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CHAMNESS SQUARE	340 HERITAGE DRIVE BOURBONNAIS, IL 60914

(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 370	Continued From page 50 the gastrostomy port and the feeding through the jejunostomy site. Z1 said she could not remember ever training staff before but has trained family members. Z1 said she has never been trained in rule 116. Z1 said she did not keep sign in sheets or other documentation of the training. There is no evidence of the competency based training records including route of administration for R2's G tube medications. There is no evidence that staff were trained on all new medications and feedings by a certified nurse trainer.	W 370		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.1210a 350.1230b)6)7) 350.1230d)1)2) 350.3240a) 350.3750 350.3760k) 350.3760l) Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. Section 350.1230 Nursing Services b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in: 6) Development of a written plan for each	W9999		

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W9999	Continued From page 51 resident to provide for nursing services as part of the total habilitation program. 7) Modification of the resident care plan, in terms of the resident's daily needs, as needed. 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. Section 350.3760 Medication Policies	W9999		

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W9999	Continued From page 52 k) All medications taken by residents in this type of facility must be administered by a nurse or physician licensed to practice in Illinois unless the medication is self-administered by the resident. Facility staff shall not administer medication to residents unless the staff person is a properly licensed nurse or physician. l) Medication may be administered by non-licensed direct care staff who have been trained and authorized in accordance with 59 Ill. Adm. Code 116 (Administration of Medication in Community Settings). These Regulations were not met as evidenced by: Based on observation, interview and record review the facility failed to ensure 1 of 1 client in the facility with repetitive incidents of Aspiration Pneumonia is provided with nursing services including administration of tube feeding, medications via tube, oversight and recommendations for nursing needs when the facility failed to: 1. Prevent Aspiration Pneumonia, provide adequate hydration, ensure weight maintenance and deliver medication by staff adequately trained by appropriate licensed personnel for one of one individuals (R2) who receives feedings via a gastrostomy/jejunostomy tube. The clinical record documents: A. September 20, 2009 - October 1, 2009 hospital admission for aspiration pneumonia, syncope, dehydration and placement of a gastrostomy (G) feeding tube. B. December 4, 2009 emergency room visit due to a malfunctioning G tube. C. December 14 - December 21, 2009 hospital	W9999		

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W9999	Continued From page 53 admission for bronchitis, dehydration and leukocytosis. D. January 6, 2010 emergency room visit due to Upper Respiratory Infection. E. January 14 - January 18, 2010 hospital admission for pneumonia. F. February 19, 2010 outpatient procedure for malfunctioning G tube. G. March 16 - March 30, 2010 hospital admission for aspiration pneumonia and jejunostomy insertion. H. March 30, 2010 emergency room visit due to R2 removing jejunostomy tube upon return to facility. I. April 16 - April 21, 2010 hospital admission dehydration, jejunostomy site infection and placement of gastrostomy/jejunostomy tube. 2. monitor skin integrity for 1 of 4 individuals in the sample, R3 and one other individual R5. 3. obtain laboratory work as ordered for 1 of 4 individuals in the sample, R1. Findings include: According to the 10/23/09 Individual Service Plan, R2 is a 41 year old female whose diagnoses include Moderate Mental Retardation, Down's Syndrome, Sleep Apnea Syndrome, Gastroesophageal Reflux, Airway Disease, Asthma, Oropharyngeal Dysphagia, History of Aspiration Pneumonia, History of MRSA (Methicillin Resistant Staph Aureus) Sputum, and G (gastrostomy)-tube placement. R2 was observed being administered medications and tube feeding via a gastrostomy/jejunostomy tube by direct support	W9999		

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W9999	Continued From page 54 staff, E8 on 5/10/10 at 6:00 p.m. R2 was lying in bed with her head elevated less than thirty degrees when the feeding was initiated using a feeding pump. Physician orders dated 3/30/10 taken from the hospital discharge instructions read, "Jevity 1.5 cal at 80 ml/hr for 12 hours nightly with an additional 730 ml of free water." On 5/13/10 at 9:18 a.m. E1, RSD, said there is only one night staff at this time. Staff from other shifts help out and fill in. E11, direct support staff was interviewed on 5/13/10 at 9:20 a.m. E11 said she is the only regular staff on nights and works 5 days a week. E11 said R2 is sleeping when E11 comes in to work. R2 receives tube feeding at night. E11 said sometimes R2 has a wedge. E11 said R2 wheezes a little but nebulizers are given in the morning. E11 said when the pulse oximeter was being used three times nightly the range on the pulse oximeter was in the low 90's usually 92 - 94. During interview with E12, facility physician on 5/13/10 at 12:08 p.m., E12 said, "if R2 is laying down during feedings it would make her more prone to aspiration. I would prefer she sits up for feeding." During interview with surgeon Z4 on 5/18/10 at 11:50 a.m., Z4 said R2 should be fed sitting up due to her Hiatal Hernia and GERD (Gastroesophageal Reflux Disease). Notes from the Adult Down Syndrome Center physician visit Z6, read "Plan WEIGHT LOSS/DYSPHAGIA/FEEDING TUBE (R2) had a G-tube placed and only gets feeding through this. Please note that studies show that there can still be aspiration with a feeding tube...remain seated for 30 minutes after eating." A nasal cannula was laying on the floor in R2's	W9999		

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W9999	Continued From page 55 bedroom on 5/10/10 at 6:00 p.m. It was connected to an oxygen concentrator. The nasal cannula was laying on the floor on 5/11/10 at 10:50 a.m. Surveyor notified E1, Residential Services Director (RSD), E3 facility representative and E6, Licensed Practical Nurse (LPN) to observe the nasal cannula laying on the floor. R2 receives Oxygen per nasal cannula at 2 liters during the night, according to interview with E6, Licensed Practical Nurse on 5/11/10 at 9:20 a.m. E1, E3 and E6 acknowledged nasal cannula should not be on the floor. Surveyor requested all nursing care plans and instructions given to direct support staff regarding gastrostomy/jejunostomy tube feedings, oxygen administration and medication training. Upon arrival at the facility on 5/10/10 surveyor was given a Nursing Care Plan dated 9/09, written by E4 Facility Representative/Registered Nurse and co signed by E5 Registered Nurse. The Long Term Goal reads "1. (R2) maintains stable health status. 2. G-tube remains patent and intact." During the entrance conference (5/10/10) E1, Residential Services Director (RSD) stated this Nursing Care Plan is located in R2's medical record and in the Medication Administration Record for staff review. In the plan, specific instructions to staff about positioning during feeding are only related to situations where nausea or vomiting occurs. No nursing care plan was presented that addresses all of R2's needs such as feeding position with continuous feedings via a G-J tube and oxygen delivery. An In-service education meeting/report dated 9/29/09 includes directions that the head of bed must be kept at 45 degrees for 30 minutes after feeding. These instructions are for bolus	W9999		

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W9999	Continued From page 56 feedings. It reads in part "*** Key point. Even with the G-tube (R2) can still aspirate 1. make sure (R2) is sitting up during bolus and for 1 hour after bolus" There are no further positioning instructions to staff in Inservice Education meetings dated 10/23/09 and 12/4/09, and the care plan dated 3/30/10 (addressing time period when there were 2 separate tubes a gastrostomy and jejunostomy tube). The in-service for R2's oxygen is dated 11/30/10, and reads, "See attached information from (equipment provider)." When asked on 3/12/10 at 3:05 p.m., why the in-service is dated 11/30/10, E5, R.N., said it could be a typo it should read 11/30/09. . On 5/10/10 at 1:25 p.m. E1, RSD, was interviewed about R2's feeding and Oxygen use. E1 said R2's feeding is given from 6:00 p.m. through 6:00 a.m. E1 said the day training site does nothing with the feeding tube, it is a G-J (Gastrostomy-Jejunostomy) tube. Medication is given through the gastrostomy port and feeding through the Jejunostomy port. R2 wears an elastic binder so that she will not mess with the tube. R2 was treating it like a belt at first and swung it around. E1 said R2 gets water flushes to keep her hydrated. The G-J tube was inserted in April 2010. E1 said the staff were to use the same care plan for the gastrostomy tube dated 09/09. During interview on 5/10/10 at 1:25 p.m. E1 confirmed that R1 still gets oxygen. E1 said R2 had pulse ox (oximeter) monitoring, it was D.C.'d (discontinued). When R2 came out of the hospital her oxygen levels were low, levels were	W9999		

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W9999	Continued From page 57 monitored 3 times every night. E1 said R2's oxygen level is up now. There is no routine monitoring as a nursing protocol. E6 (LPN) said (5/11/10 at 9:20 a.m.) the pulse ox is available for her use during assessment. Surveyor attempted to interview a nurse regarding the care for R2 on 5/10/10 at 3:30 p.m. E1, RSD, said the facility nurses are not available now. E1 said he talked to E5, Registered Nurse on the phone at approximately 3:30 p.m. on 5/10/10. E1 said he was told by E5 that E6, Licensed Practical Nurse (LPN) is assigned to R2 and will answer questions. E1 said E6 had been admitted to the hospital and was not available. Staff training on the G/J tube was done by the home health nurse. Surveyor asked what would happen if a problem occurred with R2. E1 said he could call the home health nurse or hospital. E1 said he would tell staff to take R2 to the hospital. On 5/11/10 at 9:20 a.m. E6, LPN, was interviewed. E6 was hired 8 months ago and she works 3 days a week. E6 said she is assigned 1 on 1 with R2 because R2's health situation needs closer monitoring. E6 said all of R2's hospitalizations have been as a result of aspiration pneumonia or R2 removing her tube. E6 said R2 had a G tube inserted, she was still getting aspiration pneumonia. Z4, surgeon inserted a Jejunostomy tube because it is lower in the intestinal tract. The G tube was left in place because it was functioning and they wanted to make sure the J tube was established and functioning. The J tube was secured by sutures, but, not as well secured as the G tube. R2 pulled out the J tube (confirmed in nursing notes dated 4/16/10). Z4 decided to use a G/J	W9999		

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W9999	Continued From page 58	W9999		

tube that has a balloon to secure it. E6 stated she does not write care plans and is not aware of any care plans other than the care plan dated 09/09. E6 said R2 wears oxygen per nasal cannula at night for 10 hours. The flow is 2 liters. E6 said the direct support staff are responsible for applying and making sure it is at 2 liters. The support staff is also responsible for making sure the oxygen concentrator is working.

E6's nursing note of 4/6/10 reads, "J-tube site reddened, yellow thick drainage noted applied triple antibiotic ointment with 4 x 4 drainage..Spoke with (Z2) (home health nurse) will be here Friday, (4/9/10) to apply vertical drain." Nursing note dated 4/14/10 reads, "J tube site still appears to be infected, Home Health nurse (Z2) here to culture, Advised to not attach vertical drain device d/t infection at site. 1 suture still in place holding J Tube in place...Pending culture results." Nursing note dated 4/16/10 reads, "Res. brought to (local Emergency Room) D/T pulling out J tube."

E6, LPN, said in interview (5/11/10 at 9:20 a.m.) on 4/6/10 she assumed that there was an infection starting. E6 said Z2, home health nurse came out on Friday (4/9/10) and assumed there was an infection at the site. Z2 had an order from E12, facility physician and did a culture swab. E6 said she is the only person who does dressing changes. Prior to R2's 4/16/10 hospitalization, direct support staff changed the dressing and provided site care.

The Emergency Department record for 4/16/10 reads, "Primary Diagnosis 1. Dehydration," "Patient for problems related to a jejunostomy tube. Apparently tube fell out. The area around

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W9999	Continued From page 59 the site has broken down and become inflamed and appears that it might be infected....Gastrostomy tube noted in the left upper quadrant. Gastrostomy site is inflamed with surrounding purulent drainage." "Has dry mucous membranes and appears dry." R2 was admitted to the hospital and discharged on 4/21/10. Z4, surgeon was interviewed on 5/18/10 at 11:45 a.m. Z4 said he passed a tube through the G tube site because the J tube had been pulled out and the tract was lost. The tube has a gastrostomy port, jejunostomy port and a balloon port. Hospital records document the procedure being performed during hospital stay 4/16/10 through 4/21/10. E4, facility representative/Registered Nurse was interviewed (5/12/10 at 12:35 p.m.). E4 said she wrote the 09/09 care plan and was not aware of any other plan for R2 and the use of the G/J tube. E5, Registered Nurse (R.N.) was interviewed on 5/12/10 at 3:05 p.m. E5 said she is currently the house R.N. E5 said she usually comes to the facility at night. E5 said home health nurses trained staff on the G/J tube. E5 said she has given staff so many inservices, to ask E1, RSD for updates. E5 said she was not at the facility, it was hard to remember since R2 had so many hospitalizations. May 2010 Medication Administration Record entries document 240 milliliters water given one time per day through feeding tube at 7:00 a.m. Physician's orders dated 3/30/10, read 730 milliliters water, 240 milliliters water to be given before feeding begins, 240 milliliters after feeding	W9999		

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W9999	Continued From page 60 and 240 milliliters middle of the day. During interview with E7, Registered dietician on 5/11/10 at 12:35 p.m., E7 said R2 needs hydration, if not she would get dehydrated. If we didn't provide hydration (R2) would be in trouble. Surveyor observed R2 on 5/10/10 from 4:00 p.m. through 6:30 p.m. R2 appeared extremely thin. R2's body weight is recorded differently in various documents in R2's clinical record. Medical history documented by Z5, physician consultant, during 8/14/09 hospitalization states, "She weighed 185 pounds at the time; however, in 2002, she had dropped to 129 pounds,..." R2's annual nutritional assessment documents a weight of 99 pounds with a body mass index (BMI)of 19.5 September 18,2009. R2's Physical Examination dated 10/20/09 written by E12 physician, documents a weight of 88 pounds. QMRP Summary for October 2009 dated November 10, 2009 states, "(R2's) weight was 86 lbs. which is a 13 lb decrease from last month." R2's visit to the Adult Down Syndrome Center on 1/19/10, Z6, physician documented active problems "Abnormal weight Loss" "The main concern for her now is dysphagia/recurrent aspiration pneumonia and weight loss," Weight is listed as 92 pounds. Quarterly nutritional progress notation documents weight of 91 pounds 1/16/10, no BMI documented. Nursing Progress notes dated 2/7/10 document weight of 88 pounds. Quarterly nutritional progress notation documents weight of 92 pounds 3/16/10. The facility documents R2's weight weekly on the Medication Administration record. R2's weekly weights in April 2010 range 87 - 88 pounds Documented weight on 5/4/10 and 5/11/10 is 86 pounds.	W9999		

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W9999	Continued From page 61 During interview with E4, facility representative/Registered Nurse on 5/12/10 at 12:35 p.m., E4 said scales can be different. The facility presented hand written weights which states they were taken by the home health department on 5/18/10. These weights vary significantly from recorded weights in the clinical record and report from the Adult Down Syndrome Center. The weights range from 87 pounds to 100 pounds. Surveyor interviewed E7, Registered Dietician on 5/11/10 at 12:35 p.m. E7 said she developed a flow chart in September/October 2009. Initially R2 was on a formula providing 1 calorie per cc. E7 said she recommended to change the formula to provide 1.5 calories per cc. to be given in a specific time. The volume needed to be decreased to provide more calories during the time schedule. E7 said R2 was currently receiving a continuous feeding at 80 cc per hour over a 12 hour period. R2 had been receiving bolus feedings (before April 16 - 21 2010) hospitalization. With the change to continuous feeding the calories dropped. It should not have dropped her weight. E7 said she recommends changes and the doctor usually agrees with the change. E7 said the (tube feeding) rate would probably be increased to 90 cc per hour to maintain and increase R2's weight. E7 said R2 was weighed on 5/12/10 and her weight was 87.5 pounds Surveyor asked about the body mass index (BMI) recorded at 19.5 when R2's weight was recorded at 99 pounds on 9/18/09. E7 said the normal BMI range is 18.5 to 25. Surveyor asked E7 what R2's BMI is with her recorded weight of 86 pounds. E7 said her BMI is 18.3. Surveyor referred to the standard BMI calculator	W9999		

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W9999	Continued From page 62 provided online by the Department of Health and Human Services - National Institute of Health and by the Centers for Disease Control and Prevention, both sites list BMI as 16.8 using facility provided weight of 86 and height of 5 foot 0 inches. BMI for weight of 87.5 pounds and height of 5 feet 0 inches is 17.1. Both sites list normal BMI range as 18.5 to 24.9. There is no evidence in the record in nursing documentation and nutritional reports addressing the vast difference in weight documentation recorded from the home health department. Other issues with R2's health status are documented in nursing notes and day training reports as follows: Nurse note 1/4/10 "G-tube site is reddened...Resident vomited x 1 at 3:00 p.m." Nurse note 1/5/10 "DSP(Direct support person) (E9) called me and stated that resident was crying out in pain." Nurse note 1/6/10 "RSD (E1) called and told me that (staff) from workshop called him and said that (R2) had mucous coming out of her mouth"..."Resident returned from ER with diagnosis of URI" Nurse note 1/14/10 "DSP (E9) kept R2 home due to her coughing, c/o stomach pain, and being Lethargic...fever 100.0...Coughing up yellow to clear phlem (phlegm), c/o stomach pain, facial grimacing upon palpation." R2 was admitted to hospital on 1/14/10 through 1/18/10 with diagnosis of pneumonia. Nurse note 2/19/10 "Received pulse oximeter from (manufacturer), oxygen saturation 86% on	W9999		

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	14G158	A. BUILDING _____ B. WING _____	05/24/2010

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W9999	Continued From page 63 room air." There is no treatment for the reading noted. Incident report for R2 from day training site 3/12/10 "Client was sitting watching a video and suddenly starting gagging & become short of breath. She was holding her stomach as if in pain." Incident report for R2 from day training site 3/15/10 "Client began holding her stomach as if hurting. Client said she had to go to the bathroom. While in bathroom Client attempted to go but was unable to and began throwing up yellow mucus (mucous)." Nurse note 3/16/10 "res. crying out in pain, res states 'I hurt in the middle of my tummy' facial grimacing and crying upon abdominal palpation. G-tube site slightly red, thin yellowish to clear drainage noted, pink granulation tissue noted, crackles to bilateral upper and lower lobes, non-productive cough, instructed (E1) RSD to take res. to (local) hospital for eval and tx(treatment)." R2 was hospitalized from 3/16 - 3/30/10 with diagnosis of aspiration pneumonia. During the hospitalization a laparotomy was performed for J-tube insertion. History and Physical dated 3/16/10 written by E12, facility physician states, "She (R2) was transferred from the local group home because of high fever, frequent loose cough and increasing lethargy...initial temperature was 103.1 degrees Fahrenheit." Nurse note 3/30/10 "individual pulled G-tube out." E12, facility physician, was interviewed on	W9999		

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W9999	Continued From page 64 5/13/10 at 12:08 p.m. E12 said R2 has been hospitalized several times. E12 said R2 had a gastrostomy tube and she still aspirated. She was referred to a surgeon, Z4, for a J tube placement. R2 pulled out the J tube. Z4 used a guide wire to insert a special G/J tube. E12 said he spoke to R2's guardian a long time ago about the need for a G tube. R2's guardian refused, but finally agreed. I asked her father if she could go to a nursing home but her father refused. The group home is not a nursing home and she needs more care. My hands are tied. She has been at the group home a long time, we are running out of options, the group home is not skilled. Somebody needs to convince her father she needs skilled care. 2. Administrative Code Title 59: Chapter 1 Section 116.30 Master Nurse Trainer and Nurse-Trainers states, "a) The Department's master nurse-trainers are designated by the DD Clinical Director and shall meet the following criteria: 1)Demonstration of competence to teach adult learners through: A) evidence of previous teaching or training experience; or B) completion of courses in teaching and instructing. 2) Possession of two years of clinical registered professional nursing experience within the last five years, at least one of which shall have been in developmental disabilities." Section 116.40 Training and Authorization of Non-Licensed Staff by Nurse-Trainers states, "a) Only a nurse-trainer may delegate and supervise the task of medication administration to direct care staff."... "d) Initial competency-based training toward	W9999		

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W9999	Continued From page 65 delegation for medication administration shall include: 4) Specific information regarding the individuals to whom the staff will administer medication and the medication the staff will administer." On 5/10/10 at 5:50 p.m. E8, DSP (Direct Support Person) said the home care nurse showed us how to use the tube. She showed me twice. She showed us how to do meds too. E8 said E5 (R.N.) trains on new medications. On 5/10/10 at 1:25 p.m., E1, RSD said E4 is the nurse trainer for (the corporation). When new medications are started we get a new T93 (facility form) form E5 (Registered Nurse, R.N.) or E6 (Licensed Practical Nurse, LPN). It is a written piece of paper given to staff. E1 said E5 is also a nurse trainer. On 5/12/10 at 12:35 p.m., E4, facility representative/R.N., said only a certified nurse trainer can train on meds. The Home health nurse was here to train on tube not the meds. E4 said she would expect a return demonstration from staff with a minimum of 2 with accuracy on G-tube medication administration. E4 said she has not trained staff here on medications for R2. E4 also said she did not train staff at another facility on R2's medications when R2 was briefly transferred to another facility. Nursing note dated 2/1/10 states "Resident went to (another facility) for a week visit. MAAR transferred to (another facility), along with Residents belongings. Staff inserviced on G-tube care, feedings and medication Administration." The note is signed by E6, LPN. E5, R.N., was interviewed on 5/12/10 at 3:05	W9999		

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W9999	Continued From page 66 p.m. E5 said she comes to the home in the evening. If new medications come in during the day the orders would be executed. E6 would do training and I would review what she wrote for staff on the T93. Home health was set up by E12, facility physician. They trained staff on the G-J tube and how to give medication through it at the hospital and at the home. Z2, Home health R.N., was interviewed on 5/13/10 at 12:00 p.m. Z2 said she is not trained in rule 116 and is not a certified nurse trainer. Z2 confirmed she taught staff on the G-J tube and feeding pump. Z2 said she trained E6 LPN on the tube. Z1, Home health R.N., was interviewed on 5/13/10 at 12:22 p.m. Z1 said she trained the staff on how and where medications are to be given. The medications should be given through the gastrostomy port and the feeding through the jejunostomy site. Z1 said she could not remember ever training staff before but has trained family members. Z1 said she has never been trained in rule 116. Z1 said she did not keep sign in sheets or other documentation of the training. There is no evidence of the competency based training records including route of administration for R2's G tube medications. There is no evidence that staff were trained on all new medications and feedings by a certified nurse trainer. 3. R1's Individual Service Plan (ISP) dated 12/31/09 was reviewed and documents that R1 is a 26 year old male with a diagnosis of Mild Mental Retardation.	W9999		

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W9999	Continued From page 67 R1's Physician Order Sheet dated May 2010 was reviewed and documented a physicians's order for CBC (Complete Blood Count) every week, Depakote, Clozapine, Liver Profile every 3 months. Laboratory results were reviewed from 1/1/10 to 5/13/10. The results of this review indicated a CBC was not completed the week of 3/7/10, 4/18/10 and 4/25/10, no Clozapine levels were completed between 1/1/10 and 5/13/10, and no Depakote Level completed between 1/1/10 and 5/3/10. E5, Registered Nurse, was interviewed on 5/13/10 at 2:55 p.m., by phone, regarding R1's bloodwork, and E5 stated pharmacy will not send R1's medications if the bloodwork is not completed. Bloodwork may not be filed yet. E1, Residential Service Director was interviewed on 5/13/10 at 2:30 p.m. and stated he will call the laboratory for the results. No results could be presented to the surveyor for missing CBC results of 3/7/10, 4/18/10 and 4/25/10, Clozapine levels between 1/1/10 and 5/13/10, and Depakote Level between 1/1/10 - 5/3/10. 4. R5's Individual Service Plan dated 5/29/09 was reviewed and documented that R5 is a 56 year old male with a diagnosis of Moderate Mental Retardation, Disorder of Circulatory System, Postphlebitic Syndrome, and Chronic Venous. R5's nursing progress notes written by E5, Registered Nurse, were reviewed. E5 documented that, on 4/27/10, "staff report skin opening on leg (L) (left) LE posterior fibular circular approx. (approximate) 3/4" x 1/2" open	W9999		

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W9999	Continued From page 68 area. Wound reportedly occurred at sister's home. Serosanguinous drainage wound bed edges circular. 4/28/2010 Seen in ER for LE wound. Discharge from ...ER with order: Keflex 500 mg 4x daily x 7 days....4/29/2010 Saw (E12, physician) return appt for 5/14/2010)." No additional follow up notes regarding R5's skin integrity from 4/29/10 to 5/13/10 could be presented to the surveyor as of 5/13/10. E5 was interviewed on 5/13/10 at 2:55 p.m. by phone and stated she last saw the wound on 5/9/10. The area is now the size of a fingernail. 5. R3's Individual Service Plan dated 2/25/10 was reviewed and documents that R3 is a 32 year old male with a diagnosis of Moderate Mental Retardation, Cellulitis, and Bacterial Skin Infection. E5 was interviewed on 5/13/10 at 2:55 p.m. by phone and stated R3 he has a history of developing skin lesion. R3's nursing progress notes written by E5, Registered Nurse were reviewed. E5 documented that R3, on "5/4/2010, returned from home visit circular approx. (approximate) 1/2" lesion right mid abdomen. Slight erythematous non raised rash across abdominal fold. Lesion is closed. No drainage noted. Circular 1/8" lesion upper right abdomen no drainage noted, RSD notified." No additional follow up notes regarding R3's skin integrity from 5/5/2010 to 5/13/2010 could be presented to the surveyor as of 5/13/2010. (A)	W9999		