 thyroid medicine due to her diagnosis of hypothyroidism. E1 stated R5 had a neurology consult dated 7/23/08. R5's neurology consult dated, 7/23/08, recommended the following: "Physical therapy - gait disorder - evaluate and treated - unconditioned." E2, per interview 11/6/08 at 1:10pm, was asked if a PT evaluation was obtained based on the neurologists recommendation. E2 explained and showed surveyor an internal E-mail that documents the following: - 8/22/08 8:26am: E1 received the following, that notes in summary: Request for PT evaluation has been received, however the agency does not currently have a Physical Therapist. The E-mail questioned if it is an emergency or if their has been a change in R5's functioning. - 8/22/08 10:30am: E1 responded it is not an emergency (for R5) and whenever a PT evaluation can be scheduled will be fine. - 8/22/08 2:00pm: E1 received a follow up E-mail that notes the agency is planning on contracting with a Physical Therapist and annual evaluations, including looking at R5, will be started in October (2008). E1 verified R5 has not yet been evaluated by a Physical Therapist. Surveyor requested, from E1, the facility's policy regarding Abuse and Neglect. E1 provided to surveyor an undated policy titled, "Client	W9999		

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W9999	Continued From page 23 Treatment Policy." This policy, in summary, notes the following: "Under no circumstances shall any abuse or neglect of a client be tolerated. ... Any person witnessing or observing evidence of abuse or neglect of a client must report it immediately to the Administrator or the Administrator's designee. ... Any report of abuse or neglect of a client shall be communicated to the Administrator for immediately and thorough investigation and proper action.... " E1 was interviewed 11/6/8 at 2:20pm. E1 was asked if the facility had any other policy that defined Neglect. E1 reviewed the "Client Treatment Policy" and verified this policy does not define Neglect. E1 also provided a policy titled "Incident and Accident Investigation Policy" dated 2/98. This policy includes a paragraph titled "Trend Analysis" that documents the following: " ... (The agency) has developed an agency-wide method for the analysis of trends. All unusual Incident reports will be forwarded to the Behavior Department. The Behavior Department will generate an Unusual Incident Report summary, listing the number of incidents, the type of incident, the time of the incidents, and the location of these incidents. These reports will be reviewed by the individual programs in their respective staff meetings on a monthly basis. The review will include discussion of whether or not there are any apparent trends. If there are such trends, the staff will develop strategies for incident reduction and/or elimination. These discussions will be documented in the staff meeting minutes."	W9999		

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W9999	Continued From page 24 Based on review of R5's 13 falls, from the time period of 5/1/08 thru 10/30/08, the facility did not implement their policy and analyze the falls for trends. The facility did not develop a strategy for reduction and/or elimination of R5's falls. (A)	W9999		