STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G109	A. BUILDING _____ B. WING _____	C 05/05/2010

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ROYAL LIVING CENTER, INC	200 SOUTH 9TH STREET NEW BADEN, IL 62265

(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 105 fully implement and evaluate the effectiveness of their plan.	W 449		
W 460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on interview and record review, the facility has failed to ensure that individuals receive a specially prescribed diets for 1 of 1 individual (R3) who has orders for a regular diet with seconds as requested. Findings include: The Physician Orders (dated 02/01 - 02/28/10) identifies that R3 has orders for a regular diet with seconds as requested. R3's Speech and Language Development Evaluation dated 04/01/09 states that he is non verbal with profound sensorineural loss in both ears and wears an aid in his right ear. E6 (Direct Care Staff/part time cook) was interviewed on 03/09/10 at 2:55 P.M. and stated, "R3 does not get seconds on foods. Once I gave him (R3) an extra piece of chicken and E4 (Direct Care staff) took it off his plate and threw it away. She (E4) told me that no one gets seconds on food."	W 460		6/11/10
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS	W9999		

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W9999	Continued From page 106 350.1060e) 350.1060j) 350.1070 350.3240a) 350.3240d) 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. j) Appropriate records shall be maintained for 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 350.1070 Training and Habilitation Staff Appropriately qualified staff shall be provided in sufficient numbers to meet the training and habilitation needs of the residents. At a minimum, staffing shall be provided as described in Section 350.810(b) of this Part. 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) d) A facility administrator, employee, or agent	W9999		

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W9999	Continued From page 107 who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act) These Regulations were not met as evidenced by: Based on observation, interview and record review, the facility failed to implement a behavior intervention plan with necessary supervision to ensure that 8 of 16 individuals (R4, R5, R7, R8, R10, R11 and R16) are not subjected to abuse from another individual of the facility (R2). This failure has resulted in incidents of physical abuse to six individuals (R4, R5, R7, R8, R10 and R16) by R2 affecting 6 of 15 individuals living at the facility in the past year. with the potential to affect additional individuals living at the facility (R1, R3, R9, R12, R13, R14 and R15). In addition, the facility has failed to report incidents of client to client abuse by R2 against his peers (R4, R5, R7, R8, R10 and R16) to the Illinois Department of Public Health in accordance with state law which has the potential to affect additional individuals living at the facility (R1, R3, R9, R12, R13, R14 and R15). Findings include: The Physician's Order sheet dated 02/01/10 to 02/28/10 identifies that R2 is a 40 year old male who functions at a mild level mental retardation. In reviewing the Maladaptive Behavior Records for R2 from 01/10/09 to 12/18/09, eighteen behavioral incidents were noted, which include: 01/30/09 "Slamming doors almost all night.	W9999		

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W9999	Continued From page 108 Threw cup after snack at 8:30 P.M.. R2 admitted to slamming door on Z1's (code used by the facility for R4) (L) (left) arm..." 04/16/09 "R2 when came home found out one of the staff was not going to be here went over to Z006's (R4's) wheelchair and pushed it, then stomped down the hall and slammed the door to his bedroom several times was told no through out out the night slammed the door several times throughout the night during programs was told to get something to do went down the hall Z006 (R4) just got out of the room and I (E7 Direct Care staff) was in front of the door to make sure Z006 (R4) did not get hurt when he slammed the door in my face..." 05/28/09 "R2 has been throwing himself on the floor slamming door to bedroom. Has slammed the door so much that the door is cracked and coming apart..." 07/29/09 "As R2 was going for a walk around the track, R2 took his glasses off and threw them on the ground. After being asked to pick them up he got them and then turned and head bumped Z013 (R7) in the back of the head twice with his forehead. R2 just continued walking afterwards, talking to himself." 08/04/09 "Tonight, R2 had been slamming doors on and off. However, around 7:30 (P.M.) I (E16 Direct Care Staff) had asked R4 to go back to his room so that we could do his upper and lower body exercises. Yet as R4 was going back to his room, nearing the doorway, R2 slamed (slammed) the door to the room right in R4's face. R4 was not physically hurt, but he was very shaken... I used the sign language book to sign	W9999		

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W9999	Continued From page 109 to R4 that he needs to talk to E1 (QMRP) about switching room and the issue between R2 and him..." 10/28/09 states, "R2 was coming out of the kitchen with his drinks and went right for Z013 (R7) hitting her in the head causing her to scream and react. He continued to get his breakfast while talking to himself about hitting his peer. Later when getting his eggs he again charged at another peer Z015 (R8) almost knocking her food out of her hands. Once he was done eating and was going to take his dishes to the cart Z011 (R5) was putting her things in the cart and he charged at her as well..." R3's bedroom door was observed on 03/16/10 at 1:20 P.M. with E13 (Direct Care Staff in training). The wood on R2's door was cracked in the middle by the latch, causing the wood of the door to split. R2's Behavior Program dated 01/25/10 states that he has inappropriate behaviors of throwing his drinking glass/other objects at other, hit a peer while walking past them on the way to his room, slam his room door shut and or throwing himself on the floor. Interventions within this program states, "Remember: How you approach him is very important. Always ask in a soft, friendly respectful tone of voice. Offer him choices as much as possible of when to complete tasks. Avoid bossing or telling him that he has to do something right now. If his response to you is negative or non-compliant, offer to come back later. Do not allow requests to take his medication, bathing or other activities of daily	W9999		

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W9999	Continued From page 110	W9999		

living to lead to a behavior. Ask him and then if he says "no" or is otherwise non compliant in his response to you, then stop asking, It is not worth the behavior it may cause. When he does any of these behaviors, he will be asked to come out of his room and sit for 15 minutes in his seat at the table where he takes his breaks. Since he can tell time, he will monitor when his 15 minutes are up..."

This program does not identify what safeguards are put in place after incidents of R2's aggressive behavior or what staff are to do if R2 refuses to come to the dining room after his behavior.

E7 (Direct Care Staff) was interviewed on 03/10/10 at 3:55 P.M. and stated, "R2 throws things. He threw a bookcase, cans of furniture polish and shoves others. It was so bad at one time he used to drink out of a foam cup because he was slamming and throwing his glass.

E9 (Direct Care Staff) was interviewed on 03/09/10 at 3:28 P.M. and stated, "R2 has temper tantrums. He pushes others and throws items. I have seen him throw a shoe at his roommate (R4). I don't know about him throwing forks and plates, but I know he slams the dishes down..."

Z3 (R4's guardian) was interviewed by telephone on 03/10/10 at 8:23 A.M.. and stated, "R4 is deaf and has his own form of sign (language). He's in a wheelchair and I'm not sure if he can move quick enough to get out of R2's way. He's complained to me about R2 and that R2 had taken money out of his room. I am concerned about R4 being in the same room with R2. I went up there (to the facility) and the window was broken in the bedroom. (Z3 was unsure of the

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W9999	Continued From page 111 date but thought that it occurred in the summer.) There was a piece of plywood over the window. A staff rep (representative) (unsure which staff) said that R2 threw a shoe through the window. I talked with E17 (prior QMRP/Qualified Mental Retardation Professional) and no one has ever said anything else about R2's behavior to me..." E1 (QMRP) was interviewed on 03/12/10 at 9:40 A.M. and stated, "I am not aware of R2 throwing a bookcase or breaking a window in his bedroom." E1 then called for E4 (Direct Care Staff) and asked her if she was aware of R2 throwing a bookcase or breaking a window. E4 stated, "R2 could have but it was not recent. He did not throw the bookcase he pushed the bookcase over. I'm not aware of the broken window." E7 (Direct Care Staff) was interviewed on 03/12/10 at 11:10 A.M. and stated, "R2 threw the bookcase last summer or last fall of 2009." In reviewing the Shift Change log from 06/09 to present, no documentation was noted regarding R2 throwing and or pushing over a bookcase. It was noted that R2 has had twenty eight documented incidents of physical aggression towards others and/or to himself. Only four of these twenty eight behavioral incidents are documented on a Maladaptive Behavior Record sheet (07/29/09, 08/04/09, 10/28/09 and 12/03/09). Examples of the Shift Change log documentation includes: 06/06/09 "... throwing glasses in kitchen, slamming doors, jumping getting some residents upset..." (The names of these residents are not identified.)	W9999		

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W9999	Continued From page 112 06/12/09 "...throwing silverware at the table..." (The names of the individuals that were present at the table and or that were in the dining room are not identified.) 06/13/09 "... slamming doors, and throwing coat hangers towards R4's (roommate's) side of the room..." 06/14/09 "... went off slamming doors, jumping on floor, turned over, pushed over book shelf, broke small door and some glass item..." 07/29/09 "...head butted R7 in the back of the head..." 08/01/09 "... throwing self on the floor..." 08/04/09 "... was throwing fits every since he foot off workshop bus. He was slamming door on his roommate (R4) and throwing himself on floor... He needs to be watched so that he doesn't harm himself or peers. R4 was very mad after the door to his bedroom was slammed in his face when he tried entering. He gestured to staff (staff name not identified) that this made him mad and he showed staff the empty bed in R10's room. Apparently he is feed (fed) up and wants to have a different roommate so he no longer has to deal with his current roommate." 08/11/09 "... threw his glasses at a new girl on the bus and hit R9 in the head." 08/18/09 "... threw his empty laundry basket at R4 while R4 (roommate) was bringing the mop bucket into the laundry room... slamming his door again tonight. R4 avoided sitting next to R2 during snack..." 09/20/09 "...threw a hangar across his room and it hit R4 (roommate) in his head and knocked off his pictures on his box in the corner. R4 really upset..." 09/25/09 "... got upset with R9, threw dishes couple times staff had (to) calm him down..." (The names of the individuals that were present	W9999		

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W9999	Continued From page 113 at the table and or that were in the dining room are not identified.) 10/25/09 "... grabbed R4's (roommate's) wheelchair and pushed it. R4 was upset. R2 slamming doors, running down hallway..." 10/28/09 "... had a few behaviors this morning. Charged @ (at) R7, R8 and R5 at separate times." 11/10/09 "...throwing himself to the floor..." 11/12/09 "...throwing himself on the floor..." 11/17/09 "... Throwing himself off bed and slamming door tonite..." 12/06/09 "... hitting R16 with newspaper - slamming doors..." 12/17/09 (sequential entry is misdated 11/17/09) "... has been throwing himself and things (the things that were thrown were not identified) and slamming doors..." 12/18/09 "... pushed R5 tonight. Right after E4 (Direct Care Staff) left threw his glass of ice into sink slammed the Lien (Linen) door on R8 and slammed his bedroom door..." 12/20/09 "... all morning running throwing self on floor..." 12/29/09 "... attacked R4 (roommate) in his room hit him on top of his head and tried (tried) to pull him out of his chair (wheelchair)..." 01/01/10 "slamming door, running into people (these individuals are not identified)..." 01/28/10 "... very agitated this morning especially right after breakfast. He threw the paper hitting R10 in the face with it..." 02/03/10 "... got upset with R6 couple times pushing table towards R4 getting up stomping off to his room..." 02/12/10 "... slamming doors, hitting peers (the names of the individuals are not identified), acting out all night long." 02/16/10 "... getting upset on bus throwing his	W9999		

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W9999	Continued From page 114 glasses cause (because) R7 tapped him on shoulder..." 02/20/10 " threw his chair and his cup at 8:00 (P.M.) snack..." 02/26/10 "... hit R7 in the kitchen tonight." 03/01/10 "... threw himself on floor." Further review of the Shift Change log documentation identifies R2 as having twenty nine additional behavioral incidents of slamming doors which are noted for 07/25/09, 07/26/09, 07/28/09, 08/02/09, 08/09/09, 08/25/09, 08/26/09, 08/29/09,08/31/09, 09/02/09, 09/15/09, 10/15/09, 10/17/09, 10/18/09, 11/08/09, 11/14/09, 11/18/09, 12/02/09, 12/08/09, 12/09/09, 12/31/09, 01/05/10, 01/13/10, 01/14/10, 01/15/10, 01/22/10, 01/27/10, 02/05/10 and 02/23/10. During the Daily Status Meeting dated 03/18/10 at 3:30 P.M., E1 stated, "R2's behavior has improved over the last few months. I gave you a copy of his last behavior program showing that his behaviors have reduced in the past months." When E1 was asked if the facility had changed R4 as his (R2's) roommate, E1 stated, "No." In reviewing R2's Behavior Program dated 03/04/10, no changes and or revisions were made in program interventions as compared to his program dated 01/25/10. There is no documentation showing that the facility reported incidents of client to client abuse to the Illinois Department of Public Health. E1 (QMRP) was interviewed on 03/11/10 at 2:45 P.M. and stated, "No" when asked if the facility had reported incidents of client to client abuse by R2 against his peers (R4, R5, R7, R8, R10 and R16) to the Illinois Department of Public Health.	W9999		

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W9999	Continued From page 115 (A) 350.620a) 350.1210 350.1220j) 350.1230d)1)2) 350.3240a) 350.3750 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 350.1220 Physician Services j) The facility shall notify the resident's physician of any accident, injury, or change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days.	W9999		

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W9999	Continued From page 116 Section 350.1230 Nursing Services 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. 2) Basic skills required to meet the health needs and problems of the residents. 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) Section 350.3750 Consultation Services and Nursing Services Residents needing nursing care shall be admitted to an ICF/DD of 16 Beds or Less only if the facility has adequate professional nursing services to meet the resident's needs. Arrangements shall be made through formal contract for the services of a licensed nurse to visit as required. A responsible staff member shall be on duty at all times who is immediately accessible, and to whom residents can report injuries, symptoms of illness, and emergencies (see Section 350.810(a)). The consultant nurse shall provide consultation on the health aspects of the individual plan of care and shall be in the facility not less than two hours per month. These Regulations were not met as evidenced by: A) Based on interview and record review, the facility failed to develop and implement policy and	W9999		

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W9999	Continued From page 117 procedures for Seizures for 1 of 1 individual in the sample (R8) who was hospitalized on 09/25/09 after seizuring for over two hours and again on 03/05/10 after her last seizure (of three) lasted more than twenty minutes and she became choked. R8 does not have an individualized seizure protocol, nor does staff notify nursing personnel or emergency services for R8 after seizing longer than five minutes as per the facility's seizure protocol. This failure has the potential to affect 4 additional individuals who have diagnosis a of Seizure Disorder (R1, R2, R4 and R16). B) Based on interview and record review, the facility failed to ensure that nursing staff promptly assesses individuals after accidents, signs of infections, after the discovery of open sores, and when exhibiting cold and flu symptoms, and makes referrals when needed for preventative services for 4 of 16 individuals (R1, R4, R8 and R14) in the facility. This failure has the potential to affect 12 additional individuals of the facility (R2, R3, R5-R7, R9-13, R15 and R16). C) Based on interview and record review, the facility failed to develop and implement policy and procedures for Head Injuries for 3 of 3 individuals in the sample (R1, R7 and R8) who sustained head injuries. After these injuries, no neurological checks were completed by facility staff. Findings include: A) The facility failed to develop and implement policy and procedures for Seizures. The facility's undated protocol for Seizure	W9999		

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ROYAL LIVING CENTER, INC	200 SOUTH 9TH STREET NEW BADEN, IL 62265

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W9999	Continued From page 118 Disorder (Epilepsy) for general interventions states, "Individualize seizure protocol with caregiver training: a) description of the person's normal seizure pattern(s), b) safety interventions, c) degree of safety precautions in the home and community, d) caregiver instruction if person has a seizure and who to notify, when to call 911 and the administration of PRN (as needed) medications if ordered..." This protocol also states that staff are to call 911 if ... two or more seizures occur without full recovery of responsiveness between seizures (unless the seizure protocol directs otherwise) ... When a seizure lasts for more than 5 minutes (unless the seizure protocol directs otherwise)..." The Physician's Orders sheet dated 02/01/10 through 02/28/10 states that R8 is a 58 year old female who functions at a Mild level of mental retardation and has a diagnosis of Epilepsy. R8 receives Carbatrol Capsule 300 mg (milligrams), Lamictal 200 mg, Lamictal 25 mg (two tablets) every 12 hours, Klonopin 1 mg tablet at bedtime and Zonisamide capsule 100 mg three times daily for Epilepsy. R8's Interdisciplinary Team meeting report dated 01/21/10 does not contain any type of individualized seizure protocol. A seizure report dated 09/23/09 states, "Multiple Seizures 4:55 - 6:15 P.M." The Transporter Report dated 09/23/09 states that after R8 was assessed, "Pt (patient) had 1 grand mal seizure lasting 1 min and was post ictal for 4-5 minutes. Pt was given 5 mg Valium while seizing..."	W9999		

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W9999	Continued From page 119 R8's Nurse's Notes dated 09/24/09 states, "To ER (Emergency Room). Seizures on and off past hour. No seizures in ER. Ativan 2 mg IV (Intravenous) Push... Admitted for observation. Further review of R8's Seizure Reports identifies that R8 continued to have seizure activity. These reports state: 10/24/09 R8 had a seizure for 10 minutes or more while watching TV and, "just that quick R8 went onto the floor. I called for help...two other staff came to help with R8's care." 10/31/09 R8 went to take a shower... heard and (a) thud ... She (R8) was lying there shaking... She (R8) was very confused at this time..." This report states that R8's post seizure state lasted 20 minutes. 11/21/09 "... R8 woke up coming out of a seizure very dizzy-talking out of it..." R8's Nurse's Notes dated 12/14/09 states, "Report seizures to myself so can call Z8 (Neurologist)." 01/28/10 R8 had a seizure lasting 10 minutes and 30 seconds while showering and then, "... fell out of the chair onto the floor of the shower. While on the floor she gradually came out of the seizure but did not respond to staff. At this point she was asleep. She lay there for awhile before awaking (awakening) and was confused when she came to." R8's Nurse's Notes for 01/28/09 identifies that E3 (RN Consultant) was notified of R8's seizure activity lasting ten minutes. No further entries are	W9999		

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W9999	Continued From page 120 noted in R8's Nurse's Notes until 03/05/10 even though E3 had identified on 12/14/09 that staff were to report R8's seizure activity to her. Further review of R8's Seizure Records identifies: 02/22/10 At 8:40 P.M. R8 seized for 5 minutes,"... in the middle of taking her shower... She sat still in the chair completely relaxed but with her head down as if sleeping." 02/25/10 "R8 was very confused when staff asked her to come out for meds. She didn't know where she was and had excessive drool all over her clothes." The duration of R8's seizure was marked as "unknown". 02/27/10 R8 seized for 3-5 minutes when "leaving out the bathroom from shower. She went into a seizure. She hit the bathroom floor. Seized for at least 3 minutes. 3 staff assisted her back to her room. Seemed ok (okay) when she got to her room." A Seizure Report dated 03/05/10 from the outside day training site states that at 2:10 P.M., R8 had a five minute seizure while working. Z9 (Day Training Production Assistant)documented that R8's "lips were bluish" and that she lost bladder control. R8 was assessed by Z10 (RN - Day Training) and found to have a temperature of 102.3 degrees. At 2:40 P.M., Tylenol 325 mg was given for R8's temperature. At 3:00 P.M., R8's temperature was 101.1. Z10 documented that she spoke with E3 (RN Consultant) and was told (by E3) to send R8 home on the bus (near the end of the work day). Z6 (RN - Day Training) was interviewed on	W9999		

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W9999	Continued From page 121 03/10/10 at 11:45 A.M. and stated, "Z10 assessed R8 on 03/05/10. She called me because she wasn't familiar with R8 and was having difficulty in getting ahold of E1 (QMRP) or E3 (RN Consultant) after she seizured. Our protocol is to send someone to the hospital after seizing longer than five minutes, but we did not have any type of seizure protocol for R8. When the nurse finally called back, we were told (by E3) to send her home on the bus." The facility's Shift Change Book for 3/5/10 states, "R8 had 3 seizures today. Called ambulance last one lasted 25 minutes." This entry was signed by E8 (Direct Care staff in training). During a telephone interview with E8 on 03/10/10 at 7:45 A.M., E8 stated, "No" when asked by the surveyor if she had been informed that R8 had been running a 102.3 temperature during the day at workshop on 03/05/10. The Seizure Report dated 03/05/10 identifies that at 8:20 P.M., R8 seizured for over twenty minutes and that her lips and finger tips were turning blue before the nurse was contacted. E8 (Direct Care Staff in training) was interviewed by telephone on 03/10/10 at 7:45 A.M. and stated, "I was working with E11 (Direct Care Staff) on 03/05/10. I knew she (R8) had had a seizure at workshop and they had sent me to get her but they had already sent her home on the bus. She (R8) was folding laundry when she had her last seizure that lasted about 20 - 25 minutes." When E8 was asked by the surveyor why staff waited twenty five minutes before calling E3 (RN Consultant), E8 stated, "R8 was choking on her saliva... That's when we called the nurse (E3) and she (E3) told us to call 911."	W9999		

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W9999	Continued From page 122 The Transporter Report dated 03/05/10 states that R8 was still seizuring when the ambulance arrived at 8:47 P.M.. This report also states that R8 required a total of 10 mgs of Valium during her transport to the hospital. The hospital History and Physical Report dated 03/05/2010 states, "General: In the Emergency Room the patient was noted to be lethargic, initially unresponsive but later on became responsive to pain stimuli and became lethargic and easily goes to sleep, not seizing at this time with the following vital signs: Blood pressure 115/74, pulse of 149, temperature 103, respirations, 28 pulse ox 95..." "History of the Present Illness: ... Patient was noted by the staff having generalized grand mal tonic-clonic seizure... The EMS (Emergency Medical Staff) was called and she was given 10 mg of Valium on her way to the Emergency Room. When the patient arrived at the Emergency Room she was still having some seizure. They gave her some Ativan loaded with Dilantin... Staff said that the patient didn't have any fever today, didn't have any chills and she was not complaining and was taking her medications... Patient is admitted for further evaluation and treatment..." E3 (RN Consultant) was interviewed by telephone on 03/12/10 at 8:26 A.M. and stated, "R8 is being followed by Z8 (Neurologist) for generalized seizures. Staff should have called me when R8's seizures lasted longer than five minutes. If I'm not available, they should call E1 (QMRP) and seek emergency treatment." E3	W9999		

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W9999	Continued From page 123 stated, "No" when asked by the surveyor if an individualized seizure protocol had been developed for R8, or for the four other individuals with diagnosis of seizures (R1, R2, R4 and R16). . B) The facility failed to ensure that nursing staff promptly assesses individuals after accidents, signs of infections, after the discovery of open sores, when exhibiting cold and flu symptoms and makes referrals when needed for preventative services 1) The Physician's Orders sheet dated 02/01/10 through 02/28/10 states that R8 is a 58 year old female who functions at a Mild level of mental retardation and has diagnosis of Epilepsy. The Shift Change log from 11/21 - through 11/29/09 states, 11/21/09 "R8 is coughing and choking on her flem (phlegm)." 11/22/09 "R8 very congested (chest) coughing gave Tylenol Tussin... 10:40 A.M. R8 coughing choking and throwing up flem (phlegm)... R8 about 12:40 very dizzy, was put to bed to rest... R8 was feeling dizzy and has a headache gave her 2 Tylenol at 4:30 P.M. She is very congested. At 10:15 (P.M.) R8 fell trying to walk. E3 (RN Consultant was notified) at 10:30. Took vital signs T= 98.3 P =56 B/P =127/68. E3 said to put her to bed and she should be fine." No evidence is noted of nursing assessing this client's medical needs. No further documentation is noted that staff follow up with temperatures and other vital signs until 11/24/09. 11/24/09 "R8 came home sick vomiting dizzy took vitals 120/64 P. 53 Temp 95.8 3:20 P.M..." 11/25/09 "R8 home sick."	W9999		

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W9999	Continued From page 124 11/26/09 "R8 very dizzy... 11:25 A.M. 146/68 (BP) P 54 (R8's) B. P. has been going up since 11/21/09 (top number)..." No further documentation is noted in these notes until 11/29/09. 11/29/09 "R8 almost fell due to being dizzy in the kitchen at 9:50 A.M.." The Nurse's Notes from 11/21 through 11/29/09 does not identify that the E3 (RN) assessed R8's cough, checked her lung sounds or complaints of dizziness during this eight day period. 2) The Physician's Orders dated 02/01/10 through 02/28/10 states that R1 is a 54 year old male who functions at a mild level of mental retardation. In reviewing direct cares staff's documentation in the Shift Change log, an entry for 02/25/09 states that on the 6:30 A.M. to 2:30 P.M. or 7:00 A.M. to 3:00 P.M. shift that "Health Concerns" were, "R1 coughing." It was also noted that R1 was coughing on 02/27/09, 02/28/09 and 03/01/09. Documentation for 03/02/09 identifies that R1 collapsed twice (at the facility) and was hospitalized (due to seizure activity resulting in a fracture to his ankle.) Documentation for 03/04/09 - 03/11/09 identifies that there were "Health concerns" for R1, however the specific concerns were not identified. On 03/12/09 staff documented on the 3:00 P.M. to 11:00 P.M. Shift Change notes that, R1 has cough for 2 weeks." On 03/14/09 and 03/15/09 documentation states, "R1 coughing all night." On 03/18/09 documentation states, "R1 coughing a lot went to Dr. (doctor) has walking Pneumonia." The Medication Record for 02/01/09 through	W9999		

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W9999	Continued From page 125 02/28/09 identifies that R1 only received cough syrup on 02/26, 02/27 and 02/28/09. The Medication Record for 03/01/09 through 03/31/09 identifies that R1 only received cough syrup on 03/02, 03/12, three times on 03/14, twice on 03/16 and once on 03/17/09. A referral form dated 03/18/09 identifies that R1 was referred to the physician for, "coughing for three weeks." This referral form also states that he had a severe runny nose, was drinking a lot more than usual and was very tired all the time. R1 was diagnosed with Acute Bronchitis r/o (rule out) Pneumonia and was ordered Z-pac (antibiotics), Robitussin DM two teaspoons four times daily and Albuterol Nebulizer 0.5 cc (cubic centimeters) three times daily for one week. The Nurse's Notes from 02/25/09 through 03/18/09 do not identify that the nurse assessed R1's cough, checked his lung sounds or completed vitals on R1 during this three week period. Further review of the Shift Change notes identifies that R1 was noted to have open sores on his right ankle on 06/08/09 and that A & D ointment was put on his ankle. No further documentation is noted in these notes regarding the open sores on R1's ankle until seventeen days later when E1 (QMRP) documented, "... She (Z1 R1's stepmother) asked that we remind R1 to take off his socks when getting home... so that the sores on his leg can heal. The Medication Record for 06/01/09 through 06/30/09 does not identify that any type of ointment and or treatment was applied to the open sores on R1's right ankle on 06/08/08 or on	W9999		

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W9999	Continued From page 126 any other day of the month. R1's Nurse's Notes from 05/29/09 - 06/24/09 do not identify that R1's open sores were assessed by E3 (RN). There is no documentation that R1's open areas were staged or that a plan was developed to heal the open areas on his right ankle caused from wearing the air cast on his right leg. R1's Quarterly Nursing Assessment was completed by E3 on 06/24/09 and does not identify that R1's ankle was assessed and or that the open areas on his right ankle had resolved. No documentation is noted identifying that the physician was notified about R1's open areas. Further review of the Physician Referral Form identifies that R1 was seen by the physician on 05/27/09 for a rash on his groin area that he had had for "two" months. R1 was diagnosed with a fungal infection and was ordered Lotrisone cream BID for two weeks. R1's Nurse's Notes from 03/18/09 - 05/27/09 do not identify that E3 assessed R1's rash and/or that a plan was developed to resolve the fungal infection. 3) The Physician's Orders sheet dated 02/01/10 through 02/28/10 identifies that R14 is a 60 year old female who functions at moderate level of mental retardation and has diagnoses which includes, Partial Hysterectomy and Post Menopausal Syndrome. The facility's standing orders sheet (dated 08/00) states that a Pap (Papanicolaou) Smear is to be completed every two years for females who are not receiving oral contraceptives. In reviewing R14's record, no Pap Smear resulted were noted on file. On 03/18/10, the	W9999		

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W9999	Continued From page 127 facility received a fax copy of R14's Well Women Annual report. R14's Well Women Annual report dated 04/27/09 states that her last PAP was done on 05/07/03. This report also states that R14's cervix and uterus are absent. The Shift Change Log book identifies an entry for 09/06/09 which states, "I noticed a dirty pair of R14's underwear on her bedroom floor. I noticed a spot of blood in her underwear. I wasn't aware of R14 still having a monthly cycle. I think she's just spotting..." There is no further documentation indicating that staff reported the spotting to the nurse and or that nursing assessed R14 after staff noted blood in her underwear. 4) The Physician's Order sheet dated 02/01/10 through 02/28/10 identifies that R4 is a 53 year old male who functions at a mild level of mental retardation and has diagnoses which include, Deaf (ness), Seizure Disorder, and history of Esophageal Ulcer. The direct care Shift Change Notes dated 06/13 -06/14/09 states: "06/13/09 am... R4's stomach hurts around belly button. May need to keep an eye on, he had problems once before... pm ...R4's stomach and head hurts. Threw up at 9:00 PM. Gave (1) Tylenol 500 mg (milligram) at 9:15 PM. Took temp (temperature) in ear and underarm = normal no temp... R4 says he does not feel good..."	W9999		

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W9999	Continued From page 128 "06/14/09 am R4 not feeling well stomach hurts. 131/75 P. (pulse) 88 at 8:15 AM. Called E4 (RN Consultant) - E1 (QMRP)... 11:20 AM 114/73 - P 91... PM 3-11 R4 complaining of stomach hurts wanted to go to hospital. Called E4 said her is not a complainer for us to take to hospital. Took him (R4) to the ER (Emergency Room)... R4 is going to be kept in the hospital. He is going to need a blood transfusion he is a severe anemic they do not (know) were (where) he is bleeding from yet..." E15 (former Direct Care Staff) was interviewed by phone on 03/10/10 at 8:00 P.M. and stated, "R4 is deaf but he signs. His signs are hard to understand. He had a problem with an esophageal ulcer that was bleeding. This happened on a weekend and it was difficult getting ahold of the nurse. I called her cell phone, her house and the E1. Nobody answered the phone. I documented his condition in the shift book and I think I documented his temperature and blood pressure. R4 had to go to the hospital. He was pale and wasn't feeling good. Finally the cook (E7) went and got the sign language book and pointed to the sign for "hospital" and R4 shook his head yes. Nobody knows sign. We had to get the book and try to figure out what signs he was making." E1 (QMRP) was interviewed on 03/12/10 at 9:10 A.M. and stated, "No" when asked if R4 signed to staff, would staff understand what he was signing. E1 also stated, "No" when asked if staff have received training in sign language to communicate with R4. C) The facility failed to develop and implement policy and procedures for Head Injuries. Prior to	W9999		

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W9999	Continued From page 129 03/09/10 the facility did not have policy and procedures regarding Head Injuries. In reviewing the incident reports and Shift Change documentation for the dates of 04/01/09, 05/15/09, 12/02/09 and 12/30/09, the following was noted: The Accident and Illness Report dated 05/15/09 which was completed by day training staff states that R8 was exiting, "... the bus and was talking to another client... When staff (not identified) reached (the) front of the bus, client (R8) was lying with her back to the ground." R8 was assessed and found to have a two inch abrasion to the back of her head and a one cm (centimeter) laceration within the abrasion. It was also noted to have bruising to the base of her tail bone and additional bruises to her back. Neurologicals were completed by the nurse (Z13) and Tylenol was given for complaints of a headache. An Incident Report was completed by the facility which identifies the reader to refer back to the report that was filled out by Day Training. The Shift Change documentation for 05/16/09 states, "6:30 am. to 2:30 pm or 7:00 am to 3:00 pm ... Yesterday AM (morning), R8 fell getting off bus, workshop has purple bruises on bottom butt area. R8's head has a knot on it, had been bleeding and bruised. 3:00 pm to 11:00 pm R8 has bruises on bottom. Tylenol gave last at 10:05 pm..." The Shift Change documentation for 05/17/09	W9999		

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ROYAL LIVING CENTER, INC	200 SOUTH 9TH STREET NEW BADEN, IL 62265

(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 130 states, "6:30 am. to 2:30 pm or 7:00 am to 3:00 pm "Gave R8 Tylenol is in pain, can't sit tailbone, head also hurt (headache)." There is no documentation showing that a neurological assessment was continued on R8 after she returned home from day training to the facility on 05/16 or on 05/17/09. R8's Nurse's Notes do not identify that she was assessed by E3 (RN Consultant) after falling on 05/16/09. (The Shift Change log identifies that R8 was sent to the Emergency Room on 05/16/09 and was placed on bedrest due to her tailbone injury.) The Incident Report dated 12/02/09 states, "When asked R8 what happened after I (E14 former Direct Care staff) got into the room after a loud thump, she said she rolled over and fell out of bed. I asked if she was hurt and she said her head hurt from hitting the corner of the cabinet. I help (ed) her to get back up, checked her head and got her back in bed..." There is no documentation showing that a neurological assessment was completed on R8 after falling and hitting her head on the corner of the cabinet. The Shift Change Log/Incident Reports identifies that R1 fell on 04/01/09 and that R9 fell on 12/30/09, hitting their heads when they fell. 04/01/09 "R1 fell out of bed and banged his forehead." R1 sustained bruising and scratches to his forehead. 12/30/09 "R9 fell off the end of her bed this morning and hit her head real hard. She has a	W9999		