STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G039	A. BUILDING _____ B. WING _____	C 09/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 000	INITIAL COMMENTS COMPLAINT INVESTIGATION #1142612/IL 54241 - W122, W149, W368 COMPLAINT INVESTIGATION #1142658/IL 54303 - W149 INCIDENT REPORT INVESTIGATION of 5/14/11 IL 54248 - No Deficiencies INCIDENT REPORT INVESTIGATION of 8/18/11 IL 54377 - W122, W149	W 000		
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on record review and interview, the facility has failed to implement their system to prevent neglect, for 1 of 1 individual, (R2), who received a femur fracture on 8/24/11, when the facility failed to: implement their own policies and procedures for neglect, when: > the facility failed to thoroughly investigate the cause of an individual screaming all night to ensure the cause of the screaming was not medically related. >the facility failed to adequately assess and develop a plan of care for a new admission with known special needs. >the facility nursing failed to evaluate and assess and to contact the physician for a change in individuals condition.	W 122		10/3/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W 122	Continued From page 1 This resulted in an Immediate Jeopardy. Findings include: On 8/30/11 at 3:50 p.m., an Immediate Jeopardy was identified to have begun on 08/21/11, when: > the facility failed to thoroughly investigate the cause of an individual screaming all night to ensure it was not medically related. >the facility failed to adequately assess and develop a plan of care for a new admission with known special needs. >the facility nursing failed to evaluate and assess and to contact the physician for a change in individuals condition. This client was transferred to the hospital after two days of apparent discomfort/pain and diagnosed with a "moderately displaced fracture of the distal shaft of left femur". On 9/9/11 at 11:52 a.m., E1 (Administrator), was notified that the Immediate Jeopardy was removed. Refer to deficiencies cited at: W149 - Develop and implement written policies that prohibit abuse and neglect Based on observation, interview, and record review, the facility has failed to implement their system to prevent neglect, for 2 of 2 individuals who had choking episodes (R9, R7), when the facility failed to:	W 122		

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W 122	Continued From page 2 implement their own policies and procedures for neglect when: >the facility failed to carryout physician's orders to monitor while eating. >the facility failed to supervise an Individual with known special needs of choking while eating. This resulted in an Immediate Jeopardy. Findings include: On 9/7/11 at 4:55 p.m., an Immediate Jeopardy was identified to have began on 6/13/11, when: the facility failed to ensure R9 is monitored while eating as per physicians orders. On 9/16/11 at 2:55 p.m., E1 (Administrator), was notified that the Immediate Jeopardy was removed. Refer to deficiencies cited at: W149 - Develop and implement written policies that prohibit abuse and neglect	W 122		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: 1. Based on record review and interview, the facility has failed to implement their system to prevent neglect, for 1 of 1 individual (R2) who received a femur fracture on 8/24/11, when the facility failed to:	W 149		10/3/11

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W 149	Continued From page 3 implement their own policies and procedures for neglect, when: > the facility failed to thoroughly investigate the cause of an individual screaming all night to ensure the cause of the screaming was not medically related. >the facility failed to adequately assess and develop a plan of care for a new admission with known special needs. >the facility nursing failed to evaluate and assess and to contact the physician for a change in individuals condition. This resulted in an Immediate Jeopardy. Findings include: On 8/30/11 at 3:50 p.m., an Immediate Jeopardy was identified to have begun on 08/21/11, when: > the facility failed to thoroughly investigate the cause of an individual screaming all night to ensure it was not medically related. >the facility failed to adequately assess and develop a plan of care for a new admission with known special needs. >the facility nursing failed to evaluate and assess and to contact the physician for a change in individuals condition. This client was transferred to the hospital after two days of apparent discomfort/pain and diagnosed with a "moderately displaced fracture of the distal shaft of left femur". On 9/9/11 at 11:52 a.m., E1 (Administrator), was notified that the Immediate Jeopardy was removed.	W 149		

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W 149	Continued From page 4 2. Based on observation, interview, and record review, the facility has failed to implement their system to prevent neglect, for 2 of 2 individuals who had choking episodes (R9, R7), when the facility failed to: implement their own policies and procedures for neglect when: >the facility failed to carryout physician's orders to monitor while eating. >the facility failed to supervise an Individual with known special needs of choking while eating. This resulted in an Immediate Jeopardy. Findings include: On 9/7/11 at 4:55 p.m., an Immediate Jeopardy was identified to have began on 6/13/11, when: >the facility failed to carryout physician's orders to monitor while eating. >lack of supervision to Individual with known special needs of choking while eating. On 9/16/11 at 2:55 p.m., E1 (Administrator), was notified that the Immediate Jeopardy was removed. 3. Based on record review and interview, the facility failed to ensure a system is in place to evaluate and monitor individuals for injuries, for 1 of 1 individual with bruises of unknown origin (R3) that was reviewed by the surveyor during this survey. 1. In review of R2's Physical Examination dated	W 149		

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W 149	Continued From page 5 7/19/11, R2 is a 19 year old male with diagnoses of Cerebral Palsy, Seizure Disorder, and History of Fracture sternum, arm, ankle and hand. In further review of the Physical Examination, R2 has a weight of 69 pounds and is 56 inches long. During review of the facility's Illinois Department of Public Health (IDPH) Notification Report, dated 8/25/11, R2's left leg was noted to be "swollen/ warm to touch and had bruising posterior thigh." R2's left femur was x-rayed. R2 has a "moderately displaced fracture of distal shaft of left femur." R2 was sent to hospital and admitted. The facility's staff interviews, dated 8/24 through 8/26/11, for R2's fractured femur investigation were reviewed. Staff were asked "Did he have symptoms of pain last night?" E3 (DSP - Direct Service Person), documented on 8/24/11, that when changing R2's pants saw a small red spot. Put him to bed. E2 further states that R2 was quieter on 8/23/11. E4 (DSP) documented on 8/26/11, that "overnights reported some crying. When we went to get him up we discovered his leg and he was starting to tear up when he moved." E5 (DSP) documented on 8/25/11, that R2 "cried all day Tue 8/23/11 but stopped once he was put in bed around 8:45 am and he calmed down and listened to music." E6 (DSP) documented on 8/25/11, that E7 (DSP) reported that R2 cried all night Sunday and Monday. On Tuesday morning R2 was crying when gotten up, but no tears. R2 was put back to bed at 8:45 and calmed down a little. E7 (DSP) documented on 8/24/11, that R2 "Screamed all Night Long" on 8/23/11.	W 149		

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W 149	Continued From page 6 R2's sleep chart documentation was reviewed for 8/21 - 8/23/11. E7 documented that R2 "screamed the whole night" on 8/21/11. On 8/22 /11, E7 documented R2 "screamed all night again". On 8/23/11 E3 documented that R2 slept from 11:15 p.m. to 1:15 a.m., from 1:45 a.m. to 3:15 a.m., from 3:45 a.m. to 5:15 a.m., and was asleep at 5:45 a.m... In an interview on 8/30/11 at 10:20 a.m., when asked if R2's crying/screaming all night on 8/21 and 8/22/11 was investigated, E1 (Administrator), stated no. When asked if there is a policy or procedure for evaluating pain, E1 presented surveyor with a "Pain Assessment" form. In an interview on 9/7/11 at 8:40 a.m., When asked if there was a policy or procedure for this Pain Assessment tool, E1 stated that E10 (DON) only gave this form to him. E1 further stated that "I assume there is no policy or procedure with this tool." There is no evidence of a nursing assessment or a Pain Assessment in R2's record regarding being up all night and crying/screaming on 8/21/11 and 8/22/11. In an interview on 8/30/11 at 10:20 a.m., when asked if nursing assessed R2 for his crying on 8/21 and 8/22/11, E1 stated it is what it is. E1 confirmed there were no nursing assessments completed for R2. When asked if the facility has a policy or	W 149		

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W 149	Continued From page 7 procedure for notifying the physician for a change of condition, E1 presented the surveyor with the "Incident Report Policy". In review of the "Incident Report Policy", dated 5/15/2006, it states " If a medical injury is involved, the Nursing Department will examine the resident and complete an assessment. When medical or psychiatric needs are involved, the resident will be examined by the appropriate physician." In an interview on 9/1/11 at 3:50 p.m., when asked if there was a policy or procedure for notifying the physician for a change in condition, E1 stated "just the one I gave you on incident reporting." On 8/30/11, E1 gave surveyor a statement from E9 (DSP Supervisor), dated 8/28/11. E1 stated that he just received this note on 8/29/11. E9 documents in this note that R2 was up in his chair when E3 arrived to work on 8/23/11. It further documents that E9 told E3 that she would help E3 with the 2 person lifts and that E3 said, "Oh, I don't need any help." E9 told E3 that E1 wants 2 people lifting. E3 was told to call E9 for help. E9 states that E3 never asked for help. In an interview on 8/30/11 at 12:23 p.m., when asked how R2 was on 8/23/11, E3 stated after changing R2 he went to sleep. E3 stated he changed R2 several times that night and R2 went back to sleep. When asked how R2 is transferred, E3 stated that he raises the hospital bed, puts R2's wheelchair next to the bed, and lifts/cradles him to the bed. E3 stated that R2 is small and does not weigh very much.	W 149		

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W 149	Continued From page 8 In review of the facility's policy "Two Person Transfer/Lift Policy", undated, it states, "ALL resident transfers and lifts are to be done with an absolute minimum of two staff members. At no time should one staff person be transferring or lifting a resident on his/her own. This practice is in place to avoid serious safety risks to both the residents and staff. In an interview on 8/30/11 at 10:25 a.m., E1 verified that he received the note from E9, and stated that R2 was possibly transferred by one man on 8/23/11. In an interview on 8/30/11 at 3:15 p.m., E1 stated that the facility's 2 man lift/transfer policy, is to be reviewed and signed by all staff. E1 verified that E3 signed the policy on 10/2/10. In an interview on 8/30/11 at 12:36 p.m., when asked how R2's fracture could have occurred, Z2 (Physician), stated it may have occurred from a transfer or moving R2 around. Z2 further stated that R2 could have caught his leg on something as he was being transferred. In review of R2's IPP (Individualized Program Plan), dated 8/15/11, it states that R2 was admitted on 8/1/11. It further states that R2 is non verbal, but he can communicate. R2 reply's to yes or no questions by pointing to the wheelchair tray. R2 screams when he does not feel well or when he is unhappy. R2 requires complete staff assistance with all activities of daily living. In an interview on 8/31/11 at 11:10 a.m., Z1	W 149		

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W 149	Continued From page 9	W 149		

(guardian), verified that R2 was admitted to the facility on 8/1/11 and is non verbal and non ambulatory. Z1 stated that R2 is able to communicate using yes/no answers by raising his arms. Z1 stated that R2 can make choices also by raising his arms and using facial gestures.

Per review of the facility's policy titled "Admission and Discharge Policy" dated 7/18/11, it states "5. Admission decisions shall be based on a preliminary evaluation of the client.....
7. The preliminary evaluation shall include review and consideration of background information as well as currently valid assessments of functional, developmental, behavioral, social, health and nutritional status to determine if the facility can provide for the clients needs.....
11. All applicants for admission shall provide the following:
(a) A completed Admission Application on a form provided by (facility)."
This policy further states that, "the term "current" means within 6 months prior to the admission of the application."

In review of R2's Psychological Report from the school district dated 5/21/08, it states that R2 will scream when he is unhappy or does not feel well. This report further documents that R2 is non verbal and non ambulatory. R2 is dependent on others for his daily needs. R2 is able to communicate by answering yes/no questions.

There is no evidence of any current functional, developmental, behavioral, social, health and nutritional assessments on R2.

There is no evidence of a temporary plan of care

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W 149	Continued From page 10 for R2 on admission to be utilized by the staff until R2's IPP can be completed.. In an interview on 8/31/11 at 11:10 a.m., Z1 (Guardian), stated that she discussed with E1 and E2 on how to care for R2 at admission. Z1 further stated that she discussed with the direct care staff on R2's admission and at each visit on how to care for R2. In an interview on 8/30/11 at 3:15 p.m., when asked about the admission packet on R2, E1 stated that the above report was the admission packet. E1 verified that this report was dated 5/21/08. In an interview on 8/31/11 at 4:10 p.m., when asked if the facility received an admission packet on R2, E2 (Director of Social Services) said yes and showed the surveyor R2's 5/21/08 Psychological Report. E2 confirmed that this information was dated 5/21/08. There is no evidence of a nursing assessment on admission or since admission of R2. In an interview on 8/31/11 at 3:50 p.m., E1 verified that nursing should have completed an assessment of R2 on admission. E1 (Administrator), was notified that the Immediate Jeopardy was removed on 9/9/11, at 11:52 a.m., when the surveyor confirmed through interview and review of the facility's plan that the facility took the following actions to remove the Immediate Jeopardy. > All new admission placement packets will have	W 149		

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W 149	Continued From page 11 current info dated within 6 months of admit date effective immediately. > DSP staff was re-trained to report all significant resident behavioral/medical issues to nursing staff immediately to rule out pain, injury or abuse on 09/01/11. DSP staff must document in the residents chart a summary of resident's daily events effective immediately. If the nurse fails to respond in a timely manner DSP will call supervisor for assistance. > Nursing staff was re-trained to examine and assess all significant resident behavioral/medical issues to rule out pain, injury or abuse on 9/1/11. All action taken by the nurse must be documented timely and accurately in the residents chart effective immediately. > Nursing staff was re-trained on communicating with the resident's attending physician all major changes of condition on 9/1/11. Nurse will document instructions given by physician in the residents chart effective immediately. > Facility will develop a pain assessment policy by 9/9/11. > All DSP staff was re-trained on the two person lift policy on 9/1/11. If staff fails to follow policy progressive corrective action will take place up to and including discharge. > All DSP staff will receive re-training on lifting, ROM and transferring techniques on 9/9/11. > A plan of care will be developed for all new admits to meet their known special needs.	W 149		

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W 149	Continued From page 12 > Documentation will take place on all new admissions by direct care staff on a daily basis for 30 days noting any significant behavioral or medical needs on all three shifts as of 9/1/11. > Residents IPP will be monitored and changed based on changes in his behavioral or medical needs. >Administrator will monitor overall implementation of corrective action plan. 2. Based on observation, interview, and record review, the facility has failed to implement their system to prevent neglect, for 2 of 2 individuals who had choking episodes (R9, R7), when the facility failed to: implement their own policies and procedures for neglect when: >the facility failed to carryout physician's orders to monitor while eating. >the facility failed to supervise an Individual with known special needs of choking while eating. This resulted in an Immediate Jeopardy. Findings include: On 9/7/11 at 4:55 p.m., an Immediate Jeopardy was identified to have began on 6/13/11, when: >the facility failed to carryout physician's orders to monitor while eating. >lack of supervision to Individual with known special needs of choking while eating.	W 149		

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W 149	Continued From page 13 On 9/16/11 at 2:55 p.m., E1 (Administrator), was notified that the Immediate Jeopardy was removed. a) Per the facility submitted roster, dated 8/26/11, that validates level of functioning, R9 functions in the profound range of mental retardation. In review of R9's IPP (Individualized Program Plan), dated 8/29/11, R9 has additional diagnoses of Down's Syndrome, Deafness, Legally Blind Left Eye, Dysphagia, Obsessive Compulsive Disorder, and Anxiety. In review of a facility IDPH (Illinois Department of Public Health) Notification, dated 8/18/11, R9 was eating supper and appeared to choke on food. R9 had an emesis twice and would not swallow his thickened liquids. R9 was sent to hospital for evaluation. In an interview on 9/7/11 at approximately 9:00 a.m., when asked if facility investigated what R9 choked on, E1 (Administrator), stated a green bean. When asked what measures were implemented to prevent a reoccurrence, E1 stated that the facility moved R9 to a different table in the dining room. E1 stated that R9 sits with others on pureed diets. In review of the facility dining room chart, updated on 8/24/11, it has R9 at a table with 4 other individuals on pureed diets. There are 2 tables together R9 sits at one end side of a table and staff are at the end of the other table feeding R8. There is no evidence that the facility put safeguards in place related to R9's choking or to ensure this individual is monitored during the	W 149		

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W 149	Continued From page 14 meals. In an interview on 9/7/11 at 9:20 a.m., E1 verified that there was not a formal meeting on R9's choking incident. E1 stated that they saw a need to change the seating in the dining room and moved R9. In review of a facility IDPH Notification, dated 6/13/11, R9 choked on Beef Stroganoff at supper. R9 was sent to the hospital for evaluation. In further review of R9's 8/29/11 IPP, it states "on 5/4/10, R9 choked on green bean - to (name of hospital ER) for evaluation. On 5/7/10, R9 saw his physician, and orders for 1. Swallow Evaluation; 2. VOSS (Video Oropharyngeal Swallow Study) if needed; 3. Monitor during meals. 4. Remain on pureed diet. On 5/17/10, VOSS diagnosis - Moderate Oropharyngeal Dysphagia - agree with pureed diet and nectar thick liquids." In review of the 5/17/10 VOSS, there is a recommendation for feeding for R9, it states, "if volume of liquid sips can be externally paced, patient would benefit." There is no evidence that this recommendation was implemented and was not observed during the meal observations on 9/7/11. Per the 9/11 Physicians Order Sheet, R9 is on a Hi Calorie, Hi Protein, pureed diet with nectar thick liquids. In review of a "Human Rights Consent" dated, 6/14/11, it states that R9 "shall receive his meal in	W 149		

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W 149	Continued From page 15 multiple portions contained within separate bowls - no plate shall be given. This is being done to decrease the risk of choking while eating." In an interview on 9/7/11 at 11:13 a.m., E15 (Director of Dietary), stated that R9 has been on a pureed diet for a long time. When asked if R9 has stolen food, E15 stated that possibly he could have stolen from others during the 6/13/11 choking incident. E15 further stated that staff have said R9 does take food from others. In an interview on 9/7/11 at 1:55 a.m., when asked if R9 has a behavior of food stealing, E14 (QMRP-Qualified Mental Retardation Professional), stated that R9 has not stolen food off others plates before that he is aware of, until the 8/18/11 incident. In further review of R9's IPP, it documents that R9 is non - verbal, hearing impaired and uses some sign language to communicate his wants and needs to others. During observation of the noon meal on 9/7/11, at 12:00, R9 ambulated into the dining room and sat down at his table and started eating his meal which was pureed consistency and each item was in a separate bowl. There were no staff present at the table. R9 was the only individual at the table eating at this time. A staff came over to R9 at 12:05 p.m., and signed to R9 then walked away to assist another individual with her back to R9. At 12:10 p.m., R9 got up from the table and threw his paper products away. R9 was finished eating eating. During the time R9 was observed eating his meal, there was no staff directly observing this client. The staff sat down at this	W 149		

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W 149	Continued From page 16 time to start feeding R8. E1 (Administrator), was notified that the Immediate Jeopardy was removed on 9/16/11 at 2:55 p.m., when the surveyor confirmed through interview and review of the facility's plan that the facility took the following actions to remove the Immediate Jeopardy. > The dining room tables will be placed back in the arrangement of being 24 separate tables rather than 12 table configuration on 9/9/11 to cut down on food stealing behavior. Staff will be assigned specific locations in the dining room to best observe and supervise residents throughout the meal by 9/14/11. > All residents' assigned seating in the dining room will be re-assessed to ensure that residents who have special needs are properly addressed by 9/9/11. > All residents who have a history of having swallowing problems will be supervised by properly trained staff by having a staff person assigned to their table during each meal by 9/13/11. > Staff will be re-trained on assessing choking issues related to the dining room by 9/13/11. > Staff will be trained to respond immediately to provide needed assistance when they observe a choking incident. Staff must call the nurse immediately to assess the situation. Staff must call the DON and Administrator for further guidance in all choking incidents.	W 149		

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W 149	Continued From page 17 > Staff will be trained on the proper way to document a choking incident by 9/13/11. > All DSP staff will receive re-training on assessing a resident's behavior after a choking incident by 9/12/11. > Residents will meet in the atrium prior to entering the dining room. Residents will not be escorted into the dining room until 10 staff is in place to supervise the dining room by 9/13/11. > A plan of care will be developed for all new admits to meet their known special needs. > Administrator will monitor overall implementation of corrective action plan. b) Per the facility submitted roster, dated 8/26/11, that validates level of functioning, R7 functions in the severe range of mental retardation. In review of R7's IPP (Individualized Program Plan), dated 5/25/11, R7 has additional diagnoses of Alzheimer's (Dementia), Corticoadrenal Insufficiency, and Down's Syndrome. Per the 5/25/11 IPP, R7 is independent in eating. Per the 7/11 Physician's Order Sheet (POS), R7 is on a regular diet. The facility's policy titled "How to Handle a Resident Choking Issue", dated 3/19/10, was reviewed. This policy states "The following steps must take place when an incident occurs related to a resident choking on food:	W 149		

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W 149	Continued From page 18 5. The resident must be sent to the hospital for a follow up evaluation. 8. Once the resident returns from the hospital close monitoring is to occur for the next 24 hours with documentation on an hourly basis." During observation of the noon meal on 9/7/11 at 12:05 p.m., R7 was noted to be eating his lunch with no staff present at the table to monitor him. R7 was finished eating by 12:15 p.m., and still no staff present at the table. In review of R7's record, it is documented that on 5/30/11, R7 choked on a hot dog during supper and sent out for an evaluation. R7's record further documents a "Speech Pathology Swallow Evaluation" dated 6/1/11. The recommendations on this report states, "continue current diet; follow universal aspiration precautions: upright at meals, slow rate, small bite, alternate liquid/solid 1:2-3; monitor for any signs of aspiration". Based upon the observations by the surveyor on 9/7/11 at 12:05 p.m., these recommendations were not implemented. In review of R7's nursing notes, on 8/14/11 at 6:00 p.m., R7 choked on dinner and had an emesis after choking. R7 stated he ate too fast. There is no evidence that any further follow up and monitoring took place on R7 after this 8/14/11 choking incident. In an interview on 9/7/11 at 3:50 p.m., when asked if there were any changes after R7's	W 149		

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W 149	Continued From page 19 8/14/11 choking incident, E1 stated it was an isolated incident and they didn't want to disrupt his life until there was a pattern or trend. In an interview on 9/7/11 at 4:20 p.m., E1 stated that if it is serious or there is any doubt, they are sent to the hospital. E1 also stated that he relies on the nurse who is assessing the individual. If there are no signs or symptoms, they are not sent to the hospital. 3. Based on record review and interview, the facility failed to ensure a system is in place to evaluate and monitor individuals for injuries, for 1 of 1 individual with bruises of unknown origin (R3) that was reviewed by the surveyor during this survey. Findings include: In review of the facility submitted roster, dated 8/26/11, that validates level of functioning, R3 functions in the severe range of mental retardation. Per the 8/16/10 Individualized Program Plan (IPP), R3 is a 42 year old male with additional diagnoses of Major Depressive Disorder, Obsessive Control Disorder, Sleep Deprivation and Anxiety. In review of the "Unknown Origin Incident Report", dated 8/22/11 at 5:00 p.m., it states that "DSP (Direct Service Person), came to get nurse and showed bruises on pt (patient) inner right arm dime size - left rib cage area yellow bruises - and on back quarter size."	W 149		

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W 149	Continued From page 20 R3's nursing notes dated 8/22/11, documents "found dime size yellow bruise noted on left rib cage area and right inner arm - and on back area - unknown incident filled out.". In review of an Incident Report dated 8/23/11 at 6:00 p.m., R3 was found with "yellow bruises on the left rib cage - 3 cm (centimeters) x 3 cm - right inner arm - quarter size bruise area - 2 cm x 2 1/2 cm size on back area - yellow color". In an interview on 8/31/11 at 9:40 a.m., when asked about the discrepancy with the date of injury and the sizes of the bruises, E1 (Administrator), stated the date of the bruises being found is 8/22/11. E1 stated that the size difference is probably because of the documentation being done the next day. E1 further stated that he terminated this nurses' employment with the facility. E1 also stated the bruises on R3 were suspicious, so he turned it into a formal abuse investigation In further review of the Incident Report dated 8/23/11, there is a section that states "Was it necessary to notify the physician?". There is a box next to "Yes" and a box next to "No". The "No" box has an X in it. There is no evidence that the physician was notified of these suspicious bruises. In an interview on 9/1/11 at 3:50 p.m., when asked if the physician was notified, E1 stated No, but should have. When asked if there was a policy or procedure for notifying the physician for a change in condition, E1 stated "just the one I	W 149		

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gave you on incident reporting."

In review of the facility's investigation, E3 (DSP) documented that R3 has behaviors of "slapping door button on bathroom, see him walk into a wall." (typed as written)

R3's BIP (Behavior Intervention Plan) dated 7/20/11 was reviewed. R3 has a supervision level of "Same Room Supervision (SRS). SRS requires staff to be present in the room that R3 is in excluding the bedroom and the bathroom."

In an interview on 8/31/11 at 10:55 a.m., E1 verified that R3 is SRS when awake except for the bathroom. E1 also stated that when R3 is awake during the night staff are with him.

Per R3's 8/16/10 IPP, R3 requires some verbal prompts and physical assistance from staff in most aspects of the showering process like putting the right amount of shampoo and drying his body completely.

In an interview on 9/1/11 at 10:38 a.m., when asked what kind of assistance R3 requires during his bath, E13 (DSP), stated verbal prompts, step by step, otherwise R3 just stands there. E13 further stated that if R3 hurt anywhere, he would verbalize it. When asked if bruising on R3's body could be visualized during the showering process, E13 stated that R3 has very thick body hair on his chest, back and legs. E13 stated that it would be very difficult to see bruises on these areas.

In an interview on 8/31/11 at 9:40 a.m., when asked if R3 was interviewed regarding how the bruises occurred, E1 stated yes and R3's mom

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W 149	Continued From page 22 also questioned him. E1 stated that R3 said no one hurt him. R3 has a history of being abused and possibly was afraid of telling anyone anything. In an interview on 9/6/11 at 9:50 a.m., when asked how staff are to observe/monitor individuals with thick body hair to ensure there are no injuries to the body which could be potential abuse, E1 stated, "we started a new system at shower time. Staff are to stand in front of him for 5 seconds before he showers. This system is for all non-verbal individuals and those that can not communicate. Staff are to look for bruises. This is a formal body inspection in effect now."	W 149		
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a medication was administered per physicians orders for 1 of 1 individuals whose medication was unavailable from the pharmacy (R2). Findings include: In review of R2's physical exam dated 7/19/11, R2 is a 19 year old male with diagnoses of Cerebral Palsy, Seizure Disorder, and a History of Fracture sternum, arm, ankle and hand. In further review of the physical, R2 has a weight of 69 pounds and is 56 inches long.	W 368		10/3/11

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W 368	Continued From page 23 In review of R2's record, it is documented on the 08/11 Medication Administrator Record (MAR), that R2 did not receive his Vitamin D3 on 8/10/11 through 8/21/11. On the back of the MAR, it is documented that this medication is unavailable on these dates. R2 has a physician's order, dated 7/19/11, for Vitamin D3 400 units/ml Oral Liquid, give 2.5 ml daily. In an interview on 8/30/11 at 1:35 p.m., when asked why R2's Vitamin D3 was unavailable, E10 (DON- Director of Nurses) stated that their pharmacy did not supply it. E10 also stated that the facility checked other pharmacies and it was not available from the other pharmacies. E10 stated that medicaid denied the first claim, they resubmitted it and approved to pay for it.	W 368		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1210 350.1220j) 350.1230b)1)2)6) 350.1230d)1) 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	W9999		

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W9999	Continued From page 24 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 350.1220 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 ulcers or a weight loss or gain of five percent or more within a period of 30 days. 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: 1) Pre-admission evaluation study and plan. 2) Evaluation study, program design, and placement of the resident at the time of admission to the facility. 6) Development of a written plan for each resident to provide for nursing services as part of the total habilitation program. 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.	W9999		

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W9999	Continued From page 25 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 implement their system to prevent neglect for one client (R2) who received a femur fracture on 8/24/11, when the facility failed to: 1. thoroughly investigate the cause of a client screaming all night to ensure the cause of the screaming was not medically related. 2. adequately assess and develop a plan of care for a new admission with known special needs. 3. evaluate and assess the client, contact the physician for a change in client's condition. This client was transferred to the hospital after two days of apparent discomfort/pain and diagnosed with a "moderately displaced fracture of the distal shaft of left femur". Findings include: 1. In review of R2's Physical Examination dated 7/19/11, R2 is a 19 year old male with diagnoses of Cerebral Palsy, Seizure Disorder, and History of Fracture sternum, arm, ankle and hand. In further review of the Physical Examination, R2 has a weight of 69 pounds and is 56 inches long. During review of the facility's Illinois Department	W9999		

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of Public Health (IDPH) Notification Report, dated 8/25/11, R2's left leg was noted to be "swollen/ warm to touch and had bruising posterior thigh." R2's left femur was x-rayed. R2 has a "moderately displaced fracture of distal shaft of left femur." R2 was sent to hospital and admitted.

The facility's staff interviews, dated 8/24 through 8/26/11, for R2's fractured femur investigation were reviewed. Staff were asked "Did he have symptoms of pain last night?"

E3 (DSP - Direct Service Person), documented on 8/24/11, that when changing R2's pants saw a small red spot. Put him to bed. E2 further states that R2 was quieter on 8/23/11.
E4 (DSP) documented on 8/26/11, that "overnights reported some crying. When we went to get him up we discovered his leg and he was starting to tear up when he moved."
E5 (DSP) documented on 8/25/11, that R2 "cried all day Tue 8/23/11 but stopped once he was put in bed around 8:45 am and he calmed down and listened to music."
E6 (DSP) documented on 8/25/11, that E7 (DSP) reported that R2 cried all night Sunday and Monday. On Tuesday morning R2 was crying when gotten up, but no tears. R2 was put back to bed at 8:45 and calmed down a little.
E7 (DSP) documented on 8/24/11, that R2 "Screamed all Night Long" on 8/23/11.

R2's sleep chart documentation was reviewed for 8/21 - 8/23/11. E7 documented that R2 "screamed the whole night" on 8/21/11. On 8/22 /11, E7 documented R2 "screamed all night again". On 8/23/11 E3 documented that R2 slept from 11:15 p.m. to 1:15 a.m., from 1:45 a.m. to

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	14G039	A. BUILDING _____ B. WING _____	C 09/20/2011

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W9999	Continued From page 27 3:15 a.m., from 3:45 a.m. to 5:15 a.m., and was asleep at 5:45 a.m... In an interview on 8/30/11 at 10:20 a.m., when asked if R2's crying/screaming all night on 8/21 and 8/22/11 was investigated, E1 (Administrator), stated no. When asked if there is a policy or procedure for evaluating pain, E1 presented surveyor with a "Pain Assessment" form. In an interview on 9/7/11 at 8:40 a.m., When asked if there was a policy or procedure for this Pain Assessment tool, E1 stated that E10 (DON) only gave this form to him. E1 further stated that "I assume there is no policy or procedure with this tool." There is no evidence of a nursing assessment or a Pain Assessment in R2's record regarding being up all night and crying/screaming on 8/21/11 and 8/22/11. In an interview on 8/30/11 at 10:20 a.m., when asked if nursing assessed R2 for his crying on 8/21 and 8/22/11, E1 stated it is what it is. E1 confirmed there were no nursing assessments completed for R2. When asked if the facility has a policy or procedure for notifying the physician for a change of condition, E1 presented the surveyor with the "Incident Report Policy." In review of the "Incident Report Policy," dated 5/15/2006, it states "If a medical injury is involved, the Nursing Department will examine the resident	W9999		

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W9999	Continued From page 28	W9999		

and complete an assessment. When medical or psychiatric needs are involved, the resident will be examined by the appropriate physician."

In an interview on 9/1/11 at 3:50 p.m., when asked if there was a policy or procedure for notifying the physician for a change in condition, E1 stated "just the one I gave you on incident reporting."

On 8/30/11, E1 gave surveyor a statement from E9 (DSP Supervisor), dated 8/28/11. E1 stated that he just received this note on 8/29/11. E9 documents in this note that R2 was up in his chair when E3 arrived to work on 8/23/11. It further documents that E9 told E3 that she would help E3 with the 2 person lifts and that E3 said, "Oh, I don't need any help." E9 told E3 that E1 wants 2 people lifting. E3 was told to call E9 for help. E9 states that E3 never asked for help.

In an interview on 8/30/11 at 12:23 p.m., when asked how R2 was on 8/23/11, E3 stated after changing R2 he went to sleep. E3 stated he changed R2 several times that night and R2 went back to sleep. When asked how R2 is transferred, E3 stated that he raises the hospital bed, puts R2's wheelchair next to the bed, and lifts/cradles him to the bed. E3 stated that R2 is small and does not weigh very much.

In review of the facility's policy "Two Person Transfer/Lift Policy", undated, it states, "ALL resident transfers and lifts are to be done with an absolute minimum of two staff members. At no time should one staff person be transferring or lifting a resident on his/her own. This practice is in place to avoid serious safety risks to both the

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residents and staff.

In an interview on 8/30/11 at 10:25 a.m., E1 verified that he received the note from E9, and stated that R2 was possibly transferred by one man on 8/23/11.

In an interview on 8/30/11 at 3:15 p.m., E1 stated that the facility's 2 man lift/transfer policy, is to be reviewed and signed by all staff. E1 verified that E3 signed the policy on 10/2/10.

In an interview on 8/30/11 at 12:36 p.m., when asked how R2's fracture could have occurred, Z2 (Physician), stated it may have occurred from a transfer or moving R2 around. Z2 further stated that R2 could have caught his leg on something as he was being transferred.

In review of R2's IPP (Individualized Program Plan), dated 8/15/11, it states that R2 was admitted on 8/1/11. It further states that R2 is non verbal, but he can communicate. R2 reply's to yes or no questions by pointing to the wheelchair tray. R2 screams when he does not feel well or when he is unhappy. R2 requires complete staff assistance with all activities of daily living.

In an interview on 8/31/11 at 11:10 a.m., Z1 (guardian), verified that R2 was admitted to the facility on 8/1/11 and is non verbal and non ambulatory. Z1 stated that R2 is able to communicate using yes/no answers by raising his arms. Z1 stated that R2 can make choices also by raising his arms and using facial gestures.

Per review of the facility's policy titled "Admission

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and Discharge Policy" dated 7/18/11, it states "5. Admission decisions shall be based on a preliminary evaluation of the client.....
7. The preliminary evaluation shall include review and consideration of background information as well as currently valid assessments of functional, developmental, behavioral, social, health and nutritional status to determine if the facility can provide for the clients needs.....
11. All applicants for admission shall provide the following:
(a) A completed Admission Application on a form provided by (facility)."
This policy further states that, "the term "current" means within 6 months prior to the admission of the application."

In review of R2's Psychological Report from the school district dated 5/21/08, it states that R2 will scream when he is unhappy or does not feel well. This report further documents that R2 is non verbal and non ambulatory. R2 is dependent on others for his daily needs. R2 is able to communicate by answering yes/no questions.

There is no evidence of any current functional, developmental, behavioral, social, health and nutritional assessments on R2.

There is no evidence of a temporary plan of care for R2 on admission to be utilized by the staff until R2's IPP can be completed..

In an interview on 8/31/11 at 11:10 a.m., Z1 (Guardian), stated that she discussed with E1 and E2 on how to care for R2 at admission. Z1 further stated that she discussed with the direct care staff on R2's admission and at each visit on

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W9999	Continued From page 31 how to care for R2. In an interview on 8/30/11 at 3:15 p.m., when asked about the admission packet on R2, E1 stated that the above report was the admission packet. E1 verified that this report was dated 5/21/08. In an interview on 8/31/11 at 4:10 p.m., when asked if the facility received an admission packet on R2, E2 (Director of Social Services) said yes and showed the surveyor R2's 5/21/08 Psychological Report. E2 confirmed that this information was dated 5/21/08. There is no evidence of a nursing assessment on admission or since admission of R2. In an interview on 8/31/11 at 3:50 p.m., E1 verified that nursing should have completed an assessment of R2 on admission. (A)	W9999		