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PINE TERRACE	2017 NORTH PINE STREET WAUKEGAN, IL 60085

(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 368	Continued From page 24 medication on 2/20/10 thru 3/2/10 due to it not being available. On 3/19/10 E4, Regional Trainer, at 10:47am was interviewed. E4 was asked who is the nurse responsible for the facility. E4 stated they do not have a nurse but E12, Nurse, is the acting nurse. On 3/19/10 at 1:45pm Z11, Pharmacist, was interviewed. Z11 was asked why the facility did not have the medications in stock for R2. Z11 stated obviously somebody's not calling in, someone has to follow up with pharmacy. Z11 added the facility has just added a new doctor and he is reviewing the Physicians's Orders Sheet and making changes.	W 368		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.1210 350.1220j) 350.1230d)1)2) 350.3240a) 350.3750 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	W9999		

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W9999	Continued From page 25 ulcers or a weight loss or gain of five percent or more within a period of 30 days. 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:	W9999		

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W9999	Continued From page 26 Based on record review and interview, the facility failed to provide nursing care for 1 of 4 clients in the sample with a diagnosis of pneumonia with the potential to affect 13 of 13 other individuals, R1-R3 and R5 - R14. The facility failed to: 1. Ensure nursing services completed an on-going physical assessment of R4's respiratory status after being diagnosed with pneumonia, including monitoring of vital signs, temperature and lung sounds, 2. Ensure guidelines specified related to Adult Pneumonia from the hospital are maintained and documented upon return to the facility. (i.e. milk/rest) 3. Ensure an on-going evaluation of R4's vital signs including temperature are monitored for evaluation and reporting to the physician by the nurse. 4. Ensure direct care staff are trained in detecting signs/symptoms of pneumonia, continued illness. 5. Ensure individuals are capable of attending day training/shopping regardless of staff availability to monitor the client who is ill in his/her home. 6. Ensure nursing staff perform an evaluation of R4's progress through evaluation of R4's person, review of documented data and collection of such data. Findings include:	W9999		

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W9999	Continued From page 27 R4, per the Physician's Orders Sheet dated 3/17/10, was a 50 year old male whose diagnoses included Profound Mental Retardation and Seizure Disorder. R4's Individual Service Plan dated 6/17/09 notes he was ambulatory and non verbal, but did state some simple words. R4 indicated his basic needs by gesturing and pulling. An incident report from day training (DT) dated 3/18/10 at 1:35pm notes, "R4 was sitting down at his work area. According to Z3, Training Specialist, R4 immediately stood up to walk towards the staff desk (approx. 5 ft away from where he was sitting). As R4 stood to his feet, Z3 observed him shaking uncontrollably, clenching his jaw and hands. In addition, Z3 also observed R4 appearing to have difficulty breathing. Z7, Case Manager, was immediately notified. Upon arriving into the classroom, I (Z7) observed R4 standing with his hands and jaw clenched. He also appeared to be shaking. Site Director, Z5, took R4's temperature, which registered at 100 degrees. Home facility staff was notified in addition to R4's sister, Z8. Paramedics were called as a precaution. R4 was escorted to the hospital." The facility informed the Illinois Department of Public Health (IDPH) on 3/19/10 of the following, "R4 while at workshop had developed a fever and was diagnosed at the hospital as having early stages of pneumonia . He was prescribed antibiotics and released without restrictions." R4 was released from the hospital and returned to the facility with the following guidelines specific to Pneumonia - Adults including: What should I know and do for pneumonia. It noted, "Rest as	W9999		

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W9999	Continued From page 28 much as possible. This is very important. Do not drink milk. This may thicken mucus." Under the heading of when and why should I follow up with the doctor it notes, "If you continue to have a fever after 2 to 4 days of treatment. If you are not improving in 3 - 5 days. If you seem to be getting worse not better." E4, Regional Trainer, on 4/2/10 at 2:03pm was asked why R4 did not remain home on 3/19/10 as the workshop was closed on that date. E4 stated all of the residents who attend that workshop were brought to another facility owned by the corporation. E4 was asked if R4 is to have rest why was he not in his own home and bed. E4 stated R4 was released from the hospital with no restrictions and if day training had been open he would have attended day training. When asked while he was located at the other facility what if R4 wanted to lie down and rest, E4 stated there was an empty bed available at the other home if needed. On 4/2/10 at 9:50am Z1, Day Training Case Manager, was interviewed. Z1 stated on 3/22/10 the facility tried to send R4 to the day training site. She said the bus driver was aware R4 had pneumonia and contacted Z7, Day Training Case Manager, and was told by Z7 R4 is not to get on the bus to day training without a doctor's note. On that same day, R4 saw Z9, Attending Clinic Doctor. Z9 wrote in a Progress Note dated 3/22/10 under Assessment/Plans: Pneumonia - CPM (continue present management) with afebrile from hospital add cough medicine PRN (as needed). RTW (return to work) - 3/24/10. Record review of the day training notes for R4 written by Z4, Training Specialist document on	W9999		

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W9999	Continued From page 29 3/25/10, "R4 appeared lethargic (head down, refused to communicate, appeared tired) today. Refused to engage. Very quiet." The day training note of 3/26/10 documents, "R4 appeared tired today. He had a cough today and fever. Home staff was notified." A day training incident report dated 3/26/10 at 10:20am written by Z7, Case Manager, notes, "R4 was sitting at his work area. Z3, Training Specialist, called this morning expressing concern about R4. According to Z3, R4 arrived to day training, appearing to look lethargic and sluggish. Upon arriving into the HAB (habilitation) services classroom #2, R4 was observed sitting down at his work area with his head down on the table. I immediately felt R4's forehead and he appeared to be warm. Five minutes later, I took his temperature and it registered 99.5 degrees. The facility was contacted at 10:25am to inform them about the incident. I spoke to E8, Qualified Mental Retardation Professional (QMRP), who indicated that no one was available to pick up R4. It was determined that R4 would be re-evaluated after lunch. R4 was observed participating at work area after lunch without any additional symptoms." On 4/6/10 at 3:02pm E8, QMRP, was interviewed. E8 was asked what communication did she have with day training site regarding R4 on 3/26/10. E8 stated, "I was told R4 had a low grade fever. I asked if a nurse could give (Acetaminophen) and they informed me they didn't have a nurse. I asked if they could transport him home to us and then he would be home." E8 was asked if she told the day training site no one was available to pick R4 up. She stated she couldn't recall. She added it is the day	W9999		

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W9999	Continued From page 30 training sites' responsibility per contract to transport him back. E8 confirmed R4 remained at day training and was not transported home. On 4/2/10 at 1:10pm E6, Direct Service Person, stated to surveyor she took R4 out to the store on an outing on Saturday, 3/27/10. On 4/1/10 at 2:45pm E5, Direct Service Person, stated he worked on 3/26/10 and R4 appeared fine. He played with his trucks, did not seem flushed or hot but did seem tired. On 3/28/10 he ate breakfast and was not running a fever. Right before noon R4 wanted to go to bed and I gave him a glass of milk. E5 was asked if he was given any instructions by the nurse regarding R4's pneumonia. E5 stated some medicine came in on 3/18/10 but he did not receive any other instructions other than for the medications. Record review of the facility staff schedule for March, 2010 notes E7, Direct Service Person (DSP), worked on 3/27/10 from 7:30am thru 3:30pm and on 3/28/10 from 9:30am thru 5:30pm. On 4/2/10 E7, DSP, was interviewed at 1:30pm. E7 stated she started working on 3/310. She stated she observed at the facility R4 and he had constant drool, sneezing a lot and he always had his jacket on. When asked what instructions she had received regarding R4's pneumonia, E7 stated no one gave her any instructions. E7 was told R4 had slight pneumonia and to keep an eye on him. On Saturday (3/27/10) R4 was fine. I was walking with him. He ate - drank milk. On Sunday (3/28/10) he was playing with his trucks and I know he ate breakfast. I'm not sure what he was doing Sunday.	W9999		

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W9999	Continued From page 31 Record review of the facility staffing schedule indicates E11, Direct Service Person (DSP), worked on 3/25/10, 3/26/10/, 3/27/10 and 3/28/10 from 3:30pm thru 11:30pm. On 4/8/10 at 10:40am E11, DSP, was asked if she had received any instruction/training regarding R4's pneumonia. E11 stated she was told he had a touch of pneumonia, watch him and if anything out of the ordinary to call E4, Regional Trainer. When asked who gave you this information, E11 stated, either E5, Direct Service Person, or E6, Direct Service Person. When asked if R4 drank liquids, E11 stated, "Milk, water, juice, mostly milk." On 4/8/10 at 11:10am E6, Direct Service Person, (DSP) said, "I worked from 2:30pm thru 10:30pm on 3/28/10. I saw R4 at 5:30pm laying in bed. I took him his dinner and he ate all of his meal. The next time I saw R4 was at snack time at 8:00pm. He was laying in bed under the blankets sweating. I got E10, DSP, because it takes two to take R4's temperature. We (E6 and E10) couldn't get him out of bed. He wouldn't get up. We (E6 and E10) called E9, Executive Director, and he said to contact Z8, R4's guardian, and find out which hospital she wanted us to take him to. He did walk but his balance was a little off. He normally comes with much more ease. I took washcloths and wiped his face. I changed his diapers and put on clean pajamas. We (E6 and E10) were still we not able to take his temperature. At that point we (E6 and E10) took him to the hospital. He had no difficulty breathing but was moaning. I don't remember any wheezing, no coughing and he was alert sitting upright during transport."	W9999		

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W9999	Continued From page 32 The Medication Administration Record (MAR) indicates on 3/28/10 R4 received Acetaminophen at 9:10am with the reason listed, "Fever." At 1:00pm R4 received Acetaminophen with the documented reason, "Painful cough" and cough medicine for, "Phlegm/drool." However, per review of progress notes, nurses notes and MAR there is no documented evidence that R4's vital signs had been monitored by the nursing staff or direct care staff since R4's initial diagnosis on 3/18/10 at this facility. Record review of Progress Notes completed by E12, Registered Nurse include no evidence that nursing evaluated R4's respiratory status since the initial diagnosis of pneumonia on 3/18/10. Nursing progress notes include: 3/18/10 - R4 taken to hospital ER (Emergency Room) for tx (treatment) of cough. New med (Levaquin) ordered for tx of Pneumonia. Staff given care instructions and plan to f/u (follow up) w/PCP (with primary care physician) as directed. R4 appears in no distress upon discharge. 3/19/10 - R4 had no SOB, (shortness of breath) minimal non-productive cough intermittently. Afebrile. Plan to continue ABX (Antibiotic) tx for pneumonia, observe and f/u as directed. 3/22/10 - R4 to physician for f/u for tx of pneumonia. Cough continues. Robitussin DM PRN (as needed) order received, staff in-serviced on change. R4 remains afebrile. Infection control maintained within the facility. R4 to return to physician as indicated.	W9999		

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W9999	Continued From page 33 3/28/10 - DSP reported R4 oppositional to ADL, (adult living skills) assist and appears sleepy. R4 taken to hospital ER for eval and tx. R4 treated for pneumonia. Guardian requested transfer to different hospital. Staff notified guardian. 3/31/10 - R4 remains hospitalized, condition guarded. On 4/6/10 at 10:20am E12, Registered Nurse, was asked if she physically assessed R4 from 3/18/10 thru 3/28/10. E12 stated, "No." E12 was asked how she wrote R4's progress notes without seeing him. E12 stated they were based on the reports from the hospital and from facility staff. E12 was asked about the 3/18/10 note which included, "Staff given care instructions," how this was completed. E12 stated she provided the instructions over the phone to staff. When surveyor informed E12 that E5, E11 and E7 had said they were not given specific instructions regarding pneumonia other than keep an eye on him and report anything out of the usual, E12 stated the facility practice is that when E12 contacts direct care staff at the time of her phone call, the direct care staff are to then train the other direct care staff. E12 said R4 did not raise any red flags and was not in acute distress. Regarding the direction from the hospital that R4 required rest due to the pneumonia, E12 stated that was a judgement call. Regarding the giving of milk to R4, E12 stated she would not have expected R4 to have milk. On 4/6/10 at 12:55pm Z9, Clinic Doctor, was interviewed. Regarding R4's pneumonia, Z9 stated usually when a person is diagnosed with pneumonia we keep him home for a week to 2 weeks. Surveyor asked if R4 was diagnosed on	W9999		

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W9999	Continued From page 34 3/18/10 why he was cleared for work on 3/24/10. She acknowledged that was 6 days and not a week. Surveyor asked Z9 if she was aware on 3/26/10 at day training R4 had a fever of 99.5 and was lethargic with his head down at a desk. Z9 stated, no. She did not have any contact with the facility regarding R4 other than on 3/22/10 when she evaluated him and released him to attend work on 3/24/10. Z9 stated neither she nor Z10, Primary Care Physician, were contacted regarding R4's symptoms of 3/26/10 at day training. E9, Executive Director, notified IDPH that while he remained hospitalized on 3/30/10 R4 was placed on a ventilator. On 4/5/10 at approximately 1:30pm, the facility was notified by R4's guardian that they had elected to discontinue life support yesterday. R4 passed away at approximately 2:00pm on 4/4/10 at the hospital. On 4/9/10 at approximately 3:30pm E9, Executive Director, was interviewed via phone by Z12, Field Supervisor. E9 was asked if he could verify that R4 was assessed by the nurse after the initial diagnosis of pneumonia was made by the doctor and prior to his hospitalization and death. E9 said he had documentation in front of him made by the nurse about R4. E9 was asked whether E9 could verify that the nurse physically assessed R4, made recommendations to the direct care staff on what to monitor and when to notify the nurse. E9 responded that the documentation is here, but had no response as to actual evidence the nurse visually assessed R4. E9 said to Z12 that staff did not have to document anything if there is nothing wrong. E9 was asked what evidence do you have that R4	W9999		

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W9999	Continued From page 35 was monitored based upon the diagnosis of pneumonia. E9 had no response to the actual availability of documented evidence. E9 did confirm that staff do not document if discharge orders from hospital say to monitor. E9 said the doctor released him and said R4 could go to work. When asked whether the doctor said the pneumonia was resolved, E9 said R4 could go to work. E9 was then asked how did the facility ensure that the medication R4 was receiving for pneumonia was helping. E9 replied R4 was okay and we sent him to work. E9 was asked how can you state that E12, Nurse, assessed R4 when based on an interview with E12, Nurse, she confirmed she only spoke to staff on the phone. E9 stated E12 is incorrect. E9 was asked why the facility did not send R4 to the ER after he presented not feeling well at workshop. E9 said we waited and he was not ill. When asked how often does your nurse see clients at this facility, E9 said they are required to be at the facility 4 hours per month. E9 was asked how does the nurse evaluate someone who is ill. E9 said R4 was not ill. The doctor said R4 was released. (A) 350.3240a) 350.3240b) 350.3240e) Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a	W9999		

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W9999	Continued From page 36 resident. (Section 2-107 of the Act) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act) These Regulations are not met as evidcenced by: Based on observations, record review and interview, the facility failed to ensure all 14 of 14 clients in the facility (R1 through R3 and R5 through R15) were protected from further contact with a staff (E5), who allegedly hit 1 of 1 client (R2) on the head with a shower head and pulled his right arm hurting his shoulder on 4/25/10. Findings include: R2, per his Individual Service Plan (ISP) dated 5/28/09, is a 67 year old male whose diagnoses include Mild Mental Retardation, Anti-social Personality Disorder, Bronchial Asthma and Bipolar Mixed. An incident report dated 4/26/10 at 8:42am, at the day training site, was reviewed. The description of event includes, "R2 arrived at work	W9999		

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PINE TERRACE	2017 NORTH PINE STREET WAUKEGAN, IL 60085

(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 37 and appeared to be a little upset to this writer (Z14, Program Services Supervisor). Shortly after arrival, R2 stated to writer that last night R2 did not want to take a shower saying it was too late. R2 described to writer that staff pulled on his right arm hurting his shoulder and that R2 was hit on the head twice with the shower head." The facility's report to the Illinois Department of Public Health dated 4/30/10 includes, "Please allow this letter to serve as notification of a possible inappropriate interaction involving R6, resident and an unknown staff member. On 4/30/10, the facility was notified by day training that an incident was reported to them on 4/26/10..." On 4/30/10 between 2:30pm through 3:21pm, E5, one of the two staff that worked on 4/25/10 according to the schedule provided by the facility on 4/30/10 at 2:50pm, was in the facility working with the clients, doing banking. The facility was unable to provide evidence that safeguards had been put in place when E5 was observed to be unsupervised and working with the clients. E4, Regional Trainer, was interviewed on 5/3/10 at 9:50am regarding the facility's investigation. E4 stated, "We have completed resident interviews. They (staff) were suspended after we (E4 and surveyor) talked (on 4/30/10). R2 stated both (staff) helped him with the shower and he got upset because he wanted to do it by himself. As soon as he (R2) said (that), E5, Direct Care Staff (DCS) said fine and they (E5 and E11, Direct Care Staff) completed the shower. E11 stayed to dry him (R2) and that's when he made the allegation and stated it to E11. E11 said, 'Are you sure?' He (R2) looked down and didn't say it	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G362	A. BUILDING _____ B. WING _____	C 05/06/2010

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W9999	Continued From page 38 again." The facility policy #5.24 with a revision date of 11/08 entitled as, "Investigative Committee" was reviewed. Under policy , it reads, "The facility shall establish an Investigative Committee to assist in the protection of individual resident rights and to provide a liaison between the individual and the administration of the facility. Under procedure, it includes, "A. Any facility employee or agent who witness or suspects a violation of residents' rights, abuse or neglect as well as injuries of unknown source shall immediately report the matter to facility management using the following protocol: 1. In order for the incident to be considered reported the employee or agent must speak directly to one of the following managers: > Administrator > Executive Director > Director of Operations 2. If the allegation is one of the following situations the Administrator or designee will contact law enforcement by calling 911 or the local emergency number: > Physical abuse involving physical injury inflicted on an individual by a staff member or visitor > Sexual abuse of an individual by a staff member , another resident, or a visitor > When a crime has been committed in the facility by a person other than an individual residing in the facility or: >When a resident's death has occurred other than by disease processes. 3. The employee or agent will document a brief	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W9999	Continued From page 39 note regarding the incident on a Progress Note (Form #GP-15) prior to leaving the shift. 4. Staff statements will be documented on a Progress Note (form #GP-15) by management and counter signed by the person being interviewed. B. If the allegation is that an employee committed an act of abuse or neglect, the employee shall be suspended from duty until such time as the: 1. Investigation is complete and ... 2. The Administrator considers the report and takes administrative action....." R2's record was reviewed. There is no progress notes written by E11, with regards to R2 reporting an allegation against E5 on 4/25/10. E4 was interviewed via phone on 5/3/10 at 2:50pm. E4 stated, "No, E11 didn't report the allegation to anyone in management." E4 further verified that E5 worked the 28th, the 29th and 30th of April until he was suspended after the daily status meeting when an Immediate Jeopardy was called on 4/30/10 at 3:21pm. (A)	W9999		