STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G350	A. BUILDING _____ B. WING _____	11/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THOMAS HERBSTRITT HOUSE	4003 N RTES 1 & 17, P.O. BOX 260 MOMENCE, IL 60954

(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 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 prevent neglect to one individual R5. R5 fell from his wheelchair sustained a laceration and displaced impacted tibia/fibula fracture requiring surgical repair, hospitalization and extended stay in a skilled care facility. 1. R5 was not secured in his wheelchair during transport to the hospital for an Xray as a result of a prior injury to his right leg. 2. R5 was transported by an employee not trained in resident care nor how to secure residents in the facility para transit bus. 3. R5's adaptive devices identified in assessments were not used during transport to the hospital. 4. Facility did not provide additional staff during transport in accordance with R5's identified need. 5. Equipment necessary to secure R5 was not available on the para transit bus. Findings include: Refer to W149 -	W 122		12/2/08

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 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.	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 for abuse and neglect when they failed to protect one individual (R5) while transporting him to a local hospital for an Xray. R5 was not secured in his wheelchair during the transport. R5 fell from his wheelchair sustaining a laceration and further injuring his leg resulting in a displaced impacted fracture of the tibia and offset fracture of the right fibula. R5 required hospitalization and remains in a skilled care facility. Findings include: According to the clinical record, client profile dated 7/10/2008, R5 is a 59 year old male whose diagnoses include Mental Retardation, Morbid Obesity, Organic Brain Dysfunction with Seizure Disorder, Chronic Kidney Disease, Congestive Heart Failure, and Psychotic Disorder. R5's 8/11/08 follow-up to an emergency room visit for a witnessed seizure lists R5's height as 5'6" and weight as 284 pounds. A special Interdisciplinary Team Meeting (IDT) was held on 6/18/08. The notes from the	W 149		12/2/08

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W 149	Continued From page 2 meeting read in part: "As a result of recent medical issues, a IDT was held to discuss any changes in (R5's) care plan. Items discussed include: (R5's) Celexa and Topamax were increased to prevent seizure activity. A seizure log will be kept at the house and in the Sr. classroom. Staff need to monitor behavior closely as it may be difficult to identify seizure activity..... (R5) will continue physical therapy (PT) daily (as tolerated). Staff are to use a lift to transfer until he has a PT evaluation. A new sling was brought to the house to assist with toilet transfers. (R5) is to be 1-on-1 while toileting as he is unsteady and may fall. R5's annual Individual Habilitation Plan dated 5/1/08 Assistive Devices section notes: "(R5) has difficulty walking. He uses an extra large wheelchair daily for transportation. Staff is required to assist (R5) with wheelchair mobility. Day program and house staff use a mechanical lift to transition (R5) from his wheelchair to his bed and for toileting. A gait belt and walker should be used to assist with transitions. (The facility) recently acquired a recliner with a lift to help (R5) into a standing position. (R5) also uses assistive devices for transportation to and from day program and on outings. Devices including a para-transit, wheel chair lift, and wheel chair safety straps (belts). (R5) also uses a mechanical hospital bed to help staff with transitions and for comfort. While showering (R5)	W 149		

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W 149	Continued From page 3 uses a shower seat to prevent falls." The Safety Concerns section of the 5/1/08 Individual Habilitation Plan discusses R5's assistive devices. This section notes, "(R5) also bruises very easily. Staff need to be extra careful during transfers and while pushing him in the wheel chair." A Physician's order noted 9/5/08 states: "Family does not want any further treatment. Discontinue all blood work orders." Provide comfort care. R5 was admitted to the Hospice program with a diagnosis of Unspecified non-psychotic mental disorder following organic brain damage. Surveyor reviewed injury reports. On 10/19/08 at 5:00 p.m. R5 fell while two staff were assisting him to sit on the toilet in the bathroom. His knees buckled and staff had to ease him down to the floor. He had a cut on his foot. Nursing staff was notified. The nurse came and checked R5, cleaned and wrapped his foot. The nurse (E6) documented, "Received call from staff that resident was bleeding from fall. When I got there staff had lowered resident to floor (and) (right) leg twisted under him - bleeding from foot - when we found source, it appears he has skin tears between toes - cleaned (and) pressure dressing applied - staff to monitor." E6 was interviewed on 11/5/08 at 2:40 p.m. E6 said, there was no bruising or pain after this happened. Staff from the house used a lift to get him to bed. E7 (care giver / Certified Nursing Assistant /	W 149		

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W 149	Continued From page 4 CNA) confirmed there was no pain or bruising to the leg. E7 said staff has R5 use the grab bar in the bathroom and stand so staff can clean R5 after toileting accidents. E7 said R5 can turn and pivot to sit on the toilet by using the grab bar in the bathroom. E7 said R5 was being toileted after dinner when the injury occurred. E7 said R5 requires a lift for transporting from his wheelchair to his bed. E7 said R5 did not complain of pain during the evening and slept in bed. E8 (care giver / CNA) was the second staff with R5 when the injury occurred. E8 was interviewed on 11/6/08 at 10:30 a.m. E8 confirmed the information provided by E6 and E7. E5 (Supervisor on duty on 10/19/08) was interviewed on 11/5/08 at 3:05 p.m. E5 said he was notified about the injury and said staff monitored for active bleeding. There was no complaint of pain. This was confirmed by the 10/19/08 Nurse's report log and shift report. On 11/6/08 at 1:58 p.m. E4 (Registered Nurse) was interviewed. E4 said on 10/20/08 at approximately 9:00 a.m., she had gotten a call from the home stating R5 complained of pain in his leg. There was no swelling, bruising, or deformity. E4 said R5 complained of pain when he was touched on the leg. E4 said she contacted Z1 and received an order to obtain an x-ray of the leg. According to the facility investigation on 10/20/08 at 11:15 a.m., R5 was being transported from the day training site to the hospital for x-ray of a suspected fracture to the right lower leg/ankle. During the transport, R5 lurched out of his wheelchair and fell to the floor of the bus. R5	W 149		

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W 149	Continued From page 5 was lying face up by the driver with his head partially down the stairs. R5's pant leg was wet and there was a large laceration over the front of his leg. R5 was being transported in a facility bus with one staff--the driver, E3. E12 (Registered Nurse) was following the bus in E12's car. E3 stopped the bus at the traffic light, and E12 entered the bus. Due to R5's weight, the two personnel were unable to return him to his wheelchair. E12 stabilized R5 by holding him upright and the transport was completed. R5 was admitted to the hospital and had surgery to tibial/fibular fracture. R5 had an external fixator placed to stabilize the fracture while the bone healed. According to the 10/29/08 nurse's notes R5 was transferred to a skilled care facility on 10/29/08 for short term care. At the time of the survey 11/5/08 through 11/12/08, R5 remained in the skilled care facility. The 10/20/08 report from the facility to the Department of Public Health was faxed 10/21/08. It reads as follows: "Resident was lowered to floor last night and only injury noted at time was bleeding between toes on right foot. Appears to have skin tears between several toes, dressed. This morning was complaining of pain in right leg and was being transported for x-rays when lurched forward out of (wheelchair) and sustained laceration to right lower leg. Stabilized and continued to ER (emergency room). Awaiting bed. 10/21/08 Addendum: Per report from hospital nursing staff, resident had surgery last evening, 10/20/08 to repair tibial/fibular fractures to right lower leg as appeared that fractures had become displaced	W 149		

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W 149	Continued From page 6 when resident lurched from wheelchair." On 11/5/08 at 3:20 p.m. surveyor interviewed E3 (Public Relations employee temporarily working with secretarial duties in the infirmary). E3 said on 10/20/08, she was taking R5 to the hospital for x-ray of his right leg. E3 was not sure why. E3 said she has no medical training. E3 said she was working in the infirmary, and there were not enough people to transport. One of the nurses asked E3 to transport R5, and E3 agreed. E3 said R5 was sitting in his large wheelchair at about 9:30 or 9:45 a.m. E3 said she and E9 (Day Training Instructor) transferred R5 from the ground into the bus. E3 said she was on the outside and R5 was on the lift. E9 operated the controls. E3 drove the bus. E9 secured the wheelchair by 4 locks so that the wheelchair would not move. E3 said she had never transported R5 before. His wheelchair was secured. However, R5 was not secured in his wheelchair by a strap. On 11/6/08 at 1:50 p.m. E3 said she had been trained on driving the para-transit bus but not on how to secure the residents. E3 said she was aware before leaving the facility that R5 was not secured in his wheelchair. E3 said she came to a stop at a stop light and R5 lurched forward and twisted his body so his head was going down the steps. E3 put the car in park, put the flashers on, grabbed R5 by the shirt so his head would not go down the steps. She sounded the horn to get E12's attention. E12 parked her car and joined E3 and R5 on the para-transit bus. They proceeded a few blocks to the hospital with E12 holding R5. They could not lift him into his chair.	W 149		

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W 149	Continued From page 7 R5 was completely out of his wheelchair. R5 was complaining of pain. E9 was interviewed on 11/6/08 at 11:19 a.m. E9 said a different bus was used on 10/19/08. Normally the facility bus is used. E9 said the infirmary uses whatever bus is available. E9 said she tried to click the shoulder harness into the floor latch and it did not reach. E9 said E3 was trying to get someone to accompany her during the transport to the hospital. E9 said she told E3 she did the best she could in securing R5 into the para-transit bus. E9 said the facility bus that is normally used for R5 has extenders so that the seat belt reaches the floor latch. However, the bus with the extenders was not used. E12 (Registered Nurse) was interviewed on 11/6/08 at 1:35 p.m. E12 said she followed the para-transit bus to the hospital so that she could help with lifting R5 from the bus to be seen in the emergency room. E12 confirmed E3's statement regarding R5's condition in the para-transit bus. E12 said his pant leg was wet and he had a large laceration to his right leg. E12 said when they reached the emergency room, they received help from the emergency room staff to get R5 into the hospital. E12 said she was following the para-transit bus because she was going to assist in transferring R5 when they reached the hospital. E12 said it is not uncommon to have one staff transport and another go along to assist with transfers. The second staff leaves to go back to other duties, and the driver stays with the resident. E12 said if a person is difficult to move or has behaviors, a second staff may accompany the	W 149		

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W 149	Continued From page 8 driver. E12 said she did not know why R5 was not secured in his wheelchair because she knows there are extenders for the shoulder harness. E12 also said E3 has not been trained in resident care, she mostly does secretarial duties in the infirmary. Normally the transporters are trained in resident care. E11 (Director of Nursing) was interviewed on 11/6/08 at 9:50 a.m. E11 said she completed the investigation, and all staff were trained on the use of the para-transit bus and securing the residents in place after the incident with R5. E11 said she ensured all buses had the proper equipment. E10 (vehicle maintenance repairman) was interviewed on 11/6/08 at 11:27 a.m. E10 said a problem had been identified through a work order. There was a problem on one of the para-transit buses with an extender. E10 stated all vehicles are now equipped with extenders for the shoulder harness. A memo to E2 (Administrator) from E10 dated 11/1/08 confirms the para-transit buses are fully equipped. Z2 was interviewed on 11/6/08 at 12:25 p.m. Z2 stated the fracture required surgery for fixation and an immobilizer. Z2 said there were abrasions to the right leg and a deformity of the leg when R5 was seen in the emergency room. Z2 said the displaced fracture occurred as a result of the incident on the bus. Radiology report dated 10/20/08 states: Impression: slightly displaced impacted fracture distal end of the right tibia associated with offset fracture of the distal end of the right fibula. Immobilization of the ankle is seen.	W 149		

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W 149	Continued From page 9 The facility's policy titled ABUSE AND NEGLECT AGAINST A RESIDENT (Revised January 27, 2007) defines neglect as follows: "The failure to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to an individual or in the deterioration of an individual's physical or mental condition." The facility did not implement their policy when they did not ensure trained staff accompanied R5 to the hospital. The facility did not provide identified assistive devices during transport. Facility did not ensure staff was available to tend to R5's needs while in transit. R5 was identified as a fall, behavioral, and seizure risk. R5 had an injury requiring follow-up at a hospital, and the facility did not protect him during transit. The facility did not have staff available to observe R5 in the para-transit bus while he was being driven.	W 149		
W 316	483.450(e)(4)(ii) DRUG USAGE Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to attempt an annual psychotropic medication reduction for 2 of 5 residents on behavioral medications; R2 in the sample and R7, outside the sample. Findings include:	W 316		12/7/08

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W 316	Continued From page 10 R2, per review of the I.H.P. (Individual Habilitation Plan) of 09-25-08 is a 60 year old male with diagnoses including Severe Mental Retardation, Obsessive Compulsive Disorder, possible Bi-polar Disorder and Megacolon. R2's Adaptive Age is 2 years, 4 months based on his I.C.A.P. score of 09-25-08. The I.H.P. also denotes that R2 currently receives 4 separate psychotropic medications which include: Zoloft 50 mg (milligrams) daily, Seroquel 200 mg 2 times per day, Depakote 1000 mg 2 times per day and Ativan 0.5 mg 3 times per day. Q.M.R.P. (Qualified Mental Retardation Professional) summary/progress notes were reviewed for the time period between 10/2007 and 08/2008. Every monthly note reviewed stated that R2's "behavior has improved." R2's current psychiatric notes of 01/11/08 and 04/11/08 do not indicate any behavioral issues of concern. R2's psychotropic medication reduction plan was revised on 02/15/08 with the following goal: "After a 6 month period if [R2] has less than 30 behaviors a request will be made that his Seroquel be reduced from 200 mg to 150 mg." Further review of the record did not indicate that attempts had been made to reduce any of R2's psychotropic medications for the years 2007 and 2008. E1 (Q.M.R.P.) confirmed that there have been no annual attempts to reduce R2's Seroquel or any of his other psychotropic medications. R7, per the I.H.P., is a 58 year old male with diagnoses including: Severe Mental Retardation,	W 316		

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W 316	Continued From page 11 Organic Mental Disorder and Impulse Control Disorder. R7's I.C.A.P. of 11/13/08 in the record notes an adaptive level of 1 year, 3 months. R7 was observed on the evening of 11/05/08 and the morning of 11/06/08 in his home. R7 is ambulatory and staff stated that he likes to take out the garbage. He was cooperative with staff requests and was redirectable. The current P.O.S. (physician's order sheet) for R7 lists the following psychotropic medications: Celexa 40 mg daily, Topamax 100 mg 2 times per day, Seroquel 400 mg 2 times per day, Lithium 300 mg, 3 times per day and Ativan 0.5 mg as needed for agitation. R7's Behavioral Plan dated 05/07 to 05/08 states that he will be considered for a reduction in his Celexa from 40 mg to 20 mg based on his targeted behaviors. Review of the medical record indicates that none of R7's psychotropic medications have been reduced for 2007 and 2008. E1 confirmed that R7 has not had a reduction in his Celexa or his other psychotropic medications for the past 2 years.	W 316		
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that medication was administered without error for 1 resident, R7, observed during medication administration. Findings include:	W 369		12/1/08

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W 369	Continued From page 12 R7, per the I.H.P., is a 58 year old male with diagnoses including: Severe Mental Retardation, Organic Mental Disorder , Impulse Control Disorder and Chronic Constipation. During the 5 PM medication pass on 11/05/08 E 15 was observed administering Lithium 300 mg, 1 tab and carbidopa 25/100 1 tab to R7. Review of the P.O.S. (Physician's Order Sheet) notes that R7 also has an order for lactulose 15 ml (milliliters) three times per day. E15 stated that R7 was out of the lactulose and it would have to be ordered. On 11/12/08 E 1 stated that E15 was mistaken and that R7's lactulose was available in the medication cabinet but was overlooked. E1 confirmed that R7 missed his scheduled 5:00 PM dose of lactulose on 11/05/08.	W 369		
W 488	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. This STANDARD is not met as evidenced by: Based on observation, interviews and record review the facility failed to ensure that 4 of 4 residents in the sample, R1, R2, R3 and R4 and 11 residents outside the sample, R6, R7, R8 ,R9, R10, R11, R12, R13, R14, R15 and R16 were encouraged to exercise independence to the best of their abilities while participating in family style dining. Findings include: R1, per review of the I.H.P. (Individual Habilitation Plan) of 12/06/07 is a 63 year old	W 488		12/15/08

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W 488	Continued From page 13 male with diagnoses including: Moderate Mental Retardation, Hydrocephalus and Seizure Disorder. R1's I.C.A.P. score of 06/03/08 places him at an adaptive age of 5 years, 2 months. R1 has an objective in his program plan to prepare a simple snack. R1 also attends day training 5 days a week where he works on motor skills. R2, per review of the I.H.P. of 09-25-08 is a 60 year old male with diagnoses including Severe Mental Retardation, Obsessive Compulsive Disorder, possible Bi-polar Disorder and Megacolon. R2's Adaptive Age is 2 years, 4 months based on his I.C.A.P. score of 09-25-08. One of R2's objectives in his program plan is learning to sew. R3 per review of the I.H.P. of 08/28/08 is a 63 year old male with diagnoses including: Severe Mental Retardation and Seizure Disorder. R3's I.C.A.P. of 08/25/08 notes an adaptive score of 1 year, 6 months. R3's I.H.P. notes that he has motor skills including climbing stairs and picking up small objects. R3 needs to be willing to do tasks that are asked of him. R4 per review of the I.H.P. of 04/03/08 is a 58 year old male with diagnoses including: Profound Mental Retardation and Seizure Disorder. R4's Adaptive Age is 2 years based on his I.C.A.P. score of 04/03/08. R4's programs include assisting with the canteen at day training and maintaining a journal. R4 can read and can converse with others. According to the facility roster; R6 is a 57 year old male who functions in the Moderate range Mental Retardation.	W 488		

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W 488	Continued From page 14 R7 is a 63 year old male who functions in the Severe range of Mental Retardation. R8 is a 57 year old male who functions in the Severe range of Mental Retardation. R9 is a 56 year old male who functions in the Severe range of Mental Retardation. R10 is a 54 year old male who functions in the Moderate range of Mental Retardation. R11 is a 54 year old male who functions in the Severe range of Mental Retardation. R12 is a 57 year old male who functions in the Severe range of Mental Retardation. R13 is a 51 year old male who functions in the Severe range of Mental Retardation. R14 is a 66 year old male who functions in the Severe range of Mental Retardation. R15 is a 53 year old male who functions in the Severe range of Mental Retardation. R16 is a 58 year old male who functions in the Severe range of Mental Retardation. Observation of the evening meal was conducted on 11/05/08. R6 was observed setting the table at approximately 4:45 P.M. Staff members E7 and E15 stated that R6 is always the one who sets the table because that is one of his goals. E14 (cook) was asked if the residents assist with preparation of their meals. E14 stated that she does all of the meal preparation without the assistance of the residents. During the evening meal residents participated in family style dining by passing serving dishes and scooping food onto their plates. Staff assisted those who needed help with scooping. Observation of the morning meal was done on 11/06/08. At 7 A.M. many of the residents were observed in the living room area prior to the start of the meal. In the dining room the table was	W 488		

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W 488	Continued From page 15 completely set. Waffles were observed on each resident's plate. Bowls of cereal were also observed at the place settings. E13 was in the dining room by herself. E13 was asked if the residents had participated in the preparation and serving of the meal. E13 stated that R6 set the table and she (E13) had put the waffles on the plates and the cereal in the bowls. E13 also confirmed that residents do not participate in meal preparation. E1 confirmed on 11/12/08 at 3:30 p.m., that individuals are learning to prepare simple desserts during day training, but the facility does not reinforce these skills at the residential site.	W 488		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 350.1230b) 350.1230d)2)3) 350.1230e) 350.1230g) 350.3240a) Section 350.1230 Nursing Services b) Residents shall be provided with nursing services, in accordance with their needs. d) Direct care personnel shall be trained in, but are not limited to, the following: 2) Basic skills required to meet the health needs and problems of the residents. 3) First aid in the presence of accident or illness.	W9999		

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W9999	Continued From page 16 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. 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 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 for abuse and neglect when they failed to protect one individual (R5) while transporting him to a local hospital for an Xray. R5 was not secured in his wheelchair during the transport. R5 fell from his wheelchair sustaining a laceration and further injuring his leg resulting in a displaced impacted fracture of the tibia and offset fracture of the right fibula. R5 required hospitalization and remains in a skilled care facility. Findings include: According to the clinical record, client profile dated 7/10/08, R5 is a 59 year old male whose diagnoses include Mental Retardation, Morbid Obesity, Organic Brain Dysfunction with Seizure Disorder, Chronic Kidney Disease, Congestive	W9999		

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W9999	Continued From page 17 Heart Failure, and Psychotic Disorder. R5's 8/11/08 follow-up to an emergency room visit for a witnessed seizure lists R5's height as 5'6" and weight as 284 pounds. A special Interdisciplinary Team Meeting (IDT) was held on 6/18/08. The notes from the meeting read in part: "As a result of recent medical issues, a IDT was held to discuss any changes in (R5's) care plan. Items discussed include: (R5's) Celexa and Topamax were increased to prevent seizure activity. A seizure log will be kept at the house and in the Sr. classroom. Staff need to monitor behavior closely as it may be difficult to identify seizure activity..... (R5) will continue physical therapy (PT) daily (as tolerated). Staff are to use a lift to transfer until he has a PT evaluation. A new sling was brought to the house to assist with toilet transfers. (R5) is to be 1-on-1 while toileting as he is unsteady and may fall." R5's annual Individual Habilitation Plan dated 5/1/08 Assistive Devices section notes: "(R5) has difficulty walking. He uses an extra large wheelchair daily for transportation. Staff is required to assist (R5) with wheelchair mobility. Day program and house staff use a mechanical lift to transition (R5) from his wheelchair to his bed and for toileting. A gait belt and walker should be used to assist with transitions. (The	W9999		

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W9999	Continued From page 18 facility) recently acquired a recliner with a lift to help (R5) into a standing position. (R5) also uses assistive devices for transportation to and from day program and on outings. Devices including a para-transit, wheel chair lift, and wheel chair safety straps (belts). (R5) also uses a mechanical hospital bed to help staff with transitions and for comfort. While showering (R5) uses a shower seat to prevent falls." The Safety Concerns section of the 5/1/08 Individual Habilitation Plan discusses R5's assistive devices. This section notes, "(R5) also bruises very easily. Staff need to be extra careful during transfers and while pushing him in the wheel chair." A Physician's order noted 9/5/08 states: "Family does not want any further treatment. Discontinue all blood work orders." Provide comfort care. R5 was admitted to the Hospice program with a diagnosis of Unspecified non-psychotic mental disorder following organic brain damage. Surveyor reviewed injury reports. On 10/19/08 at 5:00 p.m., R5 fell while two staff were assisting him to sit on the toilet in the bathroom. His knees buckled and staff had to ease him down to the floor. He had a cut on his foot. Nursing staff was notified. The nurse came and checked R5, cleaned and wrapped his foot. The nurse (E6) documented, "Received call from staff that resident was bleeding from fall. When I got there staff had lowered resident to floor (and) (right) leg twisted under him - bleeding from foot - when we found source, it appears he has skin tears between toes - cleaned (and) pressure	W9999		

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W9999	Continued From page 19 dressing applied - staff to monitor." E6 was interviewed on 11/5/08 at 2:40 p.m. E6 said there was no bruising or pain after this happened. Staff from the house and used a lift to get him to bed. E7 (care giver/Certified Nursing Assistant/CNA) confirmed there was no pain or bruising to the leg. E7 said staff has R5 use the grab bar in the bathroom and stand so staff can clean R5 after toileting accidents. E7 said R5 can turn and pivot to sit on the toilet by using the grab bar in the bathroom. E7 said R5 was being toileted after dinner when the injury occurred. E7 said R5 requires a lift for transporting from his wheelchair to his bed. E7 said R5 did not complain of pain during the evening and slept in bed. E8 (care giver/CNA) was the second staff with R5 when the injury occurred. E8 was interviewed on 11/6/08 at 10:30 a.m. E8 confirmed the information provided by E6 and E7. E5 (Supervisor on duty on 10/19/08) was interviewed on 11/5/08 at 3:05 p.m. E5 said he was notified about the injury and said staff monitored for active bleeding. There was no complaint of pain. This was confirmed by the 10/19/08 nurse's report log and shift report. On 11/6/08 at 1:58 p.m. E4 (Registered Nurse) was interviewed. E4 said on 10/20/08 at approximately 9:00 a.m., she had gotten a call from the home stating R5 complained of pain in his leg. There was no swelling, bruising, or deformity. E4 said R5 complained of pain when he was touched on the leg. E4 said she contacted Z1 and received an order to obtain an	W9999		

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W9999	Continued From page 20 x-ray of the leg. According to the facility investigation on 10/20/08 at 11:15 a.m., R5 was being transported from the day training site to the hospital for x-ray of a suspected fracture to the right lower leg/ankle. During the transport, R5 lurched out of his wheelchair and fell to the floor of the bus. R5 was lying face up by the driver with his head partially down the stairs. R5's pant leg was wet and there was a large laceration over the front of his leg. R5 was being transported in a facility bus with one staff--the driver, E3. E12 (Registered Nurse) was following the bus in E12's car. E3 stopped the bus at the traffic light, and E12 entered the bus. Due to R5's weight, the two personnel were unable to return him to his wheelchair. E12 stabilized R5 by holding him upright and the transport was completed. R5 was admitted to the hospital and had surgery to tibial/fibular fracture. R5 had an external fixator placed to stabilize the fracture while the bone healed. According to the 10/29/08 nurse's notes R5 was transferred to a skilled care facility on 10/29/08 for short term care. At the time of the survey 11/5/08 through 11/12/08, R5 remained in the skilled care facility. The 10/20/08 report from the facility to the Department of Public Health was faxed 10/21/08. It reads as follows: "Resident was lowered to floor last night and only injury noted at time was bleeding between toes on right foot. Appears to have skin tears between several toes, dressed. This morning was complaining of pain in right leg and was being transported for x-rays when	W9999		

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W9999	Continued From page 21 lurched forward out of (wheelchair) and sustained laceration to right lower leg. Stabilized and continued to ER (emergency room). Awaiting bed. 10/21/08 Addendum: Per report from hospital nursing staff, resident had surgery last evening, 10/20/08 to repair tibial/fibular fractures to right lower leg as appeared that fractures had become displaced when resident lurched from wheelchair." On 11/5/08 at 3:20 p.m. surveyor interviewed E3 (Public Relations employee temporarily working with secretarial duties in the infirmary). E3 said on 10/20/08, she was taking R5 to the hospital for x-ray of his right leg. E3 was not sure why. E3 said she has no medical training. E3 said she was working in the infirmary, and there were not enough people to transport. One of the nurses asked E3 to transport R5, and E3 agreed. E3 said R5 was sitting in his large wheelchair at about 9:30 or 9:45 a.m. E3 said she and E9 (Day Training Instructor) transferred R5 from the ground into the bus. E3 said she was on the outside and R5 was on the lift. E9 operated the controls. E3 drove the bus. E9 secured the wheelchair by 4 locks so that the wheelchair would not move. E3 said she had never transported R5 before. His wheelchair was secured. However, R5 was not secured in his wheelchair by a strap. On 11/6/08 at 1:50 p.m. E3 said she had been trained on driving the para-transit bus but not on how to secure the residents. E3 said she was aware before leaving the facility that R5 was not secured in his wheelchair. E3 said she came to a stop at a stop light and R5 lurched forward and	W9999		

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W9999	Continued From page 22 twisted his body so his head was going down the steps. E3 put the bus in park, put the flashers on, grabbed R5 by the shirt so his head would not go down the steps. She sounded the horn to get E12's attention. E12 parked her car and joined E3 and R5 on the para-transit bus. They proceeded a few blocks to the hospital with E12 holding R5. They could not lift him into his chair. R5 was completely out of his wheelchair. R5 was complaining of pain. E9 was interviewed on 11/6/08 at 11:19 a.m. E9 said a different bus was used on 10/20/08. Normally the facility bus is used. E9 said the infirmary uses whatever bus is available. E9 said she tried to click the shoulder harness into the floor latch and it did not reach. E9 said E3 was trying to get someone to accompany her during the transport to the hospital. E9 said she told E3 she did the best she could in securing R5 into the para-transit bus. E9 said the facility bus that is normally used for R5 has extenders so that the seat belt reaches the floor latch. However, the bus with the extenders was not used. E12 (Registered Nurse) was interviewed on 11/6/08 at 1:35 p.m. E12 said she followed the para-transit bus to the hospital so that she could help with lifting R5 from the bus to be seen in the emergency room. E12 confirmed E3's statement regarding R5's condition in the para-transit bus. E12 said R5's pant leg was wet and he had a large laceration to his right leg. E12 said when they reached the emergency room, they received help from the emergency room staff to get R5 into the hospital. E12 said she was following the para-transit bus because she was going to assist in transferring R5 when they reached the	W9999		

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W9999	Continued From page 23	W9999		

hospital. E12 said it is not uncommon to have one staff transport and another go along to assist with transfers. The second staff leaves to go back to other duties, and the driver stays with the resident.

E12 said if a person is difficult to move or has behaviors, a second staff may accompany the driver. E12 said she did not know why R5 was not secured in his wheelchair because she knows there are extenders for the shoulder harness. E12 also said E3 has not been trained in resident care, she mostly does secretarial duties in the infirmary. Normally the transporters are trained in resident care.

E11 (Director of Nursing) was interviewed on 11/6/08 at 9:50 a.m. E11 said she completed the investigation, and all staff were trained on the use of the para-transit bus and securing the residents in place after the incident with R5. E11 said she ensured all buses had the proper equipment.

E10 (vehicle maintenance repairman) was interviewed on 11/6/08 at 11:27 a.m. E10 said a problem had been identified through a work order. There was a problem on one of the para-transit buses with an extender. E10 stated all vehicles are now equipped with extenders for the shoulder harness. A memo to E2 (Administrator) from E10 dated 11/1/08 confirms the para-transit buses are fully equipped.

Z2 was interviewed on 11/6/08 at 12:25 p.m. Z2 stated the fracture required surgery for fixation and an immobilizer. Z2 said there were abrasions to the right leg and a deformity of the leg when R5 was seen in the emergency room. Z2 said the displaced fracture occurred as a

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W9999	Continued From page 24 result of the incident on the bus. Radiology report dated 10/20/08 states: Impression: slightly displaced impacted fracture distal end of the right tibia associated with offset fracture of the distal end of the right fibula. Immobilization of the ankle is seen. The facility's policy titled ABUSE AND NEGLECT AGAINST A RESIDENT (Revised January 27, 2007) defines neglect as follows: "The failure to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to an individual or in the deterioration of an individual's physical or mental condition." The facility did not implement their policy when they did not ensure trained staff accompanied R5 to the hospital. The facility did not provide identified assistive devices during transport. Facility did not ensure staff was available to tend to R5's needs while in transit. R5 was identified as a fall, behavioral, and seizure risk. R5 had an injury requiring follow-up at a hospital, and the facility did not protect him during transit. The facility did not have staff available to observe R5 in the para-transit bus while he was being driven. (A)	W9999		