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	14G191	A. BUILDING _____ B. WING _____	07/20/2009

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W 488	Continued From page 47 plate of toast to the table, and ate their toast independently. The clients each received a glass of orange juice, which was poured by E11. No evidence of family style dining occurred during this meal observation. During an interview with E11 on this same date and time, E11 stated that the clients in this home cannot participate in family style dining because it would be a "free for all". E11 continued, stating that they are only being good because of a surveyor being in the home. E11 stated that the clients would have a hard time pouring the cereal out of a bag. This surveyor asked E11 if the cereal could be place in a large bowl for the clients to scoop out, or placed in a plastic container for them to pour. E11 did not really have an answer to this question. During an interview with E12(House Manager) on 7/8/09 at 8:10am, E12 stated that the clients should be offered every opportunity to participate in family style dining. E12 stated the dry cereal could be placed into a plastic container for the clients to pour independently, or with assistance from staff. E12 stated that the clients should be given the opportunity to be as independent as possible.	W 488		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.1060a) 350.1060c)1)2) 350.1060a) 350.1060d) 350.1060f) 350.1060g)	W9999		

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W9999	Continued From page 48 350.1060j) 350.1210d) 350.1220f) 350.1220g) 350.1610e) 350.1610h)1)2) 350.3240a) Section 350.1060 Training and Habilitation Services a) The facility shall provide training and habilitation services to facilitate the intellectual, sensorimotor, and effective development of each resident in the facility. c) There shall be written training and habilitation objectives for each resident that are: 1) Based upon complete and relevant diagnostic and prognostic data. 2) Stated in specific behavioral terms that permit the progress of the individual to be assessed. d) There shall be evidence of training and habilitation services activities designed to meet the training and habilitation objectives set for every resident. f) There shall be a functional training and habilitation record for each resident, maintained by and available to the training and habilitation staff. g) Appropriate training and habilitation programs shall be provided residents with hearing, vision, perceptual, or motor impairments, in cooperation with appropriate staff. j) Appropriate records shall be maintained for	W9999		

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W9999	Continued From page 49 each resident functioning in these programs. These shall show appropriateness of the program for the individual, resident's response to the program and any other pertinent observations and shall become a part of the resident's record. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following: d) Physical and occupational therapy services for purposes of initiating, monitoring and follow-up of individualized treatment programs rendered by or under the supervision of a physician with special training or experience in the specialty or a physical therapist or an occupational therapist. Section 350.1220 Physician Services f) Physicians shall participate in the continuing interdisciplinary evaluation of individual residents, for the purposes of initiation, monitoring, and follow-up of individualized habilitation programs for treatment. g) The statement of treatment goals and management plans shall be reviewed and updated at least semiannually to insure that the goals are appropriate and that management methods are consistent with the goals; and to determine whether progress toward the goals is being achieved or the goals should be reevaluated. Section 350.1610 Resident Record Requirements	W9999		

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W9999	Continued From page 50 e) An ongoing resident record including progression toward and regression from established resident goals shall be maintained. h) The records maintained for each resident shall be adequate for: 1) Planning and continuously evaluating each resident's habilitation program, 2) Furnishing evidence of each resident's progress and response to the habilitation program, and 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 prevent neglect when they failed to ensure the safety of 1 of 1 resident (R48), with a history of 23 falls in 5.5 months, when they failed to: 1) Ensure that a system was put into place for monitoring possible trends, patterns, and causes of R48's falls. 2) Implement steps that ensured R48's safety. 3) Ensure that there is coordination of recommendations made by the interdisciplinary team. 4) Ensure that care was provided to one of one	W9999		

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W9999	Continued From page 51 resident with a history of frequent falls (R48) according to her needs. Findings include: Facility policy titled, "Reporting Unusual Incident / Accident" requires, "#3. Neglect: Failure or refusal to carry out the care-giving role and to provide for the necessities of life, ...medications, required assistance with personal care / ADL." According to R48's Individual Habilitation Plan (IHP), dated 9/12/08, she is an ambulatory 38 yr. old who has an IQ less than 20 and functions at an adaptive level of 1 year and 9 months. Her diagnoses include Profound Mental Retardation, Microcephaly, and Osteoporosis of the lumbar-sacral spine and hips. The Communication evaluation, dated 9/9/08, identifies that R48 communicates using mostly gestures and facial expressions. However she does know some words and can understand simple directions. The IHP mobility assessment includes, "[R48] walks independently inside the premises but with close supervision from staff. She needs assistance from staff to walk with her when she is outside the facility. She wears a gait belt due to falling." R48's IHP stated that she has a history of falls. R48's fall incidents were reviewed. Based on 3 different sources (the incident reports, the QMRP's (E23) list of falls and the nurse's progress notes), R48 has fallen 23 times from 2/1/09 to present, approximately 5.5 months.	W9999		

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W9999	Continued From page 52 According to the notes, most of her falls were to her knees. However she fell on her buttocks on 2/25, 3/23, and 3/27/09. On 2/3/09, R48 fell in the bathroom onto her hip and hit her head on the floor. After this fall, an x-ray of her knee was done because she was limping. The x-ray was negative. R48 fell in the bathroom against the sink on 4/14/09, sustaining an abrasion to her left hand. Nurses notes dated 2/1, 2/3, 5/28, and 6/4/09 documented that antibiotic ointment was applied to R48's knees because of abrasions. The most current physical therapy (PT) evaluation completed by Z5, dated 6/2/08, contained the following recommendation, "Physical therapy services are not recommended at the current time. Continue safety measures that are already in place, including the gait belt as needed. Recommend more supportive shoes. Will re-evaluate at future date, possible need for an orthotics consultation." A staff training sheet for Z5's PT recommendations, dated 7/23/08, included, "Gait belt is to be used as needed. Gait belt not needed within apartment, rec. room, day training (DT) or workshop. Use gait belt when ambulatory for long distances, uneven surfaces... Distant supervision (watching resident, verbal prompts) required within apartment, rec room, DT and workshop. Contact guard (hands on assistance) with long distances or uneven surfaces..." The psychiatrist's note, dated 1/28/09, documented, "Z3 wants [R48] off Abilify	W9999		

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W9999	Continued From page 53 because when she moves her, she is like a rock." The record lacked documentation that this concern was addressed. A physician consultant's (Z4) note, dated 10/17/08, requested a repeat PT evaluation and gait training for R48's repeated falls along with a follow-up in 3 months. However, there is no reproducible evidence that the PT evaluation or gait training were completed as ordered by the physician. Z4's follow up note, dated 1/13/09, included, "[R48] has a history of recurrent falls. Z3 described two types of episodes. One appears more likely to be a balance problem... Neurologist had ordered a repeat physical therapy evaluation, gait training... When she is working with physical therapy, I recommended that they startle her when she is standing and help her learn to better right herself." "R48's sodium is minimally elevated.... I recommend increasing her fluid intake... If she is mildly dehydrated, it could contribute to her falling... Follow-up in 3 months." The neurologist's note, dated 2/10/09, included, "Falls to knees. Less in past few months. Physical exam positive for orthostatic blood pressure changes [blood pressure falls when standing up / sign of possible dehydration]." The facility nurse documented the neurologist's Blood Pressure findings on 2/10/09. However the record lacked further evaluation or documentation of orthostatic vital signs as a follow-up to the physicians' exam findings. Z4's 3-month follow up note to 1/13/09, dated	W9999		

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W9999	Continued From page 54 4/14/09, included, "Follow-up on falling... Z3 reports that there is a PT at group home, but does not get reports... neurologist had recommended further PT. Z3 reports [R48] seems stiff. I recommended that Z3 discuss with R48's psychiatrist the possible use of Cogentin to see if it would reduce muscle stiffness and reduce falls. Requested that any recent PT information be sent to me." A nurse's note, dated 4/14/09, documented Z4's comments, however, there is no evidence that Z4's comments were followed-up by the facility. E5 (Director of Nursing) was interviewed on 7/10/09, at approximately 12:00 PM. She confirmed the above nurse's notes. E5 stated that nursing was aware of the physicians' findings and recommendations, but there is a lack of documentation regarding follow-up. E5 said that R48's orthostatic blood pressures should have been, but were not, checked after the doctor's findings. She said that R48 had not received PT training as recommended by the physician in 10/08. E5 stated that the nursing department does not monitor R48's falls for trends and patterns. E5 is not aware of any Special Team meeting (STM) regarding R48's falls. The Physical Therapist's (Z5's) note, undated, documents that she had acknowledged the physician's (Z4) request for a repeat PT evaluation on 10/17/08, but that she had already provided training to the staff and resident and "Per my professional opinion, the recommended PT intervention on the physician order dated 10/17/08 is not an appropriate one for R48 due to	W9999		

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W9999	Continued From page 55	W9999		

her limited mental capacity, the increased possibility of her falling and concerns related to her safety." The record lacked a repeat evaluation as recommended by the physician.

Z5 was interviewed on 7/10/09, at 10:50 AM. She felt that her 6/08 recommendation of a gait belt, used as needed, was adequate, and did not recommend the use of a walker because R48's falls do not occur when she is ambulating, just when standing. She felt that this was not a physical therapy concern that she could prevent; however Z5 stated that she had never witnessed R48 fall.

R48's QMRP, E23, was interviewed on 7/10/09, at 11:45 AM. E23 stated she has been R48's QMRP for only 4 months and assumed that the falls were being addressed.
She stated that she does not monitor the falls for trends and patterns but does keep a list of the number of falls. However she confirmed that her current list from 4/1/09 to present does not include all the falls that are documented in the nursing progress notes. She stated that she is not aware of any Special Team meeting regarding R48's falls and that usually falls are reviewed at the annual staffing. She stated she assumed that nursing was taken care of the physicians' recommendations

R48's record was reviewed. There is no evidence of any monitoring R48's falls for trends and patterns. Interventions that were put into place for prevention of further falls is not evident in the record, including recommendations made by the physician and family.

The HRC minutes were reviewed for the past

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W9999	Continued From page 56 year. They lacked documentation regarding trends, causes, and recommendations, along with implementation of safety measures addressing R48's continued falls. The last available minutes were dated 3/4/09. The most current minutes from 6/10/09, were not available. Z2 and Z3 were interviewed. They stated that they, and the facility, are trying to find out the reasons for R48's falls, and that she even falls at home. They stated that in the last year the only Interdisciplinary Team Meeting that has taken place regarding R48, was the annual meeting in the fall of 2008. The above findings in the record and HRC minutes were confirmed during interview with the Administrator, E1, on 7/15/09. She stated that the minutes from 6/10/09 were not yet typed and unavailable. She confirmed that there had not been a Special Team Meeting regarding R48's falls nor has her level of supervision been discussed for increased safety. She also confirmed that R48's IHP does not include a priority objective for safer ambulation. She stated R48 has a history of falls and has not sustained a major injury because she just falls on her knees. E1 stated that she is part of the subcommittee that reviews all incidents for patterns and trends but has not documented the conversations she has had with the different disciplines and the family regarding R48's falls. She confirmed that the PT evaluation was last done 6/08, even though the physician requested a re-evaluation along with therapy. She stated that the annual PT evaluation, along with the gait belt, new shoes, knee pads and orthotic inserts, were interventions to make R48 safer. However she	W9999		

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W9999	Continued From page 57 confirmed that the falls continue even though these interventions have been in place for months. (A)	W9999		