STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G279	A. BUILDING _____ B. WING _____	C 02/24/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE	205 PARK AVENUE PANA, IL 62557

(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 149	Continued From page 18 behavior assessment for R1 for 30 days, with behavior specialist to review findings. Although the Immediate Jeopardy was removed, non-compliance continued at the time of the exit, since the facility has not had time to assess the effectiveness of the plan.	W 149		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.3240a) 350.3240b) 350.3240d) 350.3240e) 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 350.3240 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) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act)	W9999		

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W9999	Continued From page 19 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) e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act) These Regulations were not met as evidenced by: Based on observation, interview and record review, the facility failed to implement their system to prevent abuse/neglect for 1 of 13 individuals of the facility (R1), with potential to affect 13 of 13 individuals of the facility (R's 1-13). The facility failed to: 1) Facility staff failed to notify administrative personnel of a 1/31/09 possible abuse/neglect incident until 2/3/09. Direct care staff concerns regarding E5 not allowing R1 to leave her room on 1/31/09 were not reported to administrative staff until 2/3/09. The Residential Services Supervisor/Qualified Mental Retardation Professional (RSD/QMRP) failed to notify the Administrator of the possible	W9999		

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W9999	Continued From page 20 abuse/neglect incident of 1/31/09. The facility failed to thoroughly investigate the possible abuse/neglect incident of 1/31/09 when they failed to: a) verify which staff "escorted" R1 to her room; b) verify how R1 was "escorted" to her room; c) provide reproducible evidence of an interview with E5 (alleged perpetrator); d) provide reproducible evidence of interviews with R1 and R6 (individuals of the facility who were in the immediate area at the time of the incident). The facility failed to ensure prevention of further potential abuse/neglect regarding the 1/31/09 incident when they failed to remove E5 from provision of direct care services. The facility failed to notify the Department of the 1/31/09 possible abuse/neglect incident. 2) Facility staff failed to notify administrative personnel of possible abuse/neglect regarding E7's (DSP) suspected illegal drug usage and leaving the facility during work hours until 2/11/09. 3) The facility failed to investigate injuries of unknown origin for 2 of 2 individuals in the sample who are non-verbal (R1 & R2). 4) The facility failed to investigate possible client to client mistreatment (R11 to an unidentified female resident). In review of an undated facility document that validates level of functioning, there are 13 individuals who currently reside in the facility,	W9999		

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W9999	Continued From page 21 with functioning levels as follows: 7 who function in the mild range of mental retardation (R's 2, 6, 8, 9, 10, 11 & 12); 1 who functions in the moderate range of mental retardation (R7); 3 who function in the severe range of mental retardation (R's 1, 3 & 4); and, 2 who function in the profound range of mental retardation (R's 5 & 13). An undated guardian list, and an undated resident roster, provided by the facility, documents that 7 individuals have guardians (R's 2, 3, 4, 5, 6, 7 & 13). There are 4 individuals who have Power of Attorney for healthcare (R's 1, 9, 10 & 11); and, 2 individuals who do not have guardians (R8 & R12). During observations at the facility on 2/13/09 at 3:30 p.m., all individuals of the facility are ambulatory. In an interview with E1 (RSD/QMRP), on 2/13/09 at 2:00 p.m., E1 stated that R's 1, 3, 5 and 13 are individuals who are non-verbal. An undated resident roster further documents that R's 2, 3, 6, 7, 8, 9, 10, 11 & 13 require behavior management programs and medications to assist in behavior control. Findings include: 1) In review of an undated facility document that validates level of functioning, R1 functions in the severe range of mental retardation, and has a Power of Attorney for healthcare. Her 6/25/08 Inventory of Client Agency Planning (ICAP) documents an overall age equivalent of 2 years, 9 months. Her 7/1/08 Slosson documents	W9999		

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W9999	Continued From page 22 an intelligence quotient (IQ) of 14. R1's Individual Service Plan (ISP) of 3/27/08 documents the following: R1 is non-verbal, making sounds or gestures to get attention, and does not shake her head 'yes' or 'no' in response to a question; requires total assistance for hygiene, bathing and oral care, not attempting to complete any task independently; unable to totally dress herself, but can remove clothing; requires a mechanically soft diet, eats at a very rapid pace - requiring prompts to slow down; and, requires incontinence briefs. Her 12/2008 QMRP monthly progress summary states that when R1 is upset, she will shove furniture. R1 is ambulatory (as per observations at the facility on 2/13/09 at 3:30 p.m.). As per the undated facility roster that validates level of functioning, R1 is not on a behavior management program and does not utilize medications to assist in behavior control. A 2/3/09 typed document from E1 (RSD/QMRP) was reviewed. Per this document, E3 (DSP) related the following information to E4 (DSP). E3 then related this information to E1 on 2/3/09: On 1/31/09 R1 had been taking blocks from R5 and would not stop this behavior. E5 (DSP) then escorted R1 to her room to keep her away from R5 and the blocks. E5 asked R2 (R1's roommate - as per a facility map documenting roommates) to dump R1's drawers/or laundry basket onto her bed and fold the clothing, so she would have something to do and stay in her room. E1 then contacted E4 and asked for a written	W9999		

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W9999	Continued From page 23 statement of the events of 1/31/09. E4's handwritten statement of 2/3/09 was reviewed. Per E4's statement, "we" (E4 and E5), escorted R1 to her room. E4 told E5 that R1 was not going to stay in her room, so let her go and keep an eye on her. E5 was standing in the doorway to R1's room, and E4 went back to the kitchen. E4 unloaded the dishwasher and went back down to R1's room. R6 was getting ready to take a bath. E4 told R6 to lock her door. (Per the facility map, R6's room is across the hall from R1 and R2's room). E4 then went to R1's room and opened the door. E5 was in R1's room. E4 told E5 again to let R1 go. "If she (R1) doesn't want to be in here we can't keep her in here if she doesn't want to be...I (E4) didn't find out till (until) later that (E5) had asked (R2) to take (R1's) clothes out of the drawers and throw them on the bed for (R1) to fold." In review of the January 1/31/09 staff schedule, E4 and E5 were the only staff on duty at the time of the incident (2:15 p.m.). In an interview with E1, on 2/13/09, at 10:40 a.m., E1 confirmed that she was not aware of the 1/31/09 incident until 2/3/09 when E3 reported what E4 had shared. E1 further confirmed that she then contacted E4, requesting a written statement regarding the 1/31/09 incident. > Direct care staff failed to notify administrative personnel of the 1/31/09 possible abuse /neglect incident until 2/3/09.	W9999		

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W9999	Continued From page 24 A 2/3/09 typed note to E5 from E1 was reviewed. Per this note it states, "It was reported to me today that you had asked (R2) to dump (R1's) things on her bed so that (R1) would refold them and stay down in her room...This is inappropriate. (R1) does not have to stay in her room because she is taking blocks away from (R5)." E1 (on 2/13/09 at 10:40 a.m.) further confirmed that she had not notified the Administrator of this incident. E1 further stated that she felt that it was inappropriate for E5 to escort R1 to her room, but did not feel that the situation was an abuse/neglect situation. > The RSD/QMRP failed to notify the Administrator of the 1/31/09 possible abuse/neglect incident. There is a discrepancy in E1's 2/3/09 typed report and E4's 2/3/09 handwritten report. E1's 2/3/09 report states that E5 "escorted" R1 to her room. E4's handwritten report states, "We (E5 & E4), escorted (R1) to her room." In an interview with E1 on 2/13/09 at 1:20 p.m., E1 stated that E4 and E5 each took R1 by a hand and walked her to her room. However, there is no evidence of this in E1's 2/3/09 typed report or E4's handwritten report. Additionally, there is no reproducible evidence of an interview with E5. In an interview with E1, on 2/13/09 at 10:40 a.m., E1 stated that she had spoken with E5 on the telephone regarding the 1/31/09 incident, but she did not have reproducible evidence of the conversation. As per E4's handwritten statement of 2/3/09, R2	W9999		

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W9999	Continued From page 25 was in the room with R1 during the 1/31/09 incident; and R6 was across the hall preparing for her bath (R6, R1 and R2's room location verified per facility map). In an interview with E1, on 2/13/09 at 10:40 a.m., E1 stated that she had interviewed R2 and R6, but did not have any reproducible evidence for the interviews, other than the typed 2/3/09 report. (Per review of R2's 5/22/08 ISP, R2 speaks in full sentences, and can read and write). > The facility failed to thoroughly investigate the 1/31/09 incident when E1 failed to clarify which staff "escorted" R1 to her room, and failed to verify how R1 was "escorted" to her room; > The facility failed to provide reproducible evidence that E5 was interviewed regarding the 1/31/09 incident. > The facility failed to provide reproducible evidence that R2 and R6 were interviewed regarding the 1/31/09 incident. (Per interview with E1 on 2/13/09 at 2:00 p.m., both individuals are verbal). On 2/17/09, E1 presented surveyor with an undated, typed report that had been faxed to the Department. This report stated that the 1/31/09 investigation had been re-opened on 2/13/09, further documenting that E5 was suspended on 2/13/09 pending the outcome of the investigation. Attached with this report is an undated handwritten document from E5, describing his version of the 1/31/09 incident. There is also a 2/13/09 handwritten interview with	W9999		

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W9999	Continued From page 26 R2. When asked if the door was open or shut, this report states, "It was shut and he (E5) had his foot on the door so she (R1) couldn't open it and get out." A 2/13/09 handwritten interview with R6 states, "On a Saturday, I was in tub, (E4) said (R1) was having a behavior and (R1) was trying to get out of her room, go ahead and lock the bathroom door. I guess they didn't want her out of the room...". The facility staff schedules were reviewed for 01/09 and 02/09. Per the 01/09 schedule, E5 worked from 8:00 a.m.-4:00 p.m. (The incident occurred at 2:15 p.m., 1/31/09). Per the 02/09 schedule, E5 worked 02/01/09 from 8:00 a.m.-4:00 p.m.; 02/03/09, 02/04/09 and 02/05/09 from 4:00-12:00 p.m.; 02/10/09 and 02/11/09 from 4:00-12:00 p.m. E1 confirmed (2/17/09, at 9:30 a.m.), that E5 had worked as per the above schedule, and was not removed from the schedule until 2/13/09. > The facility failed to ensure prevention of further potential abuse/neglect regarding the 1/31/09 incident; when facility staff failed to report the 1/31/09 incident to administrative personnel until 2/3/09; and, when the facility failed to ensure a thorough investigation; allowing E5 to continue to provide direct care services to individuals of the facility. In an interview with E1, on 2/13/09, at 10:40 a.m., E1 stated that the 1/31/09 possible abuse/neglect incident had not been reported to the	W9999		

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W9999	Continued From page 27 Department. > The facility failed to report the 1/31/09 possible/abuse neglect incident to the Department. 2) A 2/9/09 typed report from E1 (RSD/QMRP) was reviewed. Per this report, on 2/9/09, E9 (DSP) told E8 (DSP) that E7 (DSP) has been leaving the facility while on duty and going home to take care of her child. E9 further reported to E8 that when E7 would return to the facility, staff were concerned that E7, "was stoned on pot...." E8 reported this information to E1 on 2/9/09. A 2/11/09 interview statement from E6 (DSP) stated, "Back in May or June I told (E9 - DSP) that (E7) went home to change (Z2's) diaper and when (E7) came back she appeared to be high. I had other staff members mention it to me and they told me that they had said something to (E9) about it...." A 2/12/09 statement from E4 (DSP) stated, "I don't remember the date, but I was working with (E7) and (Z1) called her to have her go home to change (Z2's) diaper. She was gone for 20-30 mins. (minutes), and when she came back all she did was sit on the sofa and I could smell the odor of pot on her and you could tell she was stoned...." E7's possible illegal drug usage and leaving the facility during work hours was not reported by staff (who had knowledge of this information since May/June of 2008), until 2/11/09.	W9999		

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W9999	Continued From page 28 An undated letter from the facility to the Department was reviewed. (In an iterview with E1 on 2/13/09, at 9:30 a.m., E1 stated that the letter was faxed to the Department on 2/9/09). This validates that E7 (DSP) was terminated on 2/9/09 due to violation of the facility's drug and alcohol policy. 3) The facility failed to investigate injuries of unknown origin for 2 of 2 individuals in the sample who are non-verbal. In review of an undated facility document that validates level of functioning, R1 functions in the severe range of mental retardation, and has Power of Attorney for healthcare. Her 6/25/08 ICAP documents an overall age equivalent of 2 years/9 months. Her 7/1/08 Slosson documents an IQ of 14. R1's ISP of 3/27/08 documents the following: R1 is non-verbal, making sounds or gestures to get attention, and does not shake her head 'yes' or 'no' in response to a question; and requires total assistance for hygiene, bathing and oral care, not attempting to complete any task independently. Facility incident reports were reviewed. On 10/1/08 at 6:30 p.m., while in the facility bathroom, E6 discovered a scratch with some bruising on R1's back on the left side. On 2/9/08 at 6:30 p.m., while in the facility bathroom, E11 (DSP) discovered a bruise on	W9999		

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W9999	Continued From page 29 R1's buttocks. In an interview with E1 on 2/13/09 at 2:10 p.m., E1 confirmed that R1 is non-verbal and unable to respond to interviews. E1 further confirmed that these injuries of unknown origin had not been investigated to ensure abuse or neglect had not occurred. In review of an undated facility document that validates level of functioning, R3 functions in the severe range of mental retardation and has a legal guardian. Her 2/16/08 ICAP documents an overall functioning level of 1 year/l month. Her 2/1/06 Slosson documents an estimated IQ of 25. R3's ISP of 2/21/08 documents an additional diagnosis of Autism, with echolalic language. R3 is verbal, but basically communicates with yes/no, with other utterances difficult to understand. On 7/1/08 at 5:30 p.m., E11 (DSP), discovered, "bruising on the upper, inner sides of both legs." The bruises are described as, "purple." On 10/10/08 at 6:00 p.m., E6 discovered a bruise on the left side of R3's back. On 2/9/09 at 6:10 a.m., E9 discovered a purplish red bruise on the back of R3's right arm. In an interview with E1, on 2/13/09, at 2:10 p.m., E1 stated that R3 engages in self-abuse, and often puts her hands between her upper thighs. E1 stated that the 7/1/08 bruises probably resulted from R3's self-abusive behavior. E1 further confirmed that R3's injuries of unknown origin had not been investigated.	W9999		

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W9999	Continued From page 30	W9999		

4) The facility failed to investigate possible male to female client to client mistreatment.

Facility incidents were reviewed.

On 1/1/09 at 9:05 a.m., R11 was sitting at a table with two other male residents. "Female resident walked past his table and he smacked her on the butt."

Per this report the female resident is not identified.

E1 was interviewed on 2/13/09, at 2:10 p.m. E1 confirmed that the female resident who was the recipient of the smack on the buttocks was not identified in this incident report. E1 further stated that she thought she knew who the female resident was, and that the female resident probably did not have a problem with this interaction. E1 confirmed that this incident had not been further investigated.

5) The facility policy for abuse and neglect was reviewed.

"It is the policy of this facility that all residents have the right to be free from verbal, physical and mental abuse, corporal punishment, involuntary seclusion, misappropriation of property and neglect."

Abuse is defined as, "the willful infliction of injury, unreasonable confinement, intimidation punishment with resulting physical harm, pain or mental anguish. This also includes the deprivation by an individual, including a

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W9999	Continued From page 31 caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well being." Neglect is defined as, "the failure to provide goods and/or services necessary to avoid physical harm, mental anguish or mental illness." Involuntary seclusion is defined as, "a separation of a resident from other residents or from his room or confinement to his room against the resident's will, or the will of the resident's legal representative." Per this policy, "...all residents have the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, involuntary seclusion...residents are not to be subjected to abuse, corporal punishment, misappropriation of property or neglect by anyone, including, but not limited to, facility staff...At the time of an alleged incident of abuse, neglect...that staff person will immediately inform their direct supervisor...". Under the "Procedure-Reporting/Response" the following is stated: "If any incidents or possible incidents of verbal, sexual, physical and mental abuse, corporal punishment, involuntary seclusion, misappropriation of property or neglect are observed or suspected, it is the responsibility of each partner, regardless of his responsibilities, or if on or off duty, to immediately report the incident to his immediate supervisor. The supervisor will then inform the Administrator/RSD or his designee, regional director or the Corporate Compliance Officer as soon as the allegation is received...The Administrator will notify...Illinois	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G279	A. BUILDING _____ B. WING _____	C 02/24/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE	205 PARK AVENUE PANA, IL 62557

(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 32 Department of Public Health." "The administrator/RSD or...designee...will request a statement from the alleged perpetrator...statement will be put in writing...signed, dated and timed." "All residents will be protected from harm during the investigation of possible abuse...The person alleged to have abused a resident will be immediately suspended pending investigation." An incident is defined as, "Any occurrence that has produced or can produce an injury as a result of the event. Examples - bruises, falls, abrasions, skin tears, sexual aggression toward another, etc." "In the case of an injury in which the etiology is not known, the administrator or his/her designee will also investigate...Document the investigation as it is performed - who and when interviewed and the responses." "An assessment will be completed whenever...notified a staff member of any event, condition or body mark that may be indicative of abuse or neglect. A full investigation will be completed." The facility failed to ensure that their own policies for abuse/neglect were implemented when: > Facility staff failed to notify administrative personnel of a 1/31/09 possible abuse/neglect incident until 2/3/09. > The RSD/QMRP failed to notify the Administrator of the possible 1/31/09	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W9999	Continued From page 33 abuse/neglect incident. > The facility failed to thoroughly investigate the 1/31/09 possible abuse/neglect incident. > The facility failed to ensure prevention of further potential abuse/neglect regarding the 1/31/09 incident, when the facility failed to remove E5 from provision of direct care services. > The facility failed to notify the Department of the 1/31/09 possible abuse/neglect incident. > Facility staff failed to notify administrative personnel of E7's possible abuse/neglect regarding suspected use of illegal drug usage and leaving the facility during work hours. > The facility failed to investigate injuries of unknown origin for two non-verbal individuals. > The facility failed to investigate possible male to female client mistreatment. (A)	W9999		