STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G190	A. BUILDING _____ B. WING _____	C 03/17/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLFVIEW DEVELOPMENTAL CENTER	**9555 WEST GOLF ROAD DES PLAINES, IL 60016**

(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 194	Continued From page 15 specified the technique used by E11 on 2/21/09 with R3.	W 194		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS LICENSURE VIOLATIONS 350.670f)3) 350.1230d)2) 350.3240a) Section 350.670 Personnel Policies f) Orientation and In-Service Training 3) All facility employees who deal directly with residents shall be trained on the individual requirements and behavioral issues of residents who may come under their care, to ensure the safety and dignity of each client. The employees' training and competency shall be documented. Section 350.1230 Nursing Services 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. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G190	A. BUILDING _____ B. WING _____	C 03/17/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLFVIEW DEVELOPMENTAL CENTER	**9555 WEST GOLF ROAD DES PLAINES, IL 60016**

(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 16 These Regulations were not met as follows: Based on record review and interview, the facility failed to ensure 1 client in the sample (R3) was protected from neglect when facility staff failed to follow specified transferring techniques to prevent injury to R3. R3 fell while being transferred from his bed to a chair resulting in a tibial fracture, ankle, undisplaced. Findings include: R3, per the Physician's Orders Sheet dated 2/25/09, is a a 42 year old male whose diagnosis includes Severe Mental Retardation, Quadriparesis and Brain Stem Infarct. R3's Individual Habilitation Plan (IHP) dated 12/08/08 lists under mobility - uses a wheelchair. The IHP summary notes R3 is non-verbal, uses gestures and head nods to communicate. He has been adaptably assessed on 12/16/08 as functioning at the 1 year 4 month level. The Monthly Weights and Blood Pressure form for March, 2009 list his height as 5 feet 7 and a half inches with his weight as 161lbs. His ideal body weight is listed as between 125lbs and 145lbs. On the Annual Medical Staffing dated 1/30/08, "R3 fractured his left humerus in October, during a fall from his wheelchair... R3 uses a mechanical lift, with a two person assist for transfers from one place to another." The fall, according to the Quarterly Nursing Assessment of 4/30/08, occurred on a home visit. On R3's physical dated 3/6/08 under gait: Non Ambulatory, electric wheelchair, mobile independent, mechanical lift transfer.	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G190	A. BUILDING _____ B. WING _____	C 03/17/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLFVIEW DEVELOPMENTAL CENTER	9555 WEST GOLF ROAD DES PLAINES, IL 60016

(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 17 On the Fall Risk Assessment dated 4/22/08 R3 was identified as a high risk. In the Physical Habilitation Assessment Neurodevelopment - Gross Motor dated 11/21/08 under problems it identifies poor standing - balance/tolerance. On the Identified Needs Form dated 12/17/08 under Identified Needs: Mechanical - lift for all transfers Under Important Information: At the scheduled times urge him to toilet with you (2 person assist or portable urinal) plus check if wet; mechanical lift. Per a 2/21/09 Incident Report Investigation completed by E10 (Qualified Mental Retardation Professional / QMRP): "On February 21st, at approximately 4:45pm, R3 sustained an injury to his right ankle...E11 (Training Counselor) gave the following statement: R3 was laying in bed and he was incontinent. I attempted to transfer him from the bed to the chair so I could bring him to the toilet and change him. R3 stood up and I was behind him, he froze and fell. I supported him as he fell and his foot folded in and didn't straighten out. I called E12, Training Counselor, to help me lift him back into his wheelchair. R3 then assisted me in changing his clothes. I notified the nurse...This writer (E10) asked E11, if he was aware that the window schedule states that R3 is to be a two person assist as well as using a mechanical lift to transfer to and from bed. E11 admitted that he	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G190	A. BUILDING _____ B. WING _____	C 03/17/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLFVIEW DEVELOPMENTAL CENTER	**9555 WEST GOLF ROAD DES PLAINES, IL 60016**

(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 18 was aware that this was stated on the window schedule. This writer (E10) asked E11 why he did not ask another staff for assistance. E11 stated, I have seen R3 weight bear and he is pretty strong and capable of doing it. I see now that this strength is not the same from day to day and not reliable. E11 also stated after R3 had fallen he pulled his own shoes on and the foot did not appear swollen at that time." The report notes E13 (Nurse) assessed R3 at that time and did not observe any swelling and he was able to move his foot. Later, at 6:45pm while R3 was coming off the elevator she observed him grimacing and asked him what was wrong. R3 pointed to his foot. E13 observed swelling and contacted the doctor who ordered an x-ray. X-rays revealed a tibial fracture, ankle, undisplaced. On 3/10/09 at 2:22pm E11 was interviewed. E11 said R3 was wet and as he was being transferred from his bed to his wheelchair. He went to the floor in a supported manner but his leg got trapped. When E11 was asked what his understanding of how R3 is to be transferred he stated they list what is to be done on a window schedule and he was confused. He said he thought you use a 2 person transfer or the mechanical lift if additional staff are available to assist. He said he went into the hallway, called for assistance but no one responded. He added, R3 was wet and it was dinner time and he needed to be changed. A review of the 2 window schedules used by staff on 2/21/09 include the following transferring techniques for R3:	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G190	A. BUILDING _____ B. WING _____	C 03/17/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLFVIEW DEVELOPMENTAL CENTER	**9555 WEST GOLF ROAD DES PLAINES, IL 60016**

(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 19 One window schedule - At the scheduled times urge him to toilet with you (2 person assist or portable urinal) plus check if wet, use mechanical lift Other window schedule - Use mechanical lift to transfer during toileting, clothing changes, and to and from bed On 3/6/09 at 3:30pm E1 (Administrator) was interviewed. E1 was asked what transferring technique was in place on 2/21/09 for R3. E1 said, "What the QMRP had was confusing. In 2 different places there were 3 directions. Use of a mechanical lift, transfer with 2 person assist and remind him to use the bathroom. At the time of the transfer R3 was a 2 person transfer... Staff have been in-serviced and there is now no conflicting information on the window schedule." Record review of the transfer techniques for R3 in both window schedules for use of mechanical lift or 2 person transfer do not state based on the availability of staff. The facility did have 2 window schedules at the time of R3's injury but neither specified the technique used by E11 on 2/21/09 with R3. E11 failed to provide the transfer techniques as specified in R3's window schedules resulting in R3 sustaining a tibial fracture, ankle,undisplaced. (A)	W9999		