STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G058	A. BUILDING _____ B. WING _____	C 05/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARENTS & FRIENDS OF THE SLC	1450 CASEYVILLE AVENUE SWANSEA, IL 62226

(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 331	Continued From page 37 E6 are all currently CPR certified and per facility investigation none of those staff initiated the CPR procedure on R1. E1 confirmed E7 started the CPR procedure after arriving at House 4. E1 confirmed that the facility had to create a new policy and procedure to address staff involvement with the CPR procedure at the residential facility. E1 also confirmed that the facility had to create policies to address; "complete airway obstruction in unconscious victims, choking-airway obstructions, breathing problems, communication tool for seizures (communication from nursing staff to direct service staff members), seizures at the day training provider, addendum's for all clients with seizure disorders, protocol for nursing monitoring seizures and procedures for calling seizures in all houses".	W 331		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1210 350.1230b)7) 350.1230c) 350.1230d)2) 350.1235a)3)4)5) 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	W9999		

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W9999	Continued From page 38 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 350.1230 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: 7) Modification of the resident care plan, in terms of the resident's daily needs, as needed. c) A registered nurse shall participate, as appropriate, in planning and implementing the training of facility personnel. d) Direct care personnel shall be trained in, but are not limited to, the following: 2) Basic skills required to meet the health needs and problems of the residents. Section 350.1235 Life-Sustaining Treatments a) Every facility shall respect the residents' right to make decisions relating to their own medical treatment, including the right to accept, reject, or limit life-sustaining treatment. Every facility shall establish a policy concerning the implementation of such rights. Included within this policy shall be: 3) procedures for providing life-sustaining treatments available to residents at the facility; 4) procedures detailing staff's responsibility with respect to the provision of life-sustaining treatment when a resident has chosen to accept,	W9999		

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W9999	Continued From page 39 reject, or limit life-sustaining treatment, or when a resident has failed or has not yet been given the opportunity to make these choices; 5) procedures for educating both direct and indirect care staff in the application of those specific provisions of the policy for which they are responsible. 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: Based on interview and record review, the facility failed to provide adequate health care services for 1 of 1 client (R1) who expired on 3/11/10, and 10 of 10 clients (R2, R3, R4, R5, R6, R7, R8, R9, R10, R11) requiring supervision during bathing because of a medical condition, when the facility failed to: A. Ensure adequate supervision of R1 during bathing procedures as per staff training for individuals with epilepsy. B. Ensure an individual with a history of seizures is monitored appropriately when seizure activity is observed. C. Initiate Cardiopulmonary Resuscitation. D. Ensure nursing evaluates and makes recommendations for monitoring clients (R1,R2, R3, R4, R5, R6, R7, R8, R9, R10, R11) with known seizure activity that have been identified	W9999		

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W9999	Continued From page 40 by the facility as requiring supervision during bathing for their medical conditions with no monitoring policy. Findings include: 1. R1's Individual Program Plan (IPP) dated 8/3/09 states R1's "level of functioning is in the Profound range of Mental Retardation. R1's secondary diagnoses include Epilepsy, Seizure Disorder, Bronchial Asthma, Lt club foot and Strabismus. R1's date of birth is 7/31/88 and is 21 years of age. R1 receives Depakote 250mg TID & Klonopin .5mg BID for seizure control. R1 requires a low bed with safety mat's-on the floor used in an attempt to promote safety and prevent injuries that could occur with seizure activity while in bed. R1 requires staff assistance to tend to most of his basic self-care needs. For example he requires one to one assistance to wash all of his body parts (e.g. hands, face, legs, feet, arms, trunk, genital areas and ears). R1 also requires total (one to one) assistance to tend to all of his hair care needs (e.g. shampoo, rinse, dry, style and comb). R1 does not demonstrate the ability to maintain a sitting position. R1 should be given a shower in a traditional shower chair to protect his safety." A staff training, dated 12/22/09, included: Inservice training for R1; R1 is now 1:1 with a staff person. The evening staff will be assigned a day to accommodate with 1:1 for R1. When assigned 1:1 with a client (R1) it means for you to be in the client's room or close by the door where you can see the client. Staff works only with the 1:1 client. The facility incident report sent to Illinois	W9999		

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W9999	Continued From page 41 Department of Public Health (IDPH) on 3/11/10 at 12:15PM states, "This is to report that R1 was taken to the local hospital at approximately 7:10PM due to possible seizure activity while taking a bath. R1 was not breathing and CPR was initiated. R1 was transported to local hospital via ambulance and admitted to ICU. R1's mother is aware of R1's condition. R1's physician was notified. The facility is investigating." The facility incident report sent to Illinois Department of Public Health (IDPH) on 3/11/10 at 4:25PM states, "This is to report that R1 died at the local hospital due to lack of oxygen related to possible seizure activity (on 3/10/10) on 3/11/10 @ 10:00AM. This agency is investigating." Review of facility "Investigation Report" dated 3/15/10 states the following concerning the death of R1 on 3/11/10. "Allegation/Occurrence/Complaint: On 3/10/10 at approximately 7:10PM R1 was taken to local hospital due to possible seizure activity while taking a bath. R1 was not breathing and CPR had been initiated. On 3/11/10 @ 10:00AM; R1 died at local hospital. R1 who resided in House 4, was a 21 year-old man with a diagnosis of Profound Mental Retardation. Direct Care staff working in House 4 during the evening shift on 3/10/10: E2 (direct care staff (DCS)-shift lead), E3 (DCS), E4 (DCS), E5 (DCS), E6 (DCS). Direct Care Staff is certified in CPR. Per staff interview (no names stated), R1 had a seizure earlier in the day at the day training on 3/10/10. Nursing (no name stated) examined R1 when he returned home from work. R1 slept most of the evening, waking up at approximately 6:00PM. R1 felt slightly warm so E3 pulled a	W9999		

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W9999	Continued From page 42 couch outside the door of the tub room and assisted R1 into the tub. E1 placed the couch where he could both hear and see R1. The tub contained a few inches of water. R1 was playing in the water and blowing bubbles with his mouth in the water. E3 let R1 play in the water for approximately 45 minutes. At approximately 7:00PM; E3 could no longer hear R1 playing in the tub. E3 observed that R1 was on his left side in the tub and was having a seizure. E3 held R1's head out of water, let the water out of the tub and yelled for assistance. E4 was walking into the house through the kitchen door and heard E3 yelling. E4 helped E3 get R1 out of the tub. E3 yelled that he did not think R1 was breathing. Staff did an all page that there was a seizure in House 4. Within a minute or two the nurse on duty, E7(LPN) had started CPR with the assistance of E2. The Administrator on duty, called 911. R1 was lying on a towel outside the tub. E7 noted that R1's skin was blue. R1 did not have a pulse. Within a matter of minutes R1 was hooked up to oxygen by nursing. The paramedics arrived at approximately 7:10PM and took over CPR. R1 was transported to local hospital at approximately 7:20PM. R1's family and R1's Physician were advised." The report includes the following recommendations: Human Rights Committee Findings/Recommendations: 1. Disciplinary action with E3 due to failure to adequately supervise a client. Community Human Rights Findings/Recommendations: 1. Termination of E3 due to failure to adequately supervise a client. 2. Reinstatement of E2 & E6.	W9999		

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W9999	Continued From page 43 Administrator Findings/Recommendations: 1. Termination of E3 due to failure to adequately supervise a client. 2. Reinstatement of E2 & E6. The "Prehospital Care Report Summary" from the ambulance service that transported R1 on 3/10/10, stated. "Call received 6:58:11PM; Dispatched 6:58:27PM; En Route 6:58:29PM; On Scene 7:04:21PM; Patient Contact 7:06:00PM; Left Scene 7:16:00PM; At Destination 7:19:36PM. Clinical: Provider Impression: Cardiac Arrest, Pena. Chief Complaint: Cardiac Arrest. Initial Assessment: Breathing-Rate-Apneic Lung Sounds: Left/Right-Wet Skin-Color:Cyanotic; Temp: Cold; Pupils-Left/Right-Unreactive; AVPU:Unconscious Rhythm 1/2-Asystole Treatment/Medications: 7:06PM-Airway-bagged(via BV mask)/Airway-suctioning/Airway-cleared, opened or Heimlich/Airway-Orotracheal Intubation/Venous Access-Extremity/Assessment-Paramedic 7:07PM-CPR-start compressions and Ventilations Narrative History Text: EMS called to residential facility for a 21 year old male cardiac arrest. Upon our arrival patient (R1) was located in the shower room. Staff member (no name stated) with the patient stated that the patient was taking a bath and had a seizure. Patient (R1) was lying supine on the floor beside the bathtub. Patient(R1) was lying on a towel and had a sheet draped over him. Staff member (no name stated) in the room with him. But no	W9999		

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W9999	Continued From page 44 CPR was being done. Approximately 6-8 staff Members (no names stated) in the room outside where the patient(R1) was located. The patient (R1) is dry. The patient (R1) had a nasal cannula on but not attached to supplemental O2. There was a BVM laying near the patient's (R1) head. Unsure if it had been used. No CPR or ventilations being given. Patient(R1) placed on cardiac monitor with asystole in 3 leads. Staff (no name stated) stated cardiac arrest witnessed. Patient (R1) is cyanotic from nipple area up, with the patient's (R1) lips and under the patient's (R1) eyes very dark. EMS initiated CPR and ventilations @ 7:08PM. Patient (R1) placed on backboard for transfer purposes and secured with 3 straps. Patient (R1) placed on stretcher and secured. Patient (R1) transferred to the ambulance. Intubation 7.0 attempt unsuccessful. IV 18G left forearm unsuccessful. CPR and Ventilations continued. No changes in route." Hospital discharge summary dated 3/17/10 states: "Admission Date: 3/10/10/Discharge Date: 3/11/10 Principal Diagnosis: Anoxic brain injury secondary to seizure disorder. Secondary Diagnosis: Down's syndrome; Seizure disorder. Reason for Admission: Cardiopulmonary arrest. Pertinent Findings of History and Physical: R1 is a 21 year old male. R1 has Down's syndrome and history of seizure disorder. R1 was brought to the emergency room in full cardiopulmonary arrest. He was able to be resuscitated. R1 was placed on a ventilator and admitted to the ICU.	W9999		

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W9999	Continued From page 45 Clinical Course: The patient was admitted through the emergency room late on 3/10 after having been brought in full cardiopulmonary arrest. R1 was resuscitated and was able to be put on a ventilator and he was admitted to the ICU. R1's prognosis was quite poor. R1's outlook was grave. R1 was kept in the ICU. R1 expired at 9:53AM on 3/11/10 from anoxic brain injury presumably secondary to seizure disorder." Review of R1's "Medical Certification of Death" dated 3/15/10 states that R1 died on 3/11/10 and the cause of death was listed: a. Anoxic Brain Injury b. Prolonged seizure c. Epilepsy E3 (DSP) was interviewed on 3/17/10 at 1:30PM. E3 stated that he had worked R1's house for over a year and had worked with R1 on numerous occasions and was aware of R1's seizure disorder. E3 reported that R1 had a seizure "approximately two weeks ago and noted that R1 went from tremors to gasping to being rigid." E3 stated he was CPR certified, however did not administer CPR to R1 during the episode on 3/10/10. E3 stated he did not recall any bathing training for R1 or any individuals with seizure disorders." E3's statement dated 3/11/10 reads: "R1 had a seizure at workshop earlier that day. He slept through dinner. At about 6:00PM or so he woke up to eat. His head felt warm so I put him in the tub to cool him down. About 45 minutes in he got quiet. I was sitting on a couch I had moved in front of the doorway. I got up to see why he stopped playing. He was laid on his	W9999		

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W9999	Continued From page 46 left side, shaking. I called out to the other staff that he was having a seizure. I held his head up out of the water as much as possible. I opened the drain to let the water out. Staff called the seizure on the phone twice. He didn't look like he was breathing. By the time the water let out. Staff (no name stated) ran in and tried to help me get him out. The nurse (no name stated) ran in and started CPR with the shift lead (no name stated). The Administrator on Duty (AOD-no name stated) called 911 at about 7:00PM. They got there about 7:10PM, did CPR as well. There were 5 (no names stated) staff working. One was on an outing." E3 stated he called for help and E4 came in and assisted him with removing R1 from the tub. E3 stated that R1 'was not responding, had no breath sounds, no movement and was turning blue.' E3 and E4 placed R1 on a bath towel and waited for the nurse to enter and start CPR." E3 further stated that he had given R1 baths before and in the past had utilized a facility couch to sit while R1 took his bath. E3 stated "other staff members use a chair to monitor R1 during bathing. I have used the couch in the past." E3 noted that the couch was several feet away from the bathtub. When questioned about R1's health status that evening E3 stated "R1 felt warm and I thought he needed to cool off." E3 stated he did not take R1's tempurature or contact the on duty nurse. E3 was unaware of any safety precautions for clients with seizure disorders. E3 stated that there was approximately "6 inches of water in the tub when R1 was placed in the tub. R1 was placed on his knees so he could lean forward and play in the tub." E3 reported R1 was in the tub for approximately 45-60 minutes and in the last 15 minutes is when R1 became quiet in the tub." E3 stated that "sitting in the couch and R1	W9999		

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W9999	Continued From page 47 leaning over in the tub provided an obscure view of R1. E3 stated he was unable to view R1 in the tub from his position on the couch." E3 stated R1 was quiet and he got up from the couch to look at R1 in the tub. E3 stated R1 "was laying on his left side, with his left arm extended out above his body in the tub. R1's mouth was open in the water along with his left nostril." E3 stated he called for help and E4 came in and assisted him with removing R1 from the tub. E3 stated that R1 "was not responding, had no breath sounds, no movement and was turning blue." E3 and E4 placed R1 on a bath towel and waited for the nurse to enter and start CPR." E7 (LPN) was interviewed on 4/1/10 at 10:00AM. E7 confirmed hearing the all page for seizure in House 4. E7 confirmed arriving at House 4 and observing several staff members at the front of the house (unable to state specific names of staff members). E7 confirmed E3 and E4 in the bathroom with R1 "laying on his back naked on a bath towel." E7 confirmed he performed an assessment of R1 and noted "R1 had bluish extremities, no pulse, no respirations and no movement." E7 confirmed that he initiated CPR to R1 with assistance provided by E2. E7 confirmed that no other staff had begun CPR and he did not witness E3 or E4 participating in the CPR procedure. E7 stated he continued CPR until paramedics arrived at House 4. E1(ADMN) was interviewed on 3/16/10 at 11:00AM. E1 confirmed that the facility had conducted an investigation and determined that E3 had failed to supervise R1 during bathing procedures on 3/10/10. E3 confirmed removing E3 from client contact and was currently suspended with the end result to be termination	W9999		

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W9999	Continued From page 48 of E3 for failure of supervision of a client as stated in current Abuse/Neglect policy. E1 also confirmed that current direct care staff training for "assisting an individual with bathing" states that no individual with epilepsy should be alone in the tub. E1 stated that the facility had not made any changes to policy/procedures for individuals with seizure disorders. E1 confirmed that R2-R11 had current seizure disorders and there was no protocol/procedures for monitoring these individuals during bathing. In addition E1 confirmed that the facility did not have a current policy to address clients that have seizures and staff monitoring of these individuals after the seizure. E1 was again interviewed on 4/8/10 at 2:00PM. E1 confirmed that E2, E3, E4, E5 and E6 where present in House 4 during the 3/10/10 incident involving R1. E1 confirmed that E2, E3, E4, E5 and E6 are all currently CPR certified and per facility investigation none of those staff initiated the CPR procedure on R1. E1 confirmed E7 started the CPR procedure after arriving at House 4. E1 confirmed that the facility had to create a new policy and procedure to address staff involvement with the CPR procedure at the residential facility. E1 also confirmed that the facility had to create policies to address, "complete airway obstruction in unconscious victims, choking-airway obstructions, breathing problems, communication tool for seizures (communication from nursing staff to direct service staff members), seizures at the day training provider, addendum's for all clients with seizure disorders, protocol for nursing monitoring seizures and procedures for calling seizures in all	W9999		

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PARENTS & FRIENDS OF THE SLC	**1450 CASEYVILLE AVENUE SWANSEA, IL 62226**

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W9999	Continued From page 49 houses." Review of facility client roster provided on 3/15/10 @ 10:30AM the following clients were identified with health related issues (seizure disorder) and the following diagnosis: 1. R1 is a 21 year old male with a diagnosis of Profound Mental Retardation. 2. R2 is a 42 year old female with a diagnosis of Profound Mental Retardation. 3. R3 is a 42 year old female with a diagnosis of Profound Mental Retardation. 4. R4 is a 20 year old female with a diagnosis of Profound Mental Retardation. 5. R5 is a 24 year old female with a diagnosis of Profound Mental retardation. 6. R6 is a 57 year old male with a diagnosis of Profound Mental Retardation. 7. R7 is a 54 year old female with a diagnosis of Profound Mental Retardation. 8. R8 is a 19 year old male with a diagnosis of Profound Mental Retardation. 9. R9 is a 53 year old male with a diagnosis of Profound Mental Retardation. 10. R10 is a 46 year old female with a diagnosis of Profound Mental Retardation. 11. R11 is a 28 year old female with a diagnosis of Profound Mental Retardation. (A)	W9999		