STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G106	A. BUILDING _____ B. WING _____	01/08/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW WAY	80 KNUPP SCHOOL LANE ANNA, IL 62906

(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 449	Continued From page 86 during the evacuation and staff should be documenting the level of assistance needed. We will need to look at how long it actually takes to evacuate R2, R3, R4 and R5 with only one staff. We will also need to look at our forms and reassess the individuals... (R1-14)"	W 449		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.1210 350.1230b)6)7) 350.1230d)1)2) 350.1230e) 350.3240a) 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 services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in: 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. d) Direct care personnel shall be trained in, but are not limited to, the following: 1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention.	W9999		

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W9999	Continued From page 87 2) Basic skills required to meet the health needs and problems of the residents. 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. 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 observation, interview and record review, facility staff have failed to implement their own policy and procedures prohibiting mistreatment, neglect or abuse of the client when they failed to develop and implement a system for fall prevention for 1 of 1 individual in the sample (R4) who has diagnosis of Osteopenia and history of fractures and has required emergency medical attention due to falling, and 1 individual outside the sample (R5) who has fallen 18 times without intervention to prevent further falls since 06/09/08. This is evidenced by the facility's failure to: - provide necessary staff supervision to reduce the individual's risks for fall as based on a comprehensive assessment; - develop and implement individualized fall prevention plans; and - ensure documentation for all episodes of falls so that trends and patterns can be detected.	W9999		

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W9999	Continued From page 88 Findings include: 1) The Physician Order sheet dated November 1, 2008 to November 30, 2008 states that R4 is a 74 year old female who functions at a severe to profound level of mental retardation and has a diagnosis of Osteoporosis, history of fractured pelvis in 02/97 and history of fractured hip in 08/99. During Task II of the survey on 12/02/08, an incident accident report dated 11/15/08 identifies that R4 fell out of bed, resulting in a fracture of her right pinky finger. No documentation was noted on this report identifying R4's level of supervision at the time of this incident or that the facility had reviewed this fall as an allegation of neglect. During the survey dates of 12/02 thru 12/04/08, R4 was observed using a wheelchair for mobility. R4 also was observed wearing a splint wrapped in bandage on her right pinky. On 12/03/08 at 3:45 P.M., R4 was observed in the west end bathroom at the facility. R4 was observed to transfer herself from her wheelchair to the toilet with staff standing behind the wheelchair. R4 was observed to use her right hand (with splint in place) to hold onto the wall and transfer herself from the toilet to her wheelchair. Staff maintained presence in the bathroom and assisted R4 in pulling her clothing up and down and positioning her wheelchair during the transfers. Staff did not assist R4 in these transfers. Documentation within R4's Universal Progress Notes and hospitalization records identify that R4 had fallen on 04/07/08 and required hospitalization as a result of her fall. These	W9999		

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W9999	Continued From page 89 records also identified that R4 required morphine for pain during her hospitalization. Further review of R4's Physician Order sheet for November 2008 identifies that R4 has diagnosis of Osteoporosis and history of a fractured pelvis in 02/97 and history of a fractured hip in 08/99. In reviewing R4's record, a Physical Therapy Assessment was noted with a date of 02/06/01. On 12/03/08, the surveyor was provided with a faxed copy of R4's Physical Therapy Annual Assessment dated 03/20/08. This assessment identifies that R4 is to continue ambulating with a wheeled walker and CGA (contact guard assistance). This assessment also states, "Patient is to return to PT (Physical Therapy) only if decline or significant change in status is noted over the next year." Z5 (Physical Therapist) was interviewed by telephone on 12/07/08 at 2:10 P.M. and stated, "I saw R4 on 03/20/08. I was not aware that she is now using a wheelchair or had fallen since her last assessment. R4 was to have contact guard assistance (CGA) when ambulating with her walker and when transferring. Staff should be present with a hand on the patient at all times. R4 was and is not to transfer by herself." Further review of R4's record identifies that a Fall Assessment was completed for R4 on 06/23/07 resulting in a score of 12 which placed R4 at a "High" risk for falls. No further review dates were noted after 06/07. This assessment also states that a fall prevention plan should be implemented for individuals who are at "High" risks for falls. R4's IPP (Individualized Program Plan) dated 11/13/07 does not identify that her plan has been updated to include a fall prevention plan.	W9999		

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W9999	Continued From page 90 E3 (Registered Nurse Consultant) was interviewed by telephone on 12/05/08 at 11:25 A.M. and stated, "R4's Fall Assessment has not been updated since 06/23/07 and that was an oversight on my part. R4 has only fallen twice in the past year (04/08/08 requiring hospitalization and 11/15/08 resulting in fracture). No, R4 does not have a fall prevention plan". E1 (Resident Services Director/RSD) was interviewed at 10:00 A.M. on 12/02/08 regarding the Incident Report dated 11/17/08. E1 stated, "No we didn't do anything different after R4 fell. She can transfer herself independently out of bed to her wheelchair. She is not supervised during her transfers." During this interview, E1 confirmed that the facility failed to prevent neglect when they failed to ensure that R4 was provided with necessary supervision as per her PT assessment, and by their failure to develop and implement a fall prevention plan to address R4's diagnosis of Osteopenia and her "High Risk" for falls. 2) Upon review of R5's physician's order sheet dated 11-1-08 through 11-30-08, R5 is a 52 year old female who functions at a Severe level of mental retardation. Per review of R5's ICAP (Inventory for Client and Agency Planning) dated 07-17-08, R5 functions at an overall age equivalency of 4 years and 10 months. According to R5's Social History dated 07-22-08, R5's I.Q. is documented as being 32. R5 was observed at the facility on 12/02/08 from	W9999		

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W9999	Continued From page 91 3:00 P.M. to 5:00 P.M. ambulating independently without staff assistance, around the facility. R5 was observed slowing pacing back and forth between her bedroom and the activity room when not engaged in an activity. During review of the facility's incident and accident reports and R5's Universal Progress Notes from 06-09-08 through 12-04-08, surveyor noted that R5 has had 17 documented falls and one fall that was not documented but was confirmed by the direct support person on 12-03-08. Documentation on the incident and accident reports states: 06-09-08 - 3:45 p.m. - "This writer walked in her room to get her ready for bath. She was sitting on bed had half dollar size pop knot over (left) eye brow. She said she fell (and) hit it on her dresser". "Has small laceration (above) (left) eye half dollar size knot". On 06-14-08 at 9:00 a.m., E3 (Registered Nurse Consultant) documented in R5's Universal Progress Notes, "...Had fall 6/9/08 again in room - has ecchymosis (left) eye (and) (right) patella...." "...(continue) current plan of care...." 07-08-08 - 4 p.m. - "(R5) was half way in tub (with) one foot in, one foot out. She tripped and fell hitting her (left) ear on wall of bathtub." "has bruise on (left) ear." 07-25-08 - 8:30 a.m. - "(R5) entered (name of local day training site) in AM, while walking in hall she lost her balance, started shuffling her feet (and) fell. When she fell she went in slow motion	W9999		

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W9999	Continued From page 92 almost sitting herself down on the floor." 08-29-08 - 8:15 a.m. - "(R5) was walking down steps to go get on (name of local day training) van (with) staff assistance. She bent her knees falling forward. She scratched both legs on lower calf." 09-02-08 - 3:30 p.m. - "(R5) was found sitting in her bedroom floor with her nose bleeding. When asked (R5) what happened she said she didn't know." 09-07-08 - 1:45 p.m. - "I opened the door to check on (R5) (and) she fell backwards hitting her back on the toilet." During interview with E1 on 12-03-08 at 3:05 p.m., E1 stated that there were no more incident/accident reports that he had not given to surveyor. E1 continued to say that he did not know where the incident reports from the day training site were. Additional Falls/Injuries documented within R5's universal Progress Notes from 07-02-08 through 11-21-08 include: 07-11-08 - 2:00 p.m. - "(At) 8 am (R5) was walking to door to go out and load the (name of local day training site) van. She fell forward hit her head on the door. Knot and bruise (approximately) size of a quarter immediately came up on (left) side of forehead...." 07-11-08 - 6:00 p.m. - "...Staff report she fell again today - has (small) erythematic area (left) forehead...". "...Dementia? Causing falling (and) above episodes. (Continue) current plan of care.	W9999		

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W9999	Continued From page 93 Keep walkways clear. See (Z1) next week for? Labyrinthitis - maybe causing dizziness (and) falls". Documentation is signed by E3 (Registered Nurse Consultant), however there is no evidence of recommendations for safeguards to be put in place due to R5's falls. 07-24-08 - 10:00 p.m. - "(At) 4:15 p.m. (R5) missed the chair (and) landed in the floor missing the chair (and) hit her (right) cheek on the copy machine...." 09-30-08 - (no time documented) "Received a call from (name of local day training center) at 2:20 p.m. stating that (R5) had fallen. They are sending an accident report." 10-07-08 - 2:00 p.m. - "(E12) (Licensed Practical Nurse) from (name of local day training site) called 1pm stated (R5) had fallen and small cut on lower gum line Bleeding had stopped. No other injury (at this time) They started Neuro (checks). Will continue to monitor." 10-13-08 - 8:45 p.m. - "Received accident report via (name of local day training site) at 3:15 p.m. after getting off bus. Upon arrival note bruise on left knee charted on accident report as old bruise. New injury to left breast (and) back." 10-14-08 - 2:00 p.m. - "6am Staff heard noise. Went to (R5's) room to find her in the floor next to her bed. She had fallen out of bed hit her head (approximately) 1" abrasion above (left) brow Bleeding bruising. Applied pressure. Bleeding stopped." 10-24-08 - 5:00 p.m - "...Earlier in week staff report (R5) seemed disoriented (and) "lost."	W9999		

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W9999	Continued From page 94 "...Dementia - Early Alzheimer's? (Continue) current plan of care. (Continue) to offer supportive care, fall prevention, etc.". Documentation is signed by E3 (Registered Nurse Consultant). 11-20-08 - 10:00 p.m. - "(R5) has (no) injuries from fall in dining room." 11-21-08 - 2:00 p.m. - "12:45p (name of local day training) staff reported (R5) had fallen. They were unsure where she hit on her face. (R5) stated her nose. They will send report." During observations on 12-03-08, surveyor was in the dining room of the facility. E10 was assisting R5 with her shower. At 4:30 p.m. surveyor heard a loud "Thump" from the bathroom where R5 and E10 were. When surveyor entered the bathroom at approximately 4:33 p.m., R5 was sitting in the bathtub rubbing her left outer forearm. R5 appeared ready to cry at this time. E10 stated to surveyor, "She does this all the time." When surveyor asked if R5 falls all the time, E10 said, "Yes all the time, we really need a shower chair in here but we only have one and they're using it in the other bathroom." Surveyor noted that there were no handicap bars on or around the bathtub to help prevent falls. Upon review of R5's Physical Therapy Assessment dated 04-14-08 documentation states, "Pt's (patient's) caregiver stated that she had been falling in the last couple months. Pt's caregiver said her falls are getting worse in the last few weeks and would even need 2 persons when ambulating." "Pt. tends to lean back on	W9999		

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W9999	Continued From page 95 standing. Needs more knowledge in using the walker. Pt. would carry the rolling walker instead of just pushing it." "Pt's ambulation with walker was observed during the evaluation today and noted that pt. would need 2 person assist on ambulation since she tends of lean back and carry the walker." The Assessment Problems list identifies R5's deficits as poor ambulation, balance, weakness, decreased mobility, postural dysfunction and core weakness. Z5 (Physical Therapist) was interviewed by telephone on 12/07/08 at 2:10 P.M. and stated, "R5 was released from therapy due to her constant refusals. R5 is to have contact guard assistance when ambulating. Staff should be present with a hand on the patient at all times. R5 should not be roaming around the facility unsupervised." In reviewing R5's record, there is no evidence that a fall prevention program or any system for supportive care regarding her falls has been implemented as based upon R5's comprehensive assessments. Further review of R5's records did not identify that staff had documented R5's 12/0308 fall. Per interview with E1 on 12-04-08 at 9:45 a.m., E1 stated that he was not aware that R5 fell while taking a bath on 12-03-08. E1 continued to say that no incident report had been completed on the incident. When asked what should have been done when R5 fell, E1 stated: "Told me - that would have been a good thing. I was only about 20 feet away." E1 also said that staff should have	W9999		

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W9999	Continued From page 96 assessed her for injuries and filled out an incident report. On 12-05-08 at 11:15 a.m., when asked about the number of falls that R5 has had and that there are not consistent incident reports completed, E3 stated that she was not aware that R5 has had, "That many falls." E3 continued to say that vital signs should be taken with every fall, staff should assess the resident for injury and document the findings. E3 also said, "Staff really need to be trained on filling out incident reports." E3 confirmed that direct care staff have not followed the facility's policy regarding "Charting Guidelines." Per interview with E1 on 12-03-08 at 3:05 p.m., E1 confirmed there is no system to ensure that R5 does not fall again, including no fall prevention plan with appropriate safeguards.During this interview, E1 confirmed that the facility failed to develop and implement a system for fall prevention for R5 after repeated falls with injury. E1 was again interviewed at 10:25 A.M. on 12/04/08 regarding the facility's system for monitoring incidents for trends and patterns. E1 stated, "Well if staff aren't documenting incidents, then we can't track them for any type of trend or pattern." (A) 350.620a) 350.1210 350.3240a) 350.3240c)	W9999		

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W9999	Continued From page 97 350.3240d) 350.3240f) 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 350.3240 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) c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act) f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence,	W9999		

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W9999	Continued From page 98 that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act) These Regulations were not met as evidenced by: Based on observation, interview and record review, facility staff have failed to implement their own policy and procedures prohibiting mistreatment, neglect or abuse of the client when they failed to: 1) Develop and implement policies and procedures specific to client to client abuse for 1 of 1 individual in the sample (R4) who sustained visible injury to her eye and alleged that she was hit by her room mate (R5) in the eye. This is evidenced by the facility's failure to: - develop and implement policy and procedures specific to client to client abuse; - notify R4's guardian of the injury and the allegation of client to client abuse after being informed of the allegation of abuse; - notify the administrator and the Illinois Department of Public Health of this allegation; - investigate the allegation; - put safeguards in place to prevent further potential abuse; and - notify the administrator and the Illinois Department of Public Health of the results of the investigation regarding the alleged abuse.	W9999		

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W9999	Continued From page 99 2) Investigate injuries of unknown origin for 1 individual outside the sample (R5) who was found sitting in her bedroom floor on 09-02-08, with her nose bleeding, had a documented bruise to her left side from 09-17-08 through 10-06-08 and had a bruise to her left breast from 10-14-08 through 10-22-08. Findings include: 1) The facility failed to develop and implement policies and procedures specific to client to client abuse. a) The facility failed to implement their own policy and procedures for investigating an allegation of client to client abuse. The Physician Order sheet dated November 1, 2008 to November 30th, 2008 states that R4 is a 74 year old female who functions at a severe to profound level of mental retardation and has diagnosis of Osteoporosis, history of fractured pelvis in 02/97 and history of fractured hip in 08/99. An Incident Report dated 08/10/08 states, "R4 alleged that R5 hit her in the eye. Her whole right eyelid is bruised and purple in color...." During Task II of the survey, E1 (Resident Services Director/RSD) was interviewed at 10:00 A.M. on 12/02/08. E1 stated, "No" when asked by the surveyor if the facility had investigated R4's allegations of client to client abuse. E1 stated, " I didn't think that R5 had hit her." E1 also stated, "No" when asked if he had investigated to determine how R4 sustained injury to her eye.	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G106	A. BUILDING _____ B. WING _____	01/08/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW WAY	80 KNUPP SCHOOL LANE ANNA, IL 62906

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W9999	Continued From page 100 The facility's policy and procedures for reporting abuse and neglect dated September 14, 2006 states: "It is the duty of any facility employee or agent who becomes aware of or suspects abuse of neglect to report it to the Resident Services Director or his/her designee and the administrator immediately... The Resident Services Director must immediately investigate the matter fully to determine if there is credible evidence to support the allegations and have evidence that all alleged violations are thoroughly investigated..." The facility's policy and procedures for "Physical Injury" dated September 29, 2005 states, "If there is an injury of unknown origin, the RSD and Administrator will be notified as soon as the injury is discovered. Following investigation, if the cause of the injury is still unknown, the Department of Public Health will be notified... If a physical injury is found on an individual, the cause will be investigated as follows: - Ask the individual how he/she got the injury. If they are able to tell you how the injury occurred the investigation is complete. If it does not seem likely that the injury could have occurred as stated, call the day training, the employer, or any other places the individual has been recently for verification. If the individual does not know how the injury occurred, proceed with the investigation. - Call the day training; the employer; and/or other places the individual has been recently, describing the injury and ask if it is known how the injury occurred. If they explain when and how	W9999		

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W9999	Continued From page 101 the injury occurred, the investigation is complete. If they cannot find any evidence of the injury occurring, proceed with he investigation. -Ask other staff at this facility if they know how or when the injury occurred. - If a cause for the injury can not be determined, an Accident/Incident Report should be completed..." E1 (Resident Services Director/RSD) was interviewed on 12/02/08 at 10:00 A.M.. E1 stated, "No" when asked by the surveyor if the facility had investigated R4's allegation of client to client abuse. E1 also stated, "No" when asked by the surveyor if the facility had reported the allegation of client to client abuse to R4's guardian, the administrator and or to the Illinois Department of Public Health. In review of the facility's documentation for R4, the facility failed to follow their own policy and procedures for physical injury when they failed to investigate R4's allegation of client to client abuse. b) The facility has failed to develop policy and procedures specific to client to client abuse. The facility's policy and procedures for reporting abuse and neglect dated September 14, 2006 states, "When an investigation of a report of suspected abuse of an individual being supported indicates that an employee of a long term care facility is the perpetrator of abuse, that employee will immediately be barred from any further contact with the individuals supported pending the outcome of any further investigation,	W9999		

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W9999	Continued From page 102 prosecution or disciplinary action against the employee." This policy does not identify how the facility will safeguard the individual when another client is the alleged perpetrator of abuse. The Incident Report dated 08/10/08 states, "R1 alleged that R5 hit her in the eye. Her whole right eyelid is bruised and purple in color...." During Task II of the survey, E1 (Resident Services Director/RSD) was interviewed at 10:00 A.M. on 12/02/08 regarding the Incident Report dated 08/10/08 which alleged that R5 hit R4 in her eye. E1 stated, "R4 and R5 are roommates." E1 stated, "No" when asked by the surveyor if the facility had put safeguards in place to protect R4 from R5 after the incident and or during the investigation. E1 stated, " I didn't think that R5 had hit her." E1 also stated, "No" when asked if he had investigated to determine how R4 sustained injury to her eye. After reviewing the facility's policy and procedures for reporting abuse and neglect with E1, E1 confirmed that the facility's current policy does not identify how the facility will safeguard the individual when another client is the alleged perpetrator of abuse. 2) The facility failed to prevent neglect when they failed to investigate injuries of unknown origin. Upon review of R5's physician's order sheet dated 11-1-08 through 11-30-08, R5 is a 52 year old female who functions at a Severe level of mental retardation.	W9999		

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W9999	Continued From page 103 Upon review of R5's Universal Progress Notes, surveyor noted that documentation on 10-13-08 at 8:45 p.m. states, "Received accident report via (name of local day training site) at 3:15 p.m. after getting off bus. Upon arrival note bruise on left knee charted on accident report as old bruise. New injury to left breast (and) back." 10-14-08 - 10:00 p.m. - "There are no bruises on breasts or on her back. Just on her (left) eye brow." 10-16-08 - 10:00 p.m. - "(R5) still has bruise on breast (and) head." 10-22-08 - 10:00 p.m. - "(R5's) (left) eyebrow is healing. Yellow bruise under breast." No further documentation is noted identifying how R5 sustained bruising to her breast or that the facility had investigated these incidents. Per interview with E1 on 12-04-08 at 11:45 a.m., when asked if he had investigated the unknown injuries to R5, E1 stated that he had not. (A)	W9999		