STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING _____ B. WING _____	C 06/05/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(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 295	Continued From page 29 Services Director) on 5/20/09 at 10:08 AM. E6 was asked why R3 had a seat belt on? E6 related "it's a policy to have seat belts on in wheelchairs at all time. She had to have it on."	W 295		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.810a) 350.1080a) 350.1082a) 350.1082b) 350.1082c) 350.1082d) 350.1082h) 350.3240a) Section 350.810 Personnel a) Sufficient staff in numbers and qualifications shall be on duty all hours of each day to provide services that meet the total needs of the residents. Section 350.1080 Restraints a) The facility shall have written policies controlling the use of physical restraints including, but not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, wheelchair safety bars and lap trays, and all facility practices that meet the definition of a restraint, such as tucking in a sheet so tightly that a bed-bound resident cannot move; bed rails used to keep a resident from getting out of bed; chairs that prevent rising; or placing a resident who uses a wheelchair so close to a wall that the wall prevents the resident from rising. Adaptive	W9999		

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W9999	Continued From page 30 equipment is not considered a physical restraint. Wrist bands or devices on clothing that trigger electronic alarms to warn staff that a resident is leaving a room do not, in and of themselves, restrict freedom of movement and should not be considered as physical restraints. The policies shall be followed in the operation of the facility and shall comply with the Act and this Part. c) Physical restraints shall not be used on a resident for the purpose of discipline or convenience. Section 350.1082 Nonemergency Use of Physical Restraints a) Physical restraints shall only be used when required to treat the resident's medical symptoms or as a therapeutic intervention, as ordered by a physician, and based on: 1) the assessment of the resident's capabilities and an evaluation and trial of less restrictive alternatives that could prove effective; 2) the assessment of a specific physical condition or medical treatment that requires the use of physical restraints, and how the use of physical restraints will assist the resident in reaching his or her highest practicable physical, mental or psychosocial well being; 3) consultation with appropriate health professionals, such as rehabilitative nurses and occupational or physical therapists, which indicates that the use of less restrictive measures or therapeutic interventions has proven ineffective; and 4) demonstration by the care planning process that using a physical restraint as a therapeutic intervention will promote the care and services necessary for the resident to attain or maintain	W9999		

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W9999	Continued From page 31 the highest practicable physical, mental or psychosocial well being. (Section 2-106(c) of the Act) b) A physical restraint may be used only with the informed consent of the resident, the resident's guardian, or other authorized representative. (Section 2-106(c) of the Act) Informed consent includes information about potential negative outcomes of physical restraint use, including incontinence, decreased range of motion, decreased ability to ambulate, symptoms of withdrawal or depression, or reduced social contact. c) The informed consent may authorize the use of a physical restraint only for a specified period of time. The effectiveness of the physical restraint in treating medical symptoms or as a therapeutic intervention and any negative impact on the resident shall be assessed by the facility throughout the period of time the restraint is used. d) After 50 percent of the period of physical restraint use authorized by the informed consent has expired, but not less than five days before it has expired, information about the actual effectiveness of the physical restraint in treating the resident's medical symptoms or as a therapeutic intervention and about any actual negative impact on the resident shall be given to the resident, resident's guardian, or other authorized representative before the facility secures an informed consent for an additional period of time. Information about the effectiveness of the physical restraint program and about any negative impact on the resident shall be provided in writing.	W9999		

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W9999	Continued From page 32 h) The plan of care shall contain a schedule or plan of rehabilitative/habilitative training to enable the most feasible progressive removal of physical restraints or the most practicable progressive use of less restrictive means to enable the resident to attain or maintain the highest practicable physical, mental or psychosocial well-being. 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: The facility failed to ensure that policy and procedures were implemented to prevent neglect for two of two individuals (R1, R3) in the sample who were found with a wheelchair seat belt around their neck and in cardiac arrest. Findings include: 1.) R1 is a 56 year old individual with the diagnosis of Profound Mental Retardation, Obsessive Compulsive Disorder, and Downs Syndrome per Individual Service Plan (ISP) dated 8/13/08. R1's ISP, under the title "Leisure/Recreation", states "she stands alone and walks independently." Listed under Strengths on page 8 is "(R1) alternates feet when going up and down stairs. (R1) is able to pick up a full bag of items, carry it 20 feet, and set it down."	W9999		

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W9999	Continued From page 33 A wheelchair assessment was completed on R1 on 7/24/08. It states that individual uses a wheelchair as needed with the explanation added of long distances. A Physical Therapy Assessment was completed on R1 on 7/24/08 which lists all extremities as within functional limits (WFL). It also lists device as none; assists needed, none;balance, good; stride, good; endurance, as tolerated; deviations is blank; and posture is erect. Under Plan it states, "no structured physical therapy program is required at this time. Encourage resident to participate in activity programs to promote flexibility strength and endurance." Under recommendations is the statement, "resident may use wheelchair PRN for mobility." Documented on the Program Progress note dated 2/4/09 is the statement R1, "was found in the shower room, strapped in her chair, with the chair on top of her." Investigation report dated 4/4/09 reveals that on 4/4/09 at 6:54 AM, R1 was found in the television lounge on the 3rd floor with her body sliding out of her wheelchair, and the seat belt of the wheelchair obstructing her air flow. R1, was cyanotic and had no pulse. Cardiopulmonary Resuscitation was started by E3 (Registered Nurse / RN). R1, was transported to the hospital by ambulance. The investigatory report relates that nine staff were on the floor at the time of the incident. None of the nine staff members were located in the television lounge according to the report dated	W9999		

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W9999	Continued From page 34 4/4/09. Observation of the television lounge on 5/19/09 at 1:30 PM reveals a room approximately 16 feet long and 12 feet wide with two entrances both on the same side with a full wall approximately three feet in length coming into the room in the middle of the two entrances. This wall provides for two blind areas in the room, one on each side of each entrance. In order for staff to monitor these areas they would need to come to the middle of the room. An interview was conducted on 5/19/09, at 3:10PM, with E4 (Qualified Mental Retardation Professional / QMRP) regarding the use of the wheelchair for R1. E4 related that a physical therapy evaluation had been done on R1 that revealed that R1 only needed to use a wheelchair for long distances and only on a PRN basis. When asked about the use of a seat belt, E4 related, "we have a policy that anyone in a wheelchair must have a safety belt. We were having a lot of falls." Another interview was conducted on 5/20/09 at 10:20 AM with E1 (Administrator) regarding the use of seat belts in wheelchairs. E1 stated that the facility had never had a policy requiring all individuals in wheelchairs to be seat-belted. E1 stated that the day training bus had a requirement that anyone riding the bus to day training must have seat belts on the wheelchairs. E1 went on to state, "we just had so many standing up and falling. It was to keep them safe." On 5/20/09 at 8:30 AM E3 (RN) was interviewed. This surveyor asked if it was typical for R1 to be	W9999		

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W9999	Continued From page 35 in a wheelchair? E3 stated, "it was. She isn't now." Surveyor asked E3 for reason that R1 was in a wheelchair? E3 stated that she really didn't know why R1 was in a wheelchair but that sometimes R1 walks and other times she sits down and "you can't make her go anywhere." E3 was asked if anyone monitors the television lounge and how it is used by the clients. E3 related that the clients go into the lounge area after receiving their morning medications. They just kind of come and go. E3 stated "no one monitors the TV room." R1 was discharged from the hospital on 4/8/09 with the diagnosis of strangulation and aspiration pneumonia. Z8 (Physician) wrote in the discharge summary dated 4/8/09 "she had petechia about her face and obvious ligature marks across the neck from the incident." 2.) R3 is a 49 year old individual who has the diagnoses of Profound Mental Retardation and Downs Syndrome per Individual Service Plan (ISP) dated 7/17/08. R3 is ambulatory with the assistance of a wheeled walker as described in ISP. R3's ISP states, under Functional Skills, that R3 was seen on 6/5/08 for a Physical Therapy Assessment. The outcome from that assessment was as stated, "no structured physical therapy program is required at this time; staff is to encourage (R3) to participate in activities to promote flexibility, strength, and endurance. Recommendations are for (R3) to continue ambulation with wheeled walker as tolerated. R3 uses a wheelchair for long distances, a walker for	W9999		

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W9999	Continued From page 36 ambulation, and a shower chair for bathing. When R3 is in a wheelchair she utilizes a breakaway seat cushion for her safety." On page 3 of the ISP dated 7/17/09, under Pre-Vocational/Vocational Education, it states, "Occasionally she sits down on the floor and needs staff assistance to get up. She uses her wheelchair to get around. She transfers herself from the wheelchair to the chair." Page 9 of the ISP states, under secondary needs, "maintain gross motor skills, continue regular mobility as tolerated. Increase domestic skills, ambulating to dining room." There are no long term or short term goals in the ISP to address her use of the wheelchair. A six month staffing review was held on 1/31/09 for R3. The first page of the staffing states that R3 falls occasionally without serious injury. There was no mention of R3 using the wheelchair for mobility noted in the documentation. The Program Progress Note, dated 4/30/09, at 5:45 AM, relates that R3 was in a wheelchair with the seat belt in place. R3, "pitched body forward, tipping over wheelchair and striking head on floor." R3 then appeared to be having a seizure. No prior seizure activity is documented. R3 experienced a large edematous area on the left side of her forehead, near her hairline. R3 was transported to the hospital for follow up. R3 returned to the facility on 5/01/09 at 10:30 AM from local hospital per Program Progress Note. On 5/3/09, at 8:30 AM a Program Progress Note	W9999		

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W9999	Continued From page 37 related that R3 is in the wheelchair for safety. Per the incident investigation, conducted by E6 (Residential Services Director) on 5/6/09 at approximately 5:30 AM, R3 was found in the television lounge on the second floor with the seat belt from her wheelchair wrapped around her neck. R3 was unresponsive and did not have a pulse. Cardiopulmonary Resuscitation was initiated by staff and prior to the arrival of the ambulance, R3 had regained consciousness. Upon review of the investigatory report, at the time of the incident, there were 10 staff present on the unit. None were located in the television area. A consultation report, written by Z9 (Neurologist) states, "the staff is unsure why she had a gait belt on the chair rather than her usual buddy belt, and that is being evaluated at the (facility)." An interview, was conducted with E6 (Residential Services Director) on 5/20/09 at 10:08 AM. E6 was asked why R3 had a seat belt on? E6 related "its a policy to have seat belts on in wheelchairs at all times, she had to have it on." (A)	W9999		