

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14G271</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/23/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRY CLUB TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4900 WEST 183RD STREET</b> <b>COUNTRY CLUB HILLS, IL 60478</b>		
(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 149	Continued From page 4 follows:  1. Regardless of consumer functioning level, no client is ever to be left in a vehicle unattended. Any staff, regardless of position and prior work history, will be dismissed from agency service. The incident will be considered neglect and will be reported to State agencies....  You are required to sign this document which will acknowledge that you have read and understand this policy and directive."  The memorandum dated 7/10/08 was signed by E5, Residential Aide on 12/2/09.	W 149			
W9999	FINAL OBSERVATIONS  LICENSURE VIOLATIONS  350.620a) 350.1060e) 350.3240a)  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 350.1060 Training and Habilitation Services  e) An appropriate, effective and individualized	W9999			

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W9999	<p>Continued From page 5</p> <p>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.</p> <p>Section 350.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>Based on record review, observation and interview, the facility failed to ensure 1 of 4 in the sample, R1, was provided appropriate supervision when the facility failed to: 1. Ensure R1 does not have unsupervised access to a van with the engine running. 2. Ensure facility staff are trained in and implement the facility policy for vehicle usage.</p> <p>Findings include:</p> <p>Record review of the Individual Program Plan dated 8/6/09 notes R1 is a 39 year old male whose diagnoses include Profound/Severe Mental Retardation, Bipolar Disorder, Not Specified, History of Seizure Disorder and Diabetes.</p> <p>R1 has a behavior plan dated 5/09. Maladaptive behaviors include physical aggression, invasive behaviors, putting his fingers in others' mouths, leaving/running out of facilities, transporting in and out of vehicles, refusing to get into vehicles, pounding on ceiling/windows of vehicle while in transport, grabbing at females breasts/blouses and not letting go when redirected and stealing food. In the behavior plan under the heading of</p>	W9999			

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W9999	<p>Continued From page 6</p> <p>Environmental Conditions Influencing Behavior it states, "Provide close monitoring at all times. Staff should continue to monitor R1 closely. When R1 does wander out of assigned areas or does not respond to program cues, staff should cue him to return with short phrases by using a friendly tone of voice."</p> <p>Per a Resident Injury Report dated 4/8/10 at 8:30am written by E6, Nurse, R1 got in an unlocked van with the ignition engaged and running and drove off hitting a car, the facility medical van and a ditch outside the facility. E6 found R1 had his seatbelt on and was alert. 911 was called and he was taken to the emergency room for sutures for a laceration under his chin. There were no other injuries.</p> <p>On 4/16/10 at 10:15am E1, Residential Aide/Training Specialist, was interviewed. E1 stated last Thursday the van was involved in an accident. The facility van which was running was driven by R1 during the loading of clients in the process of leaving for work. There were no other clients in the van at that time. R1 happened to be outside at that time and staff were aware he was outside. There is no evidence R1 was directly supervised at that time. R1 put the running van into reverse, backed up and then put it in drive. R1 hit 2 vehicles and went into a ditch. E7 yelled out something hit her car. E1 stated other staff ran outside and the facility van was in the ditch. R1 was seated in the drivers seat and his chin was bleeding. The ambulance came and after a couple of verbal prompts R1 exited the vehicle and was sent to the hospital receiving 4 stitches.</p> <p>Observation of the driveway/parking lot on 4/16/10 at 12:30pm indicates the van R1 drove</p>	W9999			

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W9999	<p>Continued From page 7</p> <p>was parked at the end of the driveway. There are tire marks in the grass indicating the vehicle was first put into reverse. There are rubber skid marks on the pavement approximately 20 feet long. There are are tire marks dug into the grass as it approached the street. There is a sidewalk followed by a ditch right in front of the road which the vehicle struck and stopped. Just past the ditch there is a 4 lane highway with a posted speed limit of 40 miles per hour.</p> <p>On 4/16/10 at 11:00am, E3, Qualified Mental Retardation Professional/ Program Director, was interviewed. E3 stated, "We had a very bad accident on 4/8/10 in the AM. I was appropriately staffed with 4 residential aides, a nurse and a cook. The accident occurred at 8:45am about 5 minutes away from leaving for workshop. The residents were still in the living room. R1 exited out the women's side door near the parking lot. This is the first time R1 has ever gone out that door. One aide/van driver, E5, started the 14 person van. It was 40 degrees outside. E5 came back and left the vehicle unlocked. We have a strict policy we don't leave vehicles unattended nor warming up. We continually stress this through meetings and memos. R1 got in the vehicle, put it in gear, first reverse and he ended up in the grass. He floored the vehicle and there are black skid marks and burnt rubber. He took off a staff's bumper and slammed into the medical van and that van is totaled. What stopped him is the ditch.... The police were here. R1 went to the hospital and had 4 stitches to his chin, no other injuries. R1 will go out to sit on the patio or out front. He has not ever attempted to get in vehicles or leave premises."</p> <p>The facility policy on Authorized Use of Agency</p>	W9999			

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W9999	<p>Continued From page 8</p> <p>Vehicles not dated includes, "Never leave the vehicle unattended while running or with the keys in the ignition."</p> <p>Record review of a memorandum dated 7/10/08 pertaining to, "Consumers Unattended In Vehicles includes, Apparently, there is still some misinterpretation regarding agency policy as it relates to consumers being left in agency vans and other automobiles unattended... Due to a wide variety of reasons, our consumers must never be left in vehicles unattended. The agency position on this matter is best summarized as follows:</p> <p>1. Regardless of consumer functioning level, no client is ever to be left in a vehicle unattended. Any staff, regardless of position and prior work history, will be dismissed from agency service. The incident will be considered neglect and will be reported to State agencies....</p> <p>You are required to sign this document which will acknowledge that you have read and understand this policy and directive."</p> <p>The memorandum dated 7/10/08 was signed by E5, Residential Aide on 12/2/09.</p> <p style="text-align: center;">(A)</p>	W9999			