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	14G277	A. BUILDING _____ B. WING _____	09/01/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT MANOR	1404 SOUTH 14TH STREET HERRIN, IL 62948

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W 488	Continued From page 108	W 488		

and placed on one of the tables. E3 was observed to pick up the bowl of carrots and dip some onto the plates of R2, R4, R8, R9 and R14. E3 then continued to place a piece of pot roast onto their plates and dip their potatoes for them. E3 also cut up R14's meat and squirted ketchup onto his plate.

At 5:08 p.m., bowls of food were taken to the next table. E3 was noted to dip all food for R3, R6 and R10. E4 (Direct Support Person) was noted to dip all of R1's food onto her plate for her. After dipping R1's food onto her plate, E4 then cut up R10's meat for her.

During continuing observations on 07/20/10 during the dinner meal, E1 (Residential Service Director) and E3 were both observed to dip food onto the plates of R4, R5, R7 and R11.

On 07/20/10 at 5:14 p.m., R2, R8 and R14 all asked for water. E3 went into the kitchen and got glasses from the cabinet. She then came back to the table and poured water for R2, R8 and R14.

During interview with E3 on 07/21/10 at 8:20 a.m., when asked if the residents are capable of dipping their own food, E3 replied, "I'm sure they are, but it's easier for us to do it." E3 continued to say that most of the residents are capable of serving themselves but don't.

Per interview with E2 (Residential Service Director/Qualified Mental Retardation Professional) on 07/28/10 at 2:10 p.m., E2 stated that none of the residents have been assessed as to their capability to participate in family style dining. E2 also stated that the facility does not have family style dining assessments that reflect

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W 488	Continued From page 109 the residents' ability to set the table, pass serving bowls, dip their own food or pour their own drinks. During interview with E2 on 07/23/10 at 3:30 p.m., when asked how many residents in the facility were capable of doing some type of family style dining, even if it was hand over hand, E2 said, "I would say all of them are capable." None of the residents were given the opportunity to prepare a portion of the meal, set the table or serve their own food.	W 488		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.1060e) 350.3240a) 350.3240c) 350.3240d) 350.3240f) 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. 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)b) A facility	W9999		

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W9999	Continued From page 110 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) 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) c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act) f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act) These Regulations were not met as evidenced by: Based on interview and record review the facility failed to ensure that clients are not subjected to abuse or punishment impacting 14 of 14	W9999		

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W9999	Continued From page 111 individuals in the facility, when the facility failed to ensure: 1) All allegations of abuse are reported to the administrator. 2) Allegations of R3 hitting and slapping her peers is thoroughly investigated. 3) R3's physical aggression towards her peers is reported to state officials. 4) Systems are put in place to prevent R3 from continuing to physically aggress against her peers. 6) Individuals are allowed outside the facility and not punished by withholding food. (R8). 7) All allegations of abuse are reported to the Department. (R3, R8) Findings Include: 1) According to the facility roster (no date), R3 is a 58 year old female who functions at a Severe level of Mental Retardation. During review of the facility's monthly behavioral data book, documentation shows that R3 has had 19 episodes of physical aggression towards her peers since 02/07/2010. Documentation states: 02/07/10 - 6:30 p.m. - Hitting, slapping, stomping, mouthing. Documentation states that this behavior lasted 2 hours. 03/10/10 - 7:30 p.m. - Slapped peer (R5) across the face. 03/12/10 - Documentation sheet marked as	W9999		

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W9999	Continued From page 112 physical aggression and non-compliance. No additional information. 03/13/10 - 6:45 p.m. - Hitting, slapping others. 03/14/10 - 4:45 p.m. - Slapping at peers. 03/28/10 - 7:00 p.m. - Hitting others. 04/03/10 - 7:30 p.m. - Hitting others. 04/17/10 - 6:55 p.m. - Hitting others. 05/01/10 - 6:00 p.m. - Hitting others. 05/02/10 - 4:45 p.m. - Hitting others. 06/05/10 - Documentation sheet marked as physical aggression and non-compliance. No additional information. 06/06/10 - 6:45 p.m. - Hitting others. 06/11/10 - 6:35 p.m. - Hitting others. 06/12/10 - 4:30 p.m. - Hitting others. 06/13/10 - 7:15 p.m. - Hitting others. 06/14/10 - 5:45 p.m. - Hitting others. 06/25/10 - 8:00 p.m. - Hitting others. 06/28/10 - 4:30 p.m. - Hitting others. 07/11/10 - 5:30 p.m. - Verbal, physical and temper tantrum. No additional information. The facility is unable to ascertain if any injuries have been inflicted to other residents as the facility does not identify the victim, therefore ensuring his/her safety or health status. Per review of R3's Individual Program Plan dated 11/18/09, surveyor was unable to find a behavior intervention plan for R3's physical aggression. During interview with E2 (Residential Service Director) on 07/22/10 at 1:50 p.m., E2 stated that R3 is not on a behavior plan for physical aggression and that there is nothing in R3's monthly Qualified Mental Retardation Professional (QMRP) notes dated 02/2010 through 07/21/10 to identify that R3 is physically aggressing peers. When asked who R3 was	W9999		

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W9999	Continued From page 113	W9999		

hitting, E2 said, "Probably other peers." E2 said that the person filling out the behavioral data report did not write down the names of the peer or peers that R3 has hit.

Upon interview with E2 on 07/23/10 at 8:45 a.m., when asked how she could review the monthly behavioral data and not be aware of R3's physical aggression towards others, E2 said, "Obviously I missed it. I don't read every single one."

Per interview with E2 on 07/22/10 at 1:50 p.m., when asked if anyone has been injured when R3 became physically aggressive to them, E2 replied, "Not that was reported to me." Surveyor asked E2 if she was aware that R3 had slapped R5 across the face on 03/10/10. E2 said that the incident had not been reported to her. E2 continued to say that she knew that R3 was hitting others, but she did not realize it was so many times. E2 also said that she did not investigate or report any of R3's physical aggression episodes. E2 stated that there is currently no system in place to prevent R3 from continuing to hit others.

Review of the facility's, "Abuse Prevention Program" (no date) documentation within the program identifies the facility's definition of physical abuse as, "includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment." The Abuse Prevention Program continues to say, "...The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect or abuse of our residents. This will be done by:..

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W9999	Continued From page 114 ...Identifying occurrences and patterns of potential mistreatment; Immediately protecting residents in identified reports of possible abuse; Implementing systems to investigate all reports and allegations of mistreatment promptly and aggressively, and making changes to prevent future occurrences; and Filing accurate and timely investigative reports...." The facility's Abuse Prevention Program says, "Employees are required to report any occurrences of potential mistreatment they observe, hear about, or suspect to a supervisor and the administrator immediately." Continuing review of the facility's Abuse Prevention Program states, "The facility will take steps to prevent mistreatment while the investigation is underway." "Residents who allegedly mistreated another resident will be removed from contact with that resident during the course of the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement, considering his or her safety, as well as the safety of other residents and employees of the facility." Section VII of the facility's Abuse Prevention Program states, "...Within twenty-four hours after the occurrence, a written report shall be sent to the Department of Public Health. The written report should contain the following information, if known at the time of the report:	W9999		

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W9999	Continued From page 115 Name, age, diagnosis and mental status of the resident allegedly abused or neglected. Type of abuse reported (physical, sexual, theft, neglect, verbal or mental abuse). Date, time, location and circumstances of the alleged incident. Any obvious injuries or complaints of injury. Steps the facility has taken to protect the resident." Documentation continues to say, "Within five working days after the report of the occurrence, a complete written report of the conclusion of the investigation, including steps the facility has taken in response to the allegation, will be sent to the Department of Public Health." During interview with E2 on 07/22/10 at 1:50 p.m., E2 said that she has not investigated any of R3's behavioral incidents of hitting/slapping peers, has not reported any of the incidents of peer to peer aggression to the Department of Public Health and has not put systems in place to protect the other individuals who live in this facility. E2 stated that the facility's Abuse Prevention Program was not followed in regards to R3 allegedly hitting peers. The facility was unable to provide evidence that the facility had initiated a system to ensure safeguards are in place to ensure that clients do not abuse other clients by initiating safeguards. The facility did not provide evidence that the administrator was notified of the client to client abuse. The facility did not investigate the client to client abuse and was unable to provide evidence that clients are not mentally or physically injured. The facility also did not report the client to client abuse allegations to the Department of Public	W9999		

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W9999	Continued From page 116 Health. 2) Per review of the facility roster (no date), R8 is a 40 year old male who functions at a Moderate level of Mental Retardation. Upon review of R8's physician's order sheet dated 07/01/10 through 07/31/10, R8 is prescribed a Regular Diet. During review of the facility's Hab. (Habilitation) Notes regarding R8, documentation states: 03/12/10 at 8:45 p.m. - "At snack time this (p.m.) (resident) refused his snack, then after (bedtime) snacks was finished staff was putting other residents to bed, (resident) stated he wanted his snack NOW and resident became angry at staff when his request was refused. Staff explained to resident, if you refused your (bedtime) snack you cannot come to kitchen later and demand a (bedtime) snack. Staff explained that that is a rule we all follow and that he should get ready for bed. (Resident) became physically and verbally aggressive towards staff, put his coat on and repeatedly tried to walk out of the facility and across the parking lot (times) 4, stating he was F....ing leaving and walking home. Repeatedly staff convinced resident to return to facility. (Resident) verbally abuse(d) staff and slamming bedroom door (times) 5. Repeatedly staff tried to explain why he didn't receive (bedtime) snack. This behavior continued for four hours. (Resident) now refusing to go to bed. Up with clothes on and coat this four hours. (Resident) finally calmed down and went to bed about 2:45 a.m.. Before resident went to bed he apologized to staff for behavior."	W9999		

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W9999	Continued From page 117 Upon review of the facility's, "Individual Daily Schedule," (no date) the bedtime snack is served from 8:00 p.m. until 9:00. According to this schedule from 9:00 p.m. until 10:00 p.m. the residents are preparing for bed and bedtime is 10:00 p.m.. 03/21/10 at 7:05 a.m. - "(Resident) was asked to get out of bed and come eat breakfast, (resident) replied no I'm not going to eat or take my (medications). Staff asked another staff to ask (resident) to come and eat and take his (medication). (Resident) reply was I'm not eating or taking (medication)." 03/21/10 at 8:30 a.m. - "(Resident) came to living room, demanding his breakfast, staff explained to (resident) that he needed to come to breakfast when asked. (Resident) replied your (you're) not doing your job. Staff asked (resident) to go to his room. (Resident) replied I'm not going to work tomorrow." Upon review of the facility's, "Individual Daily Schedule," on weekends, breakfast is served from 8:00 a.m. until 9:00 a.m.. Per interview with E2 on 07/22/10 at 2:30 p.m., when asked whether R8 got breakfast on 03/21/10, E2 said, "It doesn't look like it." E2 continued to say that she was not aware of this incident. 03/22/10 at 8:45 p.m., - "(Late entry for 3/20/10), At snack time resident ate snack and juice. Later when we were putting other residents to bed, (resident) came and stated he wanted his snack he didn't get one. This writer watched (resident) eat snack. (Resident) stated that those are my	W9999		

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W9999	Continued From page 118 "f___ing" snacks and he wasn't going to work in the A.M. he was mad and went to room and slammed door for an hour to hour and a half (resident) kept coming back to try to get staff to give him some more snacks. Redirected resident (times) 8 to go to bed. Finally went to bed at 10 P.M." Per interview with E2 on 08/12/10 at 9:20 a.m., E2 stated there is no reason why R8 cannot have seconds on his meal or snacks. E2 said, "I have nothing from dietary saying he can't have seconds." 03/27/10 at 8:00 p.m. - "(Resident) was found walking in middle of road, was then told he could not go outside rest of day. (Resident) was found outside several more times after told not to be. (Resident) was redirected to his room. Staff removed coats (and) shoes from room." 04/03/10 at 6:00 p.m. - "...(Resident) would go outside and start walking down the street. Staff would have to get him. (Resident) was made to stay inside the building. Staff kept eyes on him all evening." 04/10/10 at 10:30 p.m. - "...Staff had to make him come in from outside (it was dark)." During interview with E2 on 07/22/10 at 1:50 p.m., E2 stated that R8 should not have been restricted from going outside. E2 continued to say that staff cannot take away R8's shoes and coat. E2 said that R8 does not have a history of elopement, has no Behavior Intervention Plan for leaving the facility and that R8's threats to leave the facility and walking in the road are not part of his Individual Program Plan. E2 said that she	W9999		

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W9999	Continued From page 119 was not aware of any of the incidents in which R8 threatened to go home and that none of the documentation in R8's habilitation notes was reported to her. E2 stated that no system has been put in place to prevent R8 from leaving the facility again or ensuring R8's food and clothing is not withheld as a punitive measure. Upon review of the facility's "Abuse Prevention Program" (no date), documentation defines: Abuse - "Abuse any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means in a facility. Abuse is the willful inflection of injury, unreasonable confinement, intimidation, or punishment and with resulting physical harm, pain, or mental anguish...." Mental abuse - "includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation." Misappropriation of resident property - "is the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent." Per interview with E2 on 07/22/10 at 1:50 p.m., E2 stated that the facility's Abuse Prevention Program has not been followed. There is no evidence that staff were prevented from using punitive measures to intervene for behavioral interventions. (A)	W9999		

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W9999	Continued From page 120 350.1210 350.1410a) 350.1410d) 350.3240a) 350.3760a) 350.3760h) 350.3760l) Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. Section 350.1410 Medication Policies and Procedures a) Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning and disposing of drugs and medications. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State and local laws. Medication policies and procedures shall be developed with the advice of a pharmaceutical advisory committee that includes at least one licensed pharmacist, one physician, the administrator and the director of nursing. This committee shall meet at least quarterly. d) All medications administered shall be recorded as set forth in Section 350.1620. Medications shall not be recorded as having been administered prior to their actual administration to the resident. Section 350.3240 Abuse and Neglect	W9999		

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W9999	Continued From page 121 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 350.3760 Medication Policies a) In order for each resident to attain the highest possible level of independent functioning, all residents shall be permitted to participate in their total health care program. This program shall include, but not be limited to, resident training in preventive health and self-medication procedures provided by a licensed nurse. Every facility shall adopt written preventative health and self-medication policies and procedures, which are consistent with the purpose of the Act and this Part and which shall be followed in the operation of the facility, for assisting residents in obtaining preventative health and self-medication skills. These policies and procedures shall be developed with consultation from an Illinois registered professional nurse and a registered pharmacist. These policies and procedures shall be part of the written program of care and services. (See Section 350.620.) h) All medications used by residents shall be properly recorded by facility staff at time of use. (See Section 350.1620(g).) A medication record need not be kept for those residents for whom the attending physician has given permission to keep their medication in their room and to be fully responsible for taking the medications in the correct dosage and at the proper times themselves. l) Medication may be administered by non-licensed direct care staff who have been	W9999		

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	14G277	A. BUILDING _____ B. WING _____	09/01/2010

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W9999	Continued From page 122 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 that all drugs are administered without error for 5 of 13 residents in the facility who were observed to receive unidentified medications during the 07/20/10 and the 07/22/10 4:00 p.m. medication passes (R2, R3, R6, R10 and R14) when they failed to ensure: 1) Only licensed staff administer injectable medications. 2) An accurate system for identifying medications prior to administration. 3) Medications are given at the time in which they are ordered. 4) Individuals receive complete dosage of medications via nebulizer. 5) The facility follows their own policy/procedure regarding medication administration. which has the potential to impact all 14 individuals residing at this facility. (R1 through R14) Findings Include: 1) Upon review of the facility roster (no date) R3 is a 58 year old female who functions at a Severe	W9999		

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W9999	Continued From page 123 level of Mental Retardation. Other diagnoses include Insulin Dependent Diabetes Mellitus. According to R3's Physician's Order Sheet dated 07/01/10 through 07/31/10, R3 is prescribed Lantus Injectable Solostar - 7 units to be given at bedtime. Per review of R3's current Medication Administration Record dated 07/01/10 through 07/20/10, documentation shows that direct care staff have initialed that they gave R3 her insulin injection daily at 8:00 p.m.. During interview with E4 (Direct Support Person) on 07/21/10 at 11:25 a.m., E4 stated that R3 receives her insulin via insulin pen. E4 continued to say that R3 is unable to set her insulin pen to the correct dosage, so direct care staff adjusts the setting for her. When asked who administers the injections to R3, E4 said that R3 would not be able to inject her own insulin so direct care staff pushes the button on top of the pen to inject the insulin." While interviewing E2 (Residential Service Director) on 07/22/10 at 2:30 p.m., E2 said that she was not aware that Direct Support Person's were not allowed to give the resident's insulin. During interview with E6 (Registered Nurse Consultant) on 07/22/10 at 4:20 p.m., E6 stated that Direct Support Staff have not been trained to administer Insulin. According to the facility's, "Medication Administration Policy" dated 09/21/02, documentation states, "No injections, rectal or vaginal administration routes may be delegated	W9999		

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W9999	Continued From page 124 (to direct care staff)." Per review of the State law Rule 116, documentation states: "Section 116.50 Administration of Medications ...b) Non-licensed staff shall not administer any medication in an injectable form...." 2) According to the facility roster (no date), R6 is a 66 year old female who functions at a Severe level of Mental Retardation. R6's Physician's Order Sheet dated 07/01/10 through 07/31/10 states that R6 has diagnoses of Syphilis, Epilepsy, Cerebellum Degeneration, Di fuse Osteoporosis, Anemia, Peripheral Ulcer Disease and Edema. Upon review of R6's current Physician's Order Sheet dated 07/01/10 through 07/31/10, R6 is prescribed the following medications daily at 4:00 p.m.: Lorazepam 1 milligram, Haldol 2 milligrams, Carbamazepine Chews 100 milligrams, Sodium Chloride 1 gram, Potassium Chloride 10 millequivilents, Senna S 8.6-50 milligrams and Osyco 500 milligrams. R6's current Physician's Order's continues to show that R6 is also prescribed Haldol 2 milligrams, Lorazepam 1 milligram and Carbamazepine 200 milligrams to be administered at 8:00 p.m.. During the 4:00 p.m. medication pass on 07/20/10, surveyor observed R6 being brought into the medication room via her wheelchair at	W9999		

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W9999	Continued From page 125 6:10 p.m.. E5 (Direct Support Person) got R6's medication cassette from the shelf on the wall and dumped the contents of the 4:00 p.m. slot onto R6's Medication Administration Record (MAR). E5 then counted the pills that were laying on the MAR and put them into her hand. Surveyor asked E5 how many pills she was administering to R6. E5 stated that she had 8 pills to give to R6. When informed that R6's MAR showed that she was to receive only 7 pills at this medication pass, E5 said that she had looked at the typewritten sheet (no date) written by E8 (Registered Nurse Consultant) in the medication book and it stated that R6 was to get 8 pills and that there were 8 pills in the medication cassette for the 4:00 p.m. slot. E5 did not identify what medications were administered to R6. At 6:15 p.m. on 07/20/10, surveyor asked E5 to identify R6's medications prior to administration. E5 laid the pills back onto the MAR and was unable to accurately identify any of the pills except for the Senna S, Lorazepam and Haldol. There were 2 white oblong tablets laying on the MAR, one had darker specks on it and one was solid white. E5 identified the 2 white oblong tablets as being Thermotabs. Surveyor informed E5 that R6 was not prescribed Thermotabs to be given at 4:00 p.m. as per R6's current physician's orders dated 07/01/10 through 07/31/10. At 6:22 p.m., E4 (Direct Support Person/Cook) came into the medication room to assist E5 with the medication identification. Both E4 and E5 continued to try and reconcile the pills with the MAR. At 6:35 p.m., both E4 and E5 were unsuccessful with the medication identification/reconciliation. At this time, surveyor informed both direct support persons that they	W9999		

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W9999	Continued From page 126 should call the facility's Registered Nurse Consultant. On 07/20/10 at 7:00 p.m., E6 (Registered Nurse Consultant) arrived at the facility. E6 said that in order to identify the pills he would look at the MAR's, find other residents who have the same medication ordered and compare R6's pills to the pills in the other resident's medication cassette. E6 stated that there was no medication reference book at the facility to identify the pills, nor were the pills identified by the pharmacy. . Per interview with E6 on 07/21/10 at 9:30 a.m., E6 said that R6's 4:00 p.m. medications were given about 7:20 or 7:25 p.m.. When asked what medication did not belong in the 4:00 p.m. medication slot on R6's medication cassette, E6 stated that he thinks that the Calcium Chloride tablet is ordered for 8:00 p.m. and not 4:00 p.m., but that the tablet had fallen into the 4:00 p.m. slot on the medication cassette. When asked if pills fall into other time slots within the medication cassettes often, E6 replied, "Probably happens a little bit too often." Upon interview with E4 (Direct Support Person) on 07/21/10 at 10:05 a.m., when asked which of the medications was not to be given at 4:00 p.m. on 07/20/10, E4 stated that R6's 8:00 p.m. seizure medication (Carbamazepine 200 milligrams) had somehow gotten into the 4:00 p.m. slot. E4 continued to say that you have to be careful when you slide the medication cassette open because sometimes a pill will fall into the 8:00 p.m. slot. E4 said that pills have fallen from an earlier time slot into the 8:00 p.m. slot in the past. E4 stated that R6's 4:00 p.m. medication was given at 7:25 p.m. on 07/20/10.	W9999		

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W9999	Continued From page 127 During interview with E6 on 07/21/10 at 9:30 a.m., when asked what time R6 received her 8:00 p.m. medication, E6 stated that he was not sure, but that he had told the Direct Care Staff to give R6's 8:00 p.m. medication later than usual so the medication times would not be so close together. E6 continued to say that R6 receives Haldol at 4:00 p.m. and bedtime and it (Haldol), "gets toxic if given too close together." R6's current Physician's Order's dated 07/01/10 through 07/31/10 shows that R6 is also prescribed Haldol 2 milligrams, Lorazepam 1 milligram and Carbamazepine 200 milligrams to be administered at 8:00 p.m.. Upon review of R6's Medication Administration Record, documentation shows that R6's 07/20/10 4:00 p.m. medication is documented as being given at 4:00 p.m. and the 8:00 p.m. medication is documented as being given at 8:00 p.m. Documentation within R6's Registered Nurse Consultant notes dated, "At 7:15 p.m. she (R6) received her medications (1600). There was some confusion while trying to identify some of her 1600 medications, however staff and I did figure out what each tablet was and then gave her medication right away." The facility was unable to provide additional evidence as to when R6 received or was have received her 4:00 p.m. and 8:00 p.m. medication on 07/20/10. 3) R2 is a 56 year old male who functions at a Moderate level of Mental Retardation.	W9999		

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W9999	Continued From page 128 During review of R2's Physician's Order Sheet dated 05/18/10, documentation states that R2 has diagnose's which include: Respiratory Failure, Chronic Hypercapnia, Congestive Obstructive Pulmonary Disease, Bronchitis and Hypoxemia. Upon review of R2's Physician's Order Sheet dated 07/01/10 through 07/31/10, at 4:00 p.m. daily, R2 is to receive: Mucinex 600 milligrams (2 tablets), Metformin 1000 milligrams, Oyst-Cal 500 milligrams, Antacid Plus Suspension (1 tablespoon before meals) and Budesonide Suspension 0.25 milligrams/2 centimeters per nebulizer. During observation of the 4:00 p.m. medication pass on 07/20/10, R2 came into the medication room at 6:05 p.m.. E5 (Direct Support Person) was noted to retrieve R2's medication cassette from the slot on the wall of the medication room. E5 poured R2's pills from the medication cassette onto R2's Medication Administration Record. When E5 picked up the pills to administer them to R2, a round white tablet fell onto the floor. E5 picked up the pill and said, "This one's not for this time, will have to see which slot it came out of." E5 then put the pill into a plastic cup and set it on the counter. When asked what the pill was, E5 stated, "I don't know." E5 gave R2 the remaining 4 tablets that were in her hand. Continuing observation shows that at 6:15 p.m., E5 poured Ipratropium Solution into a nebulizer container. E5 then added Budesonide Suspension 0.25 milligrams/2 centimeters to the Ipratropium Solution. E5 took the nebulizer medication to R2's bedroom and attached it to the nebulizer machine. E5 told R2 to use all of	W9999		

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W9999	Continued From page 129	W9999		

the medication and shake it every once in a while to get all the medicine out. E5 then left the room.

There is no evidence ensuring R2 was supervised during the nebulizer treatment, shook the medication during the treatment and, as of 7:20 p.m., the unidentified white pill remained in a plastic cup sitting on the counter in the medication room.

According to the facility's, "Medication Administration Policy" dated 09/21/02, documentation states, "Remain with the individual until the medication is taken."

4) Upon review of the facility roster (no date) R10 is a 63 year old female who functions at a Mild level of Mental Retardation.

According to R10's Physician's Order Sheet dated 07/01/10 through 07/31/10, R10 has the following medications to be taken daily at 4:00 p.m.:Terazosin 1 milligram and Calcium 600 milligrams.

During observation of the 4:00 p.m. medication pass on 07/20/10, R10 was assisted into the medication room by E5 (Direct Support Person) at 5:49 p.m.. E5 seated R10 in a straight chair in the medication room across from the medication counter. E5 poured R10's medications from R10's medication cassette into E5's hand. As E5 started to put the pills into R10's hand, a pill fell onto the floor in front of R10. E5 picked the pill up and told surveyor, "I understand we're not to pick them up off the floor and give them but this is one she really needs." E5 then rinsed off the pill with water and put it in R10's mouth. When asked what pill was dropped on the floor, E5 stated that

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W9999	Continued From page 130 it was Terazosin (Blood pressure medication). According to the facility's, "Medication Administration Policy" dated 09/21/02, documentation states, "If a medication is dropped, thrown or spit out by a client staff should place the medication in a bag and give it to the Administrator or RSD (Residential Service Director). Staff should use another days prescribed medication to replace the medication when this occurs." 5) Medications administered during the 07/20/10 4:00 p.m. medication pass that were observed not to be administered on time as identified on the Medication Administration Record: A. Per review of R2's Medication Administration Record, dated 07/01/10 through 07/31/10 documentation shows that R2 is to receive Ipratropium/Solution Albuterol via nebulizer every 8 hours at 7:00 a.m., 3:00 p.m. and 10:00 p.m.. During observation of the 07/22/10 4:00 p.m. medication pass, E4 (Direct Support Person) was observed to administer R2's 3:00 p.m. dose of Ipratropium/Solution Albuterol via nebulizer at 4:40 p.m.. E4 stated, "I know Albuterol is ordered for 3 o'clock but he got it late." B. Per review of R14's Medication Administration Record, dated 07/01/10 through 07/31/10, documentation shows that R14 is to receive Lorazepam 1 milligram at 4:00 p.m. Per observation of the 07/20/10 4:00 p.m. medication pass, E5 (Direct Support Person) was observed to administer R14's 4:00 p.m. dose of Lorazepam 1 milligram at 5:35 p.m. C. Per review of R10's Medication Administration	W9999		