STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G222	A. BUILDING _____ B. WING _____	07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STUART ESTATES	13 NORTHBROOK DRIVE MCLEANSBORO, IL 62859

(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 25 07/05/11 remains out of compliance since the facility has not had the opportunity to fully implement and evaluate the effectiveness of this plan.	W 331		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1210 350.1230b)3)7) 350.3240a) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.1210 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: 3) Periodic reevaluation of the type, extent, and quality of services and programming.	W9999		

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W9999	Continued From page 26 7) Modification of the resident care plan, in terms of the resident's daily needs, as needed. 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 observation, interview and record review, the facility failed to develop and implement an effective system for fall prevention for 1 of 1 individual outside the sample (R5) who was identified as needing closer staff supervision after falling on 03/29/11, 04/03/11 and 05/12/11 and affecting 6 of 6 additional individuals of the facility with documented falls within the past six months (R1, R2, R3, R4, R12 and R14). The facility failed to: 1) Assess and identify individuals who are at risk for falls; and 2) Develop and implement a fall prevention plan which includes the necessary supports to prevent further falls. Findings include: During Task II of the survey process, the surveyor requested a copy of the facility's protocol for fall prevention. On 06/16/11 at 1:50 P.M., E1 (QMRP/Qualified Mental Retardation Professional/RSD) stated that the facility did not have a policy and procedures and/or protocol relating to fall prevention.	W9999		

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W9999	Continued From page 27	W9999		

The facility's undated roster states that R5 is a 64 year old female who functions at a profound level of mental retardation. In reviewing the Incident/Accident Reports for the past six months, R5 fell on 03/29, 04/03 and 05/12/11.

The 03/29/11 report states that R5 was in the dining room doorway coming in from outside when she fell slowly to her knees. R5 sustained a scrape to her left knee with bruising.

The 04/03/11 report states that R5 was walking around and when she turned around, she fell forward. May have hit her face. Didn't fall hard at all. This report states that for future interventions, R5 will be watched more closely whiles she's up walking.

The 05/12/11 report states R5 was in the middle of the living room with no peers within arms length and she was walking around screaming (and) just fell down on R (right) side. R6 was checked for bruising, swelling, redness and her range of motion was checked. Mineral ice was placed on her knees. Under the section marked, "Future Interventions to Prevent Incidents" it states, "Advise staff that we need to watch R5 when having tantrums because she is more of a fall risk."

The Quarterly Nursing Assessment completed on 04/27/11 does not address R5's two falls during the quarter nor does it address the level of supervision needed for fall prevention.

R5 was observed on 06/14/11 from 4:00 to 5:30 P.M. walking/pacing the area between the dining room and the living room area of the facility

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W9999	Continued From page 28	W9999		

without staff supervision. R5 had no visible injury to her face as observed during the medication administration pass on 06/14/11 at 4:30 P.M. when staff placed medication in both of her eyes, nor when observed during the evening meal at 5:00 P.M.

R5 was observed at the offsite day training program on 06/15/11 at 11:59 A.M. R5 was noted to have visible black and blue bruising from the upper left forehead down to her left eye and left upper cheek bone. Z1 (Day Training staff) was present in the room. When Z1 was asked what happened to R5's eye, this staff shrugged her shoulders and stated, "They said she fell." When asked who she was referring to she stated, "the facility." She then went on to state, "They called this morning and told us that she had fallen and that's how she got a black eye and those bruises."

The facility's Incident/Accident Report Dated 06/14/11 states, "Unknown" as to how R5 sustained bruising to her eye. No future interventions are documented on this report as to what action the facility will take to prevent further incidents.

E1 (QMRP/RSD) was interviewed on 06/21/11 12:20 P.M. and stated that after R5 sustained injury to her eye of unknown origin. After this incident (discovered 06/14), the facility investigated and increased R5's level of supervision.

After increasing R5's level of supervision, an Incident/Accident Report dated 06/15/11 states, "Was helping set table when R5 came in dining

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W9999	Continued From page 29	W9999		

room from bed room. Turned around and found R5 at first table on floor..." This report identifies that R5 fell on her butt and L (left) hip and may have possible bruising from the fall. Further review of this report state that staff should, "Stand beside her more maybe."

In reviewing R5's record, no fall risk assessment was located.

E1 was interviewed on 06/21/11 at 12:20 P.M. and confirmed that no fall risk assessment had been completed for R5. E1 stated, "R5 does not have a fall risk assessment. I talked with E4 (RN/Registered Nurse Consultant) about completing one. R5 does not have a plan for falls. We have a fall tracking log." At this time E1 presented the surveyor with a "Resident Fall Tracking Log" for R5 dated 2011. This log identifies that R5 fell on 04/03, 05/12 and 06/14/11. The 03/29/11 fall was not included on this log until brought to E1's attention. When E1 was asked if the facility had reproducible evidence that action had been taken by the facility to prevent further falls after R5 fell on 03/29, 04/03 and 05/12/11, E1 stated, "Nothing but the Tracking Log." When E1 was asked what action the facility took after staff documented that R5 needed to be monitored more closely when she was up walking, she stated, "We increased R5's level of supervision after she sustained injury to her eye on 06/14/11." When E1 was asked if staff implement the increased level of supervision on 06/15/11, when R5 was found on the floor in the dining room, she stated, "No."

(A)