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	14G225	A. BUILDING ______ B. WING ______	C 04/12/2011

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W 149	Continued From page 8 5. Day Training protocol were modified. 6. Bus procedures were modified. Upon admission/more often as necessary, PICA behavior will be addressed as follows: a. IDT will assess the behavior and a plan will be developed to incorporate the behavior into the IPP. b. The environment will be modified accordingly in any area of concern for the safety of the resident. c. Staff supervision levels will be reviewed and addressed. d. Resident with PICA behaviors will be kept in view during waking hours and staff monitoring during sleep time. e. Documentation will summarize resident activity every shift. f. Staff will be trained on any and all revisions/developments. Although the Immediate Jeopardy is removed, the non-compliance continues at the time of the exit since the facility has not fully implemented their plan and has not had an opportunity to evaluate it's effectiveness.	W 149		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1060b) 350.1060c) 350.1060e) 350.1060j) 350.3240a)	W9999		

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W9999	Continued From page 9 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 b) Each resident shall have individual evaluations which shall: 1) Be based upon the use of empirically reliable and valid instruments whenever such tools are available. 2) Provide the basis for prescribing an appropriate program of training experiences for the resident. c) There shall be written training and habilitation objectives for each resident that are: 1) Based upon complete and relevant diagnostic and prognostic data. 2) Stated in specific behavioral terms that permit the progress of the individual to be assessed. 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. j) Appropriate records shall be maintained for	W9999		

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each resident functioning in these programs. These shall show appropriateness of the program for the individual, resident's response to the program and any other pertinent observations and shall become a part of the resident's record.

Section 350.1210 Health Services

The facility shall provide all services necessary to maintain each resident in good physical health.

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 record review and interview the facility failed to prevent neglect for 1 of 1 client (R1) in the facility with a history of behaviors associated with PICA which required R1 to be admitted to the hospital and undergo a procedure for the removal of an inedible object when the facility failed to:
1. Evaluate and ensure appropriate supervision for an individual with identified PICA behavior requiring a surgical intervention.
2. Ensure staff are retrained on R1's supervision level and environmental planning for protection.
3. Ensure programming for R1's behavior of PICA while at the day training provider.

Findings include:

1. The facility client roster provided on 3/21/11 at

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W9999	Continued From page 11 11:30AM identified the following client with behavioral/health related issues (PICA behavior). R1 is a 58 year old male with a diagnosis of Profound Mental Retardation, Autism, Impulse Control Disorder and Hepatitis B Carrier per client roster. The facility policy "Resident Abuse, Neglect, and Mistreatment Policy" (no date stated) was reviewed and included the following. "Definition:Neglect-failure to provide goods or services necessary to avoid physical or psychological harm. All incidents of alleged abuse, neglect and/or mistreatment shall be immediately reported to the RSD and Administrator. IDPH shall be notified. An investigation shall be conducted and the conclusions reported to the Administrator, guardian and IDPH. An IDT shall be held and programs will be developed and/or revised as needed. Disciplinary action shall be taken if necessary. Staff retraining will be held if necessary. Environmental factors shall be examined to see if revisions need to be made." Review of R1's Individualized Service Plan (ISP) dated 10/15/10 notes R1 receives behavior modifying medications to address his maladaptive behaviors (elopement, PICA, self-abuse and agitation) and behavior programming in relation to his diagnosis of Impulse Control disorder. It was noted that R1 "is not on a formal behavior plan at workshop but we do monitor the behaviors for the residential." It was reviewed that R1 "is non-verbal, has loud vocalizations and at times difficult to redirect."	W9999		

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R1's "Psychotropic Medication Review" dated 10/15/10 was reviewed. It was noted that R1 "ingests Thorazine 900mg & Depakote 1000mg daily to control his altered states of thought evidenced by his self abuse, elopement, agitation and PICA." It was reviewed that the section addressed as "Frequency: R1 had 1 incident of PICA from 9/24/10-10/15/10." The "Treatment Program Section" notes "staff are to redirect R1 to a manipulative activity (utilizing a slinky, string of beads ect) to occupy his hands and prompt him to utilize the object to avert self aggression." There was no evidence of staff monitoring and R1's level of supervision and no clinical definition of R1's PICA behaviors and staffs' appropriate response to the attempt to ingest inedible objects. In addition it was reviewed that R1 has a objective to address deficits in eating. R1 is to be monitored during meals to ensure R1 "takes smaller bites and chew his food thoroughly before swallowing to prevent choking."

R1's physical examination of 8/30/10 was reviewed. R1's "Impression/Comments" section noted R1 displayed PICA. [It was noted there was no reproducible evidence to document what item R1 ingested or attempted to ingest.] Findings from the 8/30/10 examination noted "PICA increases add Ativan 1 mg three times a day." In addition it was reviewed that E2(Residential Facility Director-RSD) stated he spoke with R1's guardian on 8/30/10 at 5:15PM. "R1's guardian stated she doesn't believe that R1 needs Ativan for PICA and agrees with R1's psychiatrist that R1 may just need a snack or a little extra food every now and again to prevent PICA." There was no other clinical evidence present to address the guardian/psychiatrist

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recommendations. R1's clinical record did not include these recommendations.

R1's "Physician Consultant Report" of 10/5/10 was reviewed. It stated "R1 is doing better. He gets a snack when he gets home from work and at other times & he is no longer eating feces. Since he's gotten more snacks he's done less stealing of others food or rummaging in the fridge."

Review of facility incident report of 1/3/11 for R1 sent to IDPH on 1/4/11 at 11:59AM for "Emergency Room Visit." R1 was taken to the ER by staff on the evening of 1/2/11. "They thought he may have eaten a bar of soap from his grooming box. Upon testing, it was found he had eaten the soap. Due to R1's combativeness and being very uncooperative; he was sedated and the soap was removed. He was kept overnight for observation and kept sedated. Guardian was notified and gave permission."

R1's incident report dated 1/3/11 at 4:00PM was also reviewed. "R1 vomited a mucous-white discharge. Staff (no name stated) had given R1 lunch but R1 did not eat. R1 did have kool aid but that came back up. R1 was shaken by the incident and looked startled. R1 was gurgling a soapy foam and staff (no name) looked but could not find his soap. Staff called E2(Residential Service Director) about possibly eating soap. After calling the doctor about the situation. The Doctor recommenced staff take R1 to the ER to be evaluated, (staff did try to get R1 to vomit into the toilet but it didn't help). The nurse was notified and told staff to take R1 to ER for further evaluation."

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Facility investigation of the 1/2/11 incident (no date stated) as reported by E2 indicates, "I spoke to the third shift staff (no name) which worked Saturday 1/1/11. E3 (Hab Tech) said she had replaced the bars of soap in the few of the grooming boxes on R1's end of the hallway but could not remember if R1's was in fact one of the soaps that she had replaced.
I spoke to both ladies (no names stated) who were on the shift when R1 was suspected of eating the soap. E4 (Hab Tech) told me that when staff had thought that R1 had eaten soap, they went looking in R1's grooming box and could not find the soap dish. The other staff member on duty, E5 (Hab Tech) said that she had also looked but no soap dish was found. Both staff reported that R1 barely touched his lunch.
I spoke with E6 (Hab Tech) who came on shift at 4pm (no date) and he said that after R1 had already left for the hospital he went to look for R1's soap & soap dish and found both in his grooming box with half of a bar of soap in it.
I looked through all of the residents (no names stated) soap containers as I was replacing them with liquid soap and found that a resident (no name) in the room next to R1's did not have a bar of soap at all. E3, who had worked the 3rd shift on 1/1/11, said that once she put soap in the grooming boxes that she places them by the resident doors and when they awaken, they can take them into their rooms. E3 believed that R1 must of gotten into the other residents grooming box before the other resident was awake."

Review of R1's "Universal Notes" dated 1/2/11 (8-4); "R1 refused to eat breakfast but had med's.

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W9999	Continued From page 15 He seemed fine until lunch time then began to get sick. R1 went to the hospital @ 4:40PM." Review of R1's "Nurse's Notes," dated 1/2/11, noted the following: "R1 was taken to the ER due to gurgling and vomiting small amounts of mucus. R1 sort of cooperated for a chest x ray but not a neck x ray. R1 was given Ativan to calm down as he kept trying to leave. Staff continued to calmly explain to him why he was there. R1 let nurses do everything that needed to be done; ie. injections, Intervenous ect. It was decided surgery would be done. During surgery an ENT (Ear, Nose & Throat) surgeon was called in and both surgeons worked on R1 due to object being really lodged. Some was gotten out but rest of object pushed down into his stomach. Doctor stated it was a full bar soap. He was kept sedated and kept overnight in the critical care unit for observation. During the night a ventilator was put in due to possible aspiration. X rays were taken 1/3/11 and pneumonia diagnosed. At this time he remains on a ventilator. 1/7/11-R1 returned home at 9:15AM. R1 was discharged with 2 additional medications; Levaquin for 7 days & Protonix to help his stomach." During interview with E2 on 3/21/11 at 3:30PM, E2 confirmed the 1/2/11 incident with R1. E2 confirmed that R1 had exhibited PICA behaviors in the past at the residential facility. E2 stated that there was no formal individualized programming to address R1's behavioral deficit in an association to PICA behaviors at the time of the 1/2/11 incident. E2 stated there was no reproducible evidence to present Inter Disciplinary Team review of R1's supervision	W9999		

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W9999	Continued From page 16 level at the residential facility. In addition E2 stated there was no reproducible evidence to address review/changes of environmental factors affecting R1. E2 was unable to provide evidence of PICA related behaviors during the 9/24/10-10/15/10 time frame. There was also no evidence to address the 8/30/10 physical examination noting PICA behavior. E2 also confirmed no formal and/or informal programming at the day training provider to address R1's PICA behaviors. During interview with E1 on 3/21/11 at 4:30PM. E1 confirmed there was no reproducible evidence to address R1's supervision level and staff instruction to address R1's supervision level or programming to address environmental factors. (A)	W9999		