STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G312	A. BUILDING ____ B. WING ____	C 05/07/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDWARDSVILLE TERRACE	808 SOUTHWEST PLACE EDWARDSVILLE, IL 62025

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W 149	Continued From page 6 E1 On 5/5/09 at 10:30 AM and client file review the committee determined that R3 has a mild seizure disorder and there is no monitoring device in place as of 4/27/09. E1 stated that since R1's incident on 4/26/09, the facility incorporated staff monitoring into R2's & R3's ISP's, and staff were in-serviced to the frequency and type of monitoring that should occur for R2 & R3 during bathing.	W 149		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1210 350.1230b)1)3)6)7) 350.3240a) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. Section 350.1230 Nursing Services b) Residents shall be provided with nursing	W9999		

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services, in accordance with their needs, which shall include, but are not limited to, the following:
The DON shall participate in:
1) Pre-admission evaluation study and plan.
3) Periodic reevaluation of the type, extent, and quality of services and programming.
6) Development of a written plan for each resident to provide for nursing services as part of the total habilitation program.
7) Modification of the resident care plan, in terms of the resident's daily needs, as needed

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 were not met as evidenced by:

Based on record review and interview, the facility failed to ensure supervision of clients with known special needs when bathing for 1 of 1 (R1) individual discovered face down in the bathtub and 2 of 2 individuals who have been identified by the facility as requiring supervision during bathing (R2 & R3).

Findings include:

1) R1, per his Individual Service Plan (ISP) of 5/2/08, was a 46 year old male with a diagnosis of Mild Mental Mental Retardation & Epilepsy. The ISP identifies that R1 requires 24 hour supervision and active treatment. The ISP identifies that R1 received Dilantin every day for Epilepsy.

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R1 is diagnosed with "grand mal epilepsy, which is being controlled with Dilantin. R1's seizures usually consist of two types. The first type his whole body would twitch and jerk and he would have these about 80% of the time. R1 could come and tell you when he was going to have one of these. The other type was when he would fall and they would come on suddenly without notice. R1 will usually seize for 5-8 minutes and then he will be lethargic for about 30 minutes while he is still coming out of the seizure. R1 did not have any unusual behavior before, during, or after his seizures."

Review of R1's Physician's Order Sheets from 4/1/09-4/30/09 identified that R1 was receiving Dilantin 360mg daily to address his Epilepsy diagnosis. R1's clinical chart (2009) identifies R1 had three seizures in 2009:

1. 1/2/09-Time start: 7:30PM-Stop-7:34PM-R1 started to fall but caught by peer. R1's whole body shaking and he bit his tongue during the seizure.

2. 1/3/09-Time start: 9:04AM-Stop-9:07AM-R1 lost consciousness but regained it quickly. R1 was staring before the seizure with no response to questions and was slow to respond to questions afterwards. R1 reported at the end of the seizure he could feel it coming on but was too weak to notify staff.

3. 3/13/09-Time start: 5:30 (no time of day identified)-Stop-5:33 (no time of day identified) -R1 fell and his head and mouth were jerking and twitching.

Review of incident report sent to IDPH on 4/27/09

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Continued From page 9

At 12:08PM. "R1 was found non responsive in bathtub at approximately 11:24AM on 4/26/09. 911 was called. The resident could not be resuscitated. Local Police department were notified and investigated the incident. R1's family was notified. Facility initiated its Investigative Committee and will submit its final report within 5 days."

Review of the results of the facility's Preliminary Report-R1 4/26/09 (no time stated):
"There are unanswered questions about the time line. The last time a staff person saw R1 was at 9:00AM and yet the water was running in the tub and not overflowing at 11:24AM. We do not know what transpired in those two hours and the staff on duty did not see him from 9:00AM to 11:24AM. The time of death cannot be determined at this time.
The staff did not check on the whereabouts of the resident when they came on duty and they did not attempt CPR due to the water in the tub and the inability of staff to lift him out of the tub."

The "Final report of Administrative Investigative Committee/Safety Committee," dated 5/1/09, was reviewed. It was noted that "R1 was found on the AM of 4/26/09 (no time noted) in the tub non-responsive. 911 was immediately called per agency policy. An off-duty paramedic was on scene within minutes of the call to 911. The EMT called the paramedics on route and reported R1 was deceased and no measures were initiated. The local Police department arrived and initiated an investigation. The coroner was called and also arrived at the facility."

The committee report noted that "R1 frequently spent one half hour to one hour in the bathroom.

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W9999	Continued From page 10 Staff reports seeing R1's personal care items in the bathroom around 9:00AM, and then again seeing his personal care items back in his room around 9:30AM. Staff was assisting other residents with personal hygiene between 9:30AM and approximately 11:20AM that morning and did not see R1 enter the bathroom. Around 11:20AM, staff knocked on the bathroom door as they heard the water running and wanted to get towels for the laundry. No one answered the staff's knocking and the staff entered the bathroom. The staff noticed the privacy curtain was pulled closed. The staff again attempted to alert the resident of their presence with no response. The staff opened the curtain and found R1 face down in the tub. The staff immediately called the second staff on duty to call 911. The staff member unplugged the drain and turned R1 over. The staff attempted to move R1 from the tub but was unsuccessful. A paramedic arrived within minutes and notified the ambulance that R1 had passed and did not initiate CPR." The committee stated that the cause of R1's death to be linked to seizure activity, but could not be confirmed without the autopsy. Review of Policy 5.24 dated 11/08 states Neglect "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." Interview was conducted with E3 (DSP) on 5/4/09 at 2:58PM. E3 confirmed knowledge of the issues related to the incident on 4/26/09 involving R1's death. E3 stated that after she discovered R1 she called for help and attempted to remove R1 from the tub. E3 stated she was unable to lift R1 due to the water still in the tub and R1's body weight. E3 stated R1 was stiff and his arms were rigid.	W9999		

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W9999	Continued From page 11 E3 stated that R1's skin felt paper thin and gave the feeling of tearing when she was trying to remove R1 from the tub. E3 stated that she gave statements to the facility investigator E1 (Administrator) and confirmed that she had not seen R1 since she came in at 9:30AM until he was discovered in the tub. E3 thought R1 had already taken his shower that AM. E3 stated that it was not normal for staff members not to see R1 during a two hour window. Interview was conducted with E4 (DSP) on 5/4/09 at 2:40PM. E4 confirmed knowledge of the issues related to the incident on 4/26/09 involving R1's death. E4 stated she was the staff person that dialed 911 after E3 yelled out for help and instructed her to call for help. E4 confirmed finding R1 being held up in the bathtub by E3 with his face out of the water as the tub was draining. E4 noted that R1 appeared stiff and his body was of a grayish shade with blue/white markings around the eyes and R1's mouth. E4 confirmed that E3 and E4 were unable to remove R1 from the tub due to the bath water and R1's body weight. E4 confirmed giving statements to E1 concerning the events on 4/26/09. E4 noted she came into the facility at 10:30AM and did not know R1 was in the tub until E3 cried out for help. Interview with E1 (Adm) on 5/5/09 at 10:30AM. E1 confirmed knowledge of the issues related to the incident on 4/26/09. E1 stated the facility conducted an investigation and confirmed there was no staff accountable for R1's whereabouts from approximately 9:00AM until time of discovery in the bathtub at 11:25 AM. E1 reported R1 was very independent and required little supervision and encouraged his privacy during bathing. E1 stated that there is no current	W9999		

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W9999	Continued From page 12 policy or procedures to address clients with seizure disorders. E1 stated client supervision levels are addressed at ISP meetings. E1 confirmed that staff had not checked on R1's status upon arrival at the facility for their assigned shifts. 2) E1 stated that the facility's Safety Committee met on 4/27/09 (no time stated) and considered safety risks associated with R2 & R3. According to facility roster of 5/4/09, R2 is a 35 year old male with a diagnosis of Moderate Mental Retardation. Based on staff interview and client file review the committee determined that R2 has a history of sleeping during bathing and there is no monitoring device in place as of 4/27/09. According to facility roster of 5/4/09; R3 is a 35 year old female with a diagnosis of Moderate Mental Retardation. Based on staff interview with E1 On 5/5/09 at 10:30 AM and client file review the committee determined that R3 has a mild seizure disorder and there is no monitoring device in place as of 4/27/09. E1 stated that since R1's incident on 4/26/09, the facility incorporated staff monitoring into R2's and R3's ISP's, and staff were in-serviced to the frequency and type of monitoring that should occur for R2 and R3 during bathing. (A)	W9999		