STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G288	A. BUILDING _____ B. WING _____	R-C 12/11/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANTHAK HOUSE	724 SECOND AVENUE OTTAWA, IL 61350

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{W 154}	Continued From page 10 E1, RSD, was interviewed on 12/04/09 at 11:50 AM and asked if there was an investigation concerning this incident. E1, related that there had not been an investigation because, "we knew where the pills had come from." The facility, did not provide a reproducible investigation including review of R4's supervison, environmental factors or a result to ensure safeguards were put in place.	{W 154}		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.700b) 350.1060e) 350.1210 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 350.700 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.	W9999		

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W9999	Continued From page 11 Section 350.1060 Training and Habilitation Services e) An appropriate, effective and individualized program that manages residents' behaviors shall be developed and implemented for residents with aggressive or self-abusive behavior. Adequate, properly trained and supervised staff shall be available to administer these programs. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. These Requirements were not met as evidenced by: Based on record review and interview, the facility failed to implement their policy on neglect for 1 of 1 individual in the sample who required emergency intervention and hospitalization after a failed suicide attempt. (R4) Findings Include: A review of Policy Number 5.24, which has a revision date of 11/08, states, "Neglect: Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. (See 42 CFR Part 488.301.)" The facility failed to implement their policy 5.24 and failed to provide a safe and secure environment for R4, after a suicide attempt that required hospitalization and treatment. The facility did not investigate the incident, nor did it implement safety precautions, when R4 was released from the hospital.	W9999		

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W9999	Continued From page 12 Per Individual Service Plan (ISP) dated 2/6/09, R4 is a 59 year old individual with diagnosis of Moderate Mental Retardation, Major Depression, and Seizure Disorder. On page 2 of the ISP it states, "...has no recent record of seizure activity." The ISP, dated 2/6/09, under "Behavior" makes no mention of suicidal thoughts or actions. It does state that R4, "does not display the following maladaptive behaviors: hurtful to self,...." R4 had a Self Administration of Medication Assessment (SAMA) completed on 1/9/09. There is no identification of the person performing the screening noted on this form. This form is all inclusive in its assessment of R4's ability to self administer medication. All areas are marked "yes" indicating that R4 is capable of self administration of medication. This is demonstrated by various statements such as #8, "Person takes the medication in the prescribed way." E2, Registered Nurse (RN) wrote on a Progress Note dated September 2009 that on 9/29/09, R4 was taken to local hospital's Emergency Room (ER) for evaluation and was admitted for observation. E1, Residential Services Director (RSD) was interviewed on 12/04/09 at 11:20 AM. When asked by the surveyor whether the facility had reported the hospitalization of R4, E1 stated, "we didn't report it, my boss said it wasn't a change in status, (R4) was put in for observation." When E1 was asked the nature of the illness that	W9999		

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W9999	Continued From page 13 contributed to the hospitalization of R4, E1, stated that R4 had ingested asprin that she had stolen. During an interview with E1, at 11:45 A.M. on 12/04/09, E1 related that the medication that R4 ingested had been stolen from a local box store, "I had taken them away and put them in my office." A Safety Committee (P29) form dated 9/30/09 was produced. On this form was a "Summary of Incident" that states that R4 informed E1 that she had taken a "bottle of pills." R4 explained to E1 that she had gotten the pills in the RSD's office and related initially that she had taken them because she "had a headache." E1 contacted E2, RN and then called 911 and requested an ambulance transport R4 to the hospital. During the treatment at the emergency room, R4 received activated charcoal and had a blood test taken that indicated an elevated level of aspirin in her blood stream. R4 also told a Psychiatrist that "she didn't want to live anymore." R4 was treated for the overdose of aspirin with activated charcoal, and was admitted to the Psychiatric unit of the hospital. The Discharge Instructions dated 10/05/09 from the hospital relate that R4 was discharged on 10/06/09. These instructions indicate that R4 has a safety plan in place and that it was reviewed with R4 prior to discharge. The Discharge Summary dated 10/06/09 relates that R4, "took close to 100 pills of aspirin 81 milligrams." This summary relates that the "only problem with (R4's) metabolic disturbance, because of the aspirin, is that she developed a couple of seizures."	W9999		

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W9999	Continued From page 14 E1, RSD, was interviewed on 12/04/09, at 11:50 AM, and was asked if there was an investigation into this incident, if there was a special staffing or special precautions implemented, and if there were changes in R4's ISP? E1 related no special staffing had been done, there were no special precautions in place and there had been no changes to R4's ISP. E1 related that all that had been done, in regards to this incident, was what the safety committee had said to do. "If she steals something take it back, don't put it in the office." E1 related that staff were trained on that. E1 also related that R4 had not experienced a seizure for many years prior to the ones she had while hospitalized. Upon review of the Safety Committee minutes dated 9/30/09, the only finding is "Medication will not be stored in an office. Stolen items will be returned to the store immediately." Review of the Inservice Education/Meeting Report dated 11/20/09, conducted by E1, RSD has listed as one of its objectives, "shopping safety practices." There is no reproducible information that explains what this training objective accomplished. R4's Behavior Management/Resident Rights Committee dated 10/30/09 was reviewed. Under "Behavior Report" there is no mention of the suicide attempt or the resulting hospitalization. On page 2 of this report is a section titled "Discussion/Comments:" This section states, "last visit with (Psychiatrist) was 8/7/09 for psychotropic medication management. He noted that she is having minimal behaviors, not throwing the phone, and no crying. Occasional irritability, stable. Orders to continue present	W9999		

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W9999	Continued From page 15 management." E1 was interviewed on 12/04/09 at 2:10 PM in the dining room. E1 was asked why the Behavior Management Plan that was written and reviewed on 10/30/09 did not address the suicide attempt on 9/29/09. E1 related the committee will not be notified of this until the following quarter because the suicide attempt occurred at the end of the quarter, on 9/29/09. It will not be reviewed until the next quarter. This surveyor specifically asked E1 whether the Specially Constituted Committee was aware/informed of the suicide attempt by R4? E1 stated, "no." (A)	W9999		