STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING _____ B. WING _____	C 08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(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 INCIDENT INVESTIGATION Incident of 04/22/2011/IL53806	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 interview and record review, the facility has failed to implement their system to prevent neglect for 1 of 1 individual who has not received thorough and timely fall risk assessment, and timely implementation of safeguards, regarding his known unsteady gait, and known repeated falls, which have resulted in physical injury or risk of additional injuries (R1). The facility failed to implement their own policies and procedures for neglect, when the facility failed to: > ensure a thorough and timely fall risk assessment for R1. > implement fall prevention safeguards in a timely manner after R1's falls that resulted in serious injuries. > re-assess, and provide any needed additional safeguards regarding R1's mobility safety after his new Seizure diagnosis. > ensure that R1's physical therapy assessments and Individual Service Plans provide specific instructions regarding R1's level of supervision and supports regarding R1's mobility safety across all environments. Findings include:	W 122		9/17/11

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING _____ B. WING _____	C 08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(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 122	Continued From page 1 On 8/11/11, at 12:10 p.m., an Immediate Jeopardy was identified to have begun on 3/29/11 when the facility failed to implement their own policies and procedures for neglect, when: > the facility failed to ensure thorough and timely fall risk assessment for R1; > the facility failed to implement fall prevention safeguards in a timely manner after R1's falls that resulted in serious injuries; > the facility failed to re-assess, and provide any needed additional safeguards regarding R1's mobility safety after his new Seizure diagnosis; and, > when the facility failed to ensure that R1's physical therapy assessments and Individual Service Plans contain specific instructions regarding R1's level of supervision and supports, regarding R1's mobility safety across all environments. On 8/17/11, at 3:35 p.m., E1 (Administrator), was notified that the Immediate Jeopardy was removed. Refer to deficiencies cited at: W149 - Develop & implement written policies prohibit abuse W218 - Sensorimotor development	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.	W 149		9/17/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING _____ B. WING _____	C 08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(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 149	Continued From page 2 This STANDARD is not met as evidenced by: Based on interview and record review, the facility has failed to implement their system to prevent neglect for 1 of 1 individual who has not received thorough and timely fall risk assessment, and timely implementation of safeguards, regarding his known unsteady gait, and known repeated falls, which have resulted in physical injury or risk of additional injuries (R1); and for 1 of 1 individual who did not receive his diet in a form consistent with physician's orders, resulting in choking, cardiac arrest, hospitalization and ventilator assisted breathing (R1). The facility failed to implement their own policies and procedures for neglect, when the facility failed to: > ensure thorough and timely fall risk assessment for R1. > implement fall prevention safeguards in a timely manner after R1's falls that resulted in serious injuries. > re-assess, and provide any needed additional safeguards regarding R1's mobility safety after his new Seizure diagnosis. > ensure that R1's physical therapy assessments and Individual Service Plans provide specific instructions regarding R1's level of supervision and supports regarding R1's mobility safety across all environments. > ensure that R1 received his physician prescribed pureed diet, resulting in a choking episode that required emergency services, hospitalization and ventilator assisted breathing. Findings include:	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING _____ B. WING _____	C 08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(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 149	Continued From page 3 On 8/11/11, at 12:10 p.m., an Immediate Jeopardy was identified to have begun on 3/29/11, when the facility failed to implement their own policies and procedures for neglect, when: > the facility failed to ensure thorough and timely fall risk assessment for R1; > the facility failed to implement fall prevention safeguards in a timely manner after R1's falls that resulted in serious injuries; > the facility failed to re-assess, and provide any needed additional safeguards regarding R1's mobility safety after his new Seizure diagnosis; and, > when the facility failed to ensure that R1's physical therapy assessments and Individual Service Plans contain specific instructions regarding R1's level of supervision and supports regarding R1's mobility safety across all environments; On 8/17/11, at 3:35 p.m., E1 (Administrator), was notified that the Immediate Jeopardy was removed. 1) In review of R1's 6/17/10 Individual Service Plan (ISP), R1 functions in the profound range of mental retardation, with additional diagnoses of Anemia, Cerebral Palsy, Hearing Loss, Dysphagia, Chronic Bronchiectasis, Pulmonary Fibrosis, and Organic Brain Syndrome with Aggressive Features. R1's birthday is 10/13/40 (70 years of age). R1 is non-verbal. This ISP states that R1 sometimes has an unsteady gait, but does not need adaptive devices for ambulation and walks independently. Under the needs section of this ISP, it documents that R1 requires corrective glasses, but needs to	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING _____ B. WING _____	C 08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(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 149	Continued From page 4	W 149		

increase his glasses wearing time, and is on a formal program to wear his glasses for 15 minutes at a time.

His 5/9/10 Leiter documents an intelligence quotient (IQ) of 23. His 6/17/10 ISP documents an adaptive age score of 2 years and 10 months.

R1 receives Risperdal to assist in behavior control and has a legal guardian.

At this 6/17/10 ISP, R1 received a pureed diet with pudding thick liquids. His 5/18/11 ISP documents that R1 was hospitalized from 3/6/11 to 3/29/11 after an upper airway obstruction, and returned to the facility with G-tube feedings, and NPO (nothing by mouth).

A 4/21/11 physical therapy evaluation documents that R1's stride is decreased to the left side and his posture is stooped, with good balance.

In an interview with E2 (Director of Nursing - DON), on 8/10/11, at 10:30 a.m., E2 stated that R1 has an, "awkward gait all the time."

In an interview with Z2 (day training staff), on 8/10/11, at 1:10 p.m., Z2 stated that R1's gait does vary and that makes us a little nervous. R1 sometimes drags his feet. If R1 comes in "that way", it will be an all day thing.

In review of facility nursing notes (2/14/10-8/6/11), and facility incident investigations (12/10/10-8/4/11), R1 has experienced falls as follows:

>2/14/10 to 12/23/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING _____ B. WING _____	C 08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(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 149	Continued From page 5 R1 experienced 4 falls. For 3 of the falls, R1 experienced injury - hit his head - fell to his knees, knocking scab off and causing bleeding - abrasion to upper mid back. On 5/26/10, when R1 fell up against his bed and received the back abrasion, nursing notes state that R1 was assisted up and noted an "unsteady gait." R1's Individual Service Plan (ISP) of 6/17/10 does not document or review R1's falls. >8/14/10 to 12/23/10 R1 experienced 6 falls - 3 falls with injury. 8/14/10 - fell to buttocks in hallway - no injury. 9/2/10 - tripped in hallway and fell to knees - hitting head on floor - right temple abrasion-neurological's initiated. 9/9/10 nursing notes document that staff have reported R1's increased difficulty ambulating, getting in and out of bed and chairs. Nursing sent a fax to physician for possible Arthritis medication, which was implemented on an as needed basis. R1 was hospitalized from 10/13/10-11/5/10. Nursing notes document the use of a wheelchair and ambulation with staff assistance from 11/9/10-11/18/10. No falls are documented within this time period while R1 was being assisted with ambulation. (In an interview with E2 (Director of Nursing - DON), on 8/10/11, at 10:30 a.m., E2 stated that when individuals are hospitalized, they often return in a weakened state, as the hospital does not get them up or ambulate them. Therefore, the facility utilizes a wheelchair or other type of mobility chair when they first come home, until	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING _____ B. WING _____	C 08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(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 149	Continued From page 6 their strength returns). 12/1/10 - R1 slid off bed to floor - 12/5/10 nursing notes document an aged yellow/purple bruise on R1's right buttock and left lower back. 12/10/10 - fell to ground in driveway at day training site - two abrasions on left palm. 12/10/10 - lost shoe - tripped and fell to floor onto buttocks - no apparent injury. 12/11/10 - fell to buttocks outside - no apparent injury. R1's six month staffing review was held on 12/23/10 (06/17/10 - 12/23/10). Per this staffing, there is no review of nursing's 9/9/10 documentation regarding staff reporting R1's increased difficulty with ambulation, and getting out of bed and chairs; no evidence of reviewing R1's falls or injuries for this time period (6 falls - 3 with injury - hit head on floor/buttocks and lower back bruising and abrasions to palm); no evidence of a fall risk assessment; no evidence of an updated physical therapy assessment; and no recommendations regarding R1's continued falls. In an interview with E2 (Director of Nursing - DON), on 8/10/11, at 10:30 a.m., E2 stated that the facility does not conduct fall risk assessments. E2 stated that regarding falls, the facility would convene a special staffing if needed, and have physical therapy evaluate the individual. In an interview with E3 (Qualified Mental Retardation Professional - QMRP), on 8/9/11, at 4:20 p.m., E3 confirmed that R1's 6/17/10 annual ISP and R1's 12/23/10 six month review, were the only IDT meetings held during this time period, without any evidence of a review of falls for R1.	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING _____ B. WING _____	C 08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(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 149	Continued From page 7 > 12/24/10 to 4/28/11 - 4 falls - one resulting in a visit to the emergency room and a Hematoma, another with abrasions and 2 without injury. 12/24/10 - fell to his left side while ambulating - no complaints of pain. R1 was hospitalized from 3/6/11-3/29/11 due to a choking incident. 3/10/11 physician consult notes document seizure activity while in the hospital. R1 was prescribed Keppra for seizure control. R1's 7/31/11 physician's orders document that R1 still receives the medication for anticonvulsant control. After his return from the hospital, nursing notes state that R1 utilized a high backed movable chair, ambulating with staff assistance and stand by assistance through 4/17/11. No falls are identified from 3/29/11-4/17/11 while R1 was being assisted with ambulation. (In an interview with E3 (QMRP), on 8/9/11, at 4:20 p.m., E3 stated that when R1 returned from the hospital on 3/29/11, nursing instructed staff on how to walk with R1. E3 stated this was not permanent, and ended on or about 4/17/11. E3 stated it was after this date, when R1 started walking alone again, that R1 started falling again). In an 8/10/11, 10:30 a.m., interview with E2 (DON), E2 stated that since R1's return from the hospital on 3/29/11, no seizure activity has been observed for R1. E2 did state that not all of R1's falls were witnessed falls. There is a possibility that R1 could be having seizures, and this could be contributing to his falls and injuries. E2 further stated that R1 received an electroencephalography (EEG), on 8/2/11, but that the results have not yet been received.	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING _____ B. WING _____	C 08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(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 149	Continued From page 8 In review of R1's personal chart, there is no evidence that the IDT convened, or that any continuing safeguards were put in place, after R1's hospital release on 3/29/11 (relative to R1's already known gait disturbance, known fall history, known injuries and his new Seizure diagnosis). In an interview with E3 (Qualified Mental Retardation Professional - QMRP), on 8/9/11, at 4:20 p.m., E3 confirmed that after R1's annual ISP of 6/17/10, and the six month review of 12/23/10, the next IDT meeting was held 4/28/1, relative to R1's return to the day training site, after his gastrostomy tube (g-tube), placement. It was not until 4/21/11 (R1 released from hospital on 3/29/11 with new Seizure diagnosis), that R1 received a physical therapy assessment. Per this assessment, R1 has decreased left side stride, stooped posture and good balance. Under the recommendations section, it states, "Resident has recently returned from hospital and needs some assist for ambulation." There are, however, no specific instructions for staff regarding what methods are to be utilized in assisting R1 in his mobility needs throughout his environments, or specific recommendations regarding R1's new Seizure diagnosis. In an interview with E2 (DON), on 8/10/11, at 10:30 a.m., E2 agreed that the 4/21/11 physical therapy instructions were not clearly defined, and that direct care staff are mainly responsible for R1's ambulation safety and activities of daily living needs.	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING _____ B. WING _____	C 08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(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 149	Continued From page 9 In an interview with E1 (Administrator), on 8/10/11 at 4:00 p.m., E1 also agreed that he had "no idea" what the 4/21/11 physical therapy recommendations mean relative to how staff should assist R1 in his mobility. 4/22/11, at 5:35 a.m. - R1 was found on the floor in his room, gesturing that he had tripped over a mat on the floor. (In an 8/10/11, 10:30 a.m., interview with E2 (Director of Nursing - DON), E2 stated that R1 has a low bed, with a mat positioned by the bed, in case R1 falls out of bed.) Nursing notes document that R1 had a "lg (large) hematoma" to his left temple area. "Pupils reactive to light but unequal....to ER (emergency room) for eval (evaluation per ambulance...was not moved - res (resident) left on floor)...". Nursing notes document that R1 returned to the facility the same day, with neurological checks to continue. Nursing notes of 4/23/11, 10:00 a.m., document that R1 is ambulating on his own. 4/24/11, at 10:35 p.m. nursing notes (2 days after the fall which resulted in the Hematoma) , document that R1 lost his balance in the bathroom and was "lowered" to his right side. "Several abrasions noted to rt (right) {lower} extremity. Staff stated that R1 did not hit his head. 4/27/11, 8:00 a.m. - nursing notes document that bruising (from 4/22/11 fall), continues to the left eye area. On this same date R1 was trying to rock in a non-rocking chair and fell to his buttocks, with no injury.	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING _____ B. WING _____	C 08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(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 149	Continued From page 10 4/28/11 nursing notes document that bruising to R1's left outer eye (4/22/11 fall), is still apparent but decreased. In review of R1's personal chart, there is no evidence that the facility convened the IDT, completed a fall risk assessment, assessed R1's room environment for possible changes, provided an updated physical therapy assessment, or put any safeguards into place for R1, after the 4/22/11 Hematoma. In an interview with E3 (QMRP), on 8/10/11, at 10:01 a.m., E3 confirmed that the IDT did not convene after this incident. In an interview with E2 (DON), on 8/10/11, at 10:30 a.m., E2 stated that regarding environmental assessments/adoptions, the investigative committee addresses this issue when completing their investigations. In review of the 4/22/11 facility investigation, R1 tripped over the mat next to his bed, and the mat was in the position that it was supposed to be in at the time of R1's fall and resultant Hematoma. Per this investigation, there is no evidence of any recommendations regarding prevention of this type of occurrence again. The investigation recommends that staff encourage, "(R1) to ask for assistance if needed and that staff will continue to monitor R1 for safety." The next IDT held was 4/28/11, regarding R1's return to the day training site after his g-tube placement. In review of this IDT, R1's new g-tube placement is discussed, and states that R1 may use a wheelchair as needed for outings and long	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING _____ B. WING _____	C 08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(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 149	Continued From page 11	W 149		

distances. There is no evidence of discussing R1's new Seizure diagnosis, and no evidence of any implementing any safeguards relative to this new diagnosis, as related to R1's mobility safety at the day training site.

Z2 (day training staff), stated (8/10/11, at 1:10 p.m.), that since R1 returned to the day training site after 4/28/11, he has consistently required extra help getting out of chairs.

> 4/30/11 to 5/18/11 - 2 falls, 1 with injury
4/30/11 - R1 fell in shower onto buttocks, with no injury.
5/15/11 - fell outside of his room - redness to left side of back.

In review of the R1's 5/18/11 ISP, R1's Seizure diagnosis is documented and is noted as a new diagnosis.

Regarding R1's ambulation, it states, "R1 does not need adaptive devices for ambulation. He sometimes has an unsteady gait, but walks independently." R1's 4/21/11 physical therapy evaluation is documented and states that no physical therapy program is required at this time. In review of the entire ISP, there is no evidence that R1's falls have been reviewed; no evidence of a fall risk assessment; and no evidence of putting safeguards in place, regarding his mobility safety in all of his environments. Confirmed on 8/9/11, at 4:20 p.m., in an interview with E3 (QMRP).

> 5/19/11 to 6/10/11 - 3 falls - 2 with injury - (12 SUTURES)
5/25/11, at 8:15 p.m. - R1 was found on the floor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING _____ B. WING _____	C 08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(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 149	Continued From page 12	W 149		

A raised bump was noted to the left side of his forehead. Nursing notes state this was "possibly from past fall", but neurologicals were initiated at 8:00 p.m. Neurological's were continued through 5/26/11 and notes document a small raised area continues to R1's left forehead.

6/2/11, at 5:00 p.m. - R1 was found on the floor in the hallway in a supine position. Nursing notes state, "moderate amount of blood draining from 3 cm (centimeter) laceration to right side of forehead. R1 was sent to the emergency room, where he received 12 sutures to the right side of his forehead. Per the facility investigation of 6/2/11, there were no witnesses to the actual fall, but staff had just spoken to R1, and observed R1 walking into his room. This staff person then heard a thump and discovered R1 as above.

Nursing notes of 6/3/11, 7:30 a.m., document that R1 is in a wheelchair this a.m. and R1 is "very unsteady".

6/6/11, 4:30 p.m. nursing notes document that R1 fell to his buttocks, with no injuries - R1 still has 12 sutures from last fall.

6/8/11 nursing notes at 4:30 a.m., document that R1 is "up amb (ambulating) in hall very unsteady put in w/c (wheelchair) for safety."

There is no evidence of any facility action to prevent falls and serious injuries for R1, (after his 6/2/11 fall resulting in 12 sutures), until 6/10/11, when a special IDT was convened. Per this IDT, R1's room will be moved closed to the central area of the floor. "This would allow him to ambulate short distances to get to designated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING _____ B. WING _____	C 08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(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 149	Continued From page 13 areas on the floor. This will allow staff to monitor R1 more closely since most of his falls have not been witnessed. It was also noted during the staffing that (R1) has an added diagnosis of seizures while in the hospital in March 2011." In review of the document, there is no evidence of a fall risk assessment, an updated physical therapy evaluation and no evidence of specific safeguards to prevent further falls and serious injuries for R1. > 6/10/11 to 7/26/11 - 5 falls - 4 with injuries 7/5/11 - fell to the floor near the shower room - redness to his bottom left shoulder blade and redness below his right armpit. 7/6/11 - nursing notes -fell to buttocks - small scratch to right buttock. 7/18/11 - fell in room - pulled over dresser - shoes untied - no injury. However, 7/21/11 nursing notes state that R1 presents with a large purple/yellow bruise on his right forearm, possibly from the previous fall. 7/22/11 - stood up from chair and lost balance, fell onto buttocks - no injuries. 7/26/11 - found on floor in bedroom on back, nurses notes state "somewhat shakey (shaky)." Small abraded area on left buttock and one small abraded area on mid back noted. On 7/26/11 a IDT was held regarding R1's falls. Per this document the team discussed whether the new Seizure Disorder diagnosis could be contributing to the falls. Recommendations from this meeting as followed: refer to neurologist to be considered for an electroencephalogram (EEG), evaluation on 8/2/11; and refer to the physical therapist for review on 8/3/11. In review of this special staffing, there is no evidence of a	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING _____ B. WING _____	C 08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(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 149	Continued From page 14 fall risk assessment, or evidence of specific safeguards put in place to keep R1 from continued falls and injuries. On 8/3/11, R1 received a physical therapy evaluation. Per this evaluation it states, Pt (patient) to be assisted with transfers possible use of bed alarm for transfer from bed. There are no further directions from this evaluation, and no specific recommendations/instructions for staff to implement across all of R1's environments. In an interview with E2 (DON), on 8/10/11, at 10:30 a.m., E2 agreed that the physical therapy recommendations were not clearly defined, and could not further define what the expectations would be for direct care staff. In an interview with E3 (QMRP), on 8/10/11, at 10:01 a.m., E3 could not further clarify the 8/3/11 physical therapy recommendations. E3 stated that R1 has been having a hard time getting out of bed, out of chairs and walking in general. Staff, "keep an eye on him", but doesn't think that staff are with him all of the time when ambulating. E1 was "not sure" of R1's level of assistance during showering, but "would assume" that he has staff help him. "Toileting is becoming 1:1 recently." Later in the same interview, E3 stated that for all residents, staff are in the room to assist during showers/bathing. E3 once again confirmed that this information is not contained in R1's ISP's, and later brought an addendum to the surveyor (dated 8/10/11), further defining R1's level of supervision. Per this addendum it states "(R1) has staff supervision while in the shower. He should be encouraged to ask for assistance as much as possible. (R1) should be assisted	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING _____ B. WING _____	C 08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(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 149	Continued From page 15 from a sitting position as much as possible. (R1) will frequently complete these tasks on his own. He should be assisted from positions that includes but are not limited to toileting, showering, getting out of bed, up from a chair or any other seated position." > 7/27/11 to 8/4/11 8/4/11 - R1 found with blood on the left side of his face and forehead. A laceration was noted on the left side of his forehead above his left eyebrow area. Neurologicals initiated and sent to the emergency room. R1 returned with 3 sutures. An abrasion was also noted to the left shoulder. On 8/5/11 at 7:30 a.m., R1 was alert and utilizing a wheelchair, "for his own safety." On 8/5/11 at 11:30 p.m., R1 noted to be ambulating on his own. On 8/5/11 at 11:45 p.m., R1 was taken to the emergency room and admitted to the intensive care unit with a diagnosis of Pneumonia. In an 8/17/11, 3:30 p.m. phone interview with E1, R1 remains in the hospital at this time. The facility's 1/10/03 policy entitled "Administrator's Investigative Committee" was reviewed. Per this policy, it states, "The facility shall ensure that all residents are free from abuse, mistreatment, and neglect." Neglect is defined as, "Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." " The facility's 2/13/01 policy entitled, "Quality Assurance Committee", states that all incidents and accidents, including injuries will be reviewed	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING _____ B. WING _____	C 08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(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 149	Continued From page 16 and action will be taken when necessary to prevent future incidents or accidents. E1 (Administrator) was notified that the Immediate Jeopardy was removed on 8/17/11, at 3:35 p.m., when the surveyor confirmed through interview and review of the facility plan that the facility took the following actions to remove the Immediate Jeopardy. >falls, addressing an annual assessment, program changes as needed, and on going staff training. R1's ISP was reviewed and revised to provide additional safeguards across all environments to prevent falls. > Physical therapy, nursing and QMRP's will assess all residents for fall risk, with ISP's reviewed and revised to ensure necessary safeguards are in place regarding fall prevention. > ISPs will be updated annually and as necessary to reflect potential fall hazards and necessary safeguards put in place. > The facility will discuss resident's current ambulatory needs with their physician regarding fall risks and proper safeguards, reflecting such in individual ISP's. > All direct care staff will receive training regarding residents at risk for falls, with training incorporated at the day training site as well. While the Immediate Jeopardy was removed on	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING _____ B. WING _____	C 08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(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 149	Continued From page 17 8/17/11, the facility remained out of compliance as the facility has not had the opportunity to fully implement and evaluate the effectiveness of their plan. 2. R1's 6/17/10 ISP documents that during this time period R1 received a pureed diet with pudding thick liquids. A 12/23/10 Six Month Staffing Review states that there are no dietary changes. A 3/6/11, facility investigation, documents that on 3/6/11, at 5:59 p.m., while eating his meal, R1 was noted to be choking. The Heimlich maneuver was initiated and 911 was called. At 6:03 p.m., the First Responders attempted to clear R1's airway. At 6:06 p.m., paramedics retrieved a small shred of a brown substance, described as approximately pea-sized. Paramedics made several attempts before retrieving a ball of food from his throat. The AED (automated external defibrillator) showed a flat-line reading. R1 was intubated and chest compressions continued. Per the Prehospital Care Report Summary, dated 3/6/11, R1's airway was completely obstructed, R1 was unresponsive, pupils fixed, speech non-verbal, pulseless and non-breathing, prior to removing a "large piece of meat". A 3/6/11 hospital patient disposition documents R1's presenting complaint as, "Cardiac Arrest, S/P (Status Post) Code Blue". A 3/10/11 physician consultation for R1 documents that R1 had an airway obstruction, resulting in Aspiration Pneumonia and Hypoxemia, was on a ventilator	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING _____ B. WING _____	C 08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(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 149	Continued From page 18 for a period of time and appeared to have ongoing seizure activity. R1 was prescribed Keppra and the report states that his seizures may be a post hypoxic event. (R1's ISP of 5/18/11 documents that the Seizure diagnosis is new. In an 8/10/11, 10:30 a.m. interview with E2 {Director of Nursing - DON}, E2 further confirmed that R1's Seizure diagnosis was new, and that R1 did not have a history of diagnosis of Seizures prior to the 3/6/11 incident.) Facility nursing notes of 3/29/11 document R1's return to the facility on this date. In an 8/10/11, 12:38 p.m., phone interview with Z1 (Paramedic), Z1 stated that he retrieved a "solid piece of meat" from R1, that was "half-dollar" in size. During the event, Z1 stated that one of the attending staff (unidentified by Z1), stated that R1 was supposed to be on a pureed diet.	W 149		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.670f)3) 350.1210 350.1230b)3)7) 350.1250a) 350.1250b) 350.1840b) 350.3240a) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING _____ B. WING _____	C 08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W9999	Continued From page 19 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 350.670 Personnel Policies f)3) All facility employees who deal directly with residents shall be trained on the individual requirements and behavioral issues of residents who may come under their care, to ensure the safety and dignity of each client. The employees' training and competency shall be documented. 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. 7) Modification of the resident care plan, in terms of the resident's daily needs, as needed. Section 350.1250 Physical and Occupational Therapy Services a) Physical and occupational therapy services shall be provided as needed by the residents through personal contact of the therapists directly	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING _____ B. WING _____	C 08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W9999	Continued From page 20 with the residents or indirectly with persons involved with the residents. b) Physical therapy and occupational therapy by the facility or by arrangements with an outside resource shall provide treatment training programs that are designed to preserve and improve abilities for independent function, such as range of motion, strength, tolerance, coordination, and activities of daily living; and to prevent, insofar as possible, irreducible or progressive disabilities, through means such as the use of orthotic and prosthetic appliances, assistive and adaptive devices, positioning, behavior, adaptation, and sensory stimulation. Section 350.1840 Diet Orders b) Physicians shall write a diet order, in the medical record, for each resident indicating whether the resident is to have a general or a therapeutic diet. The diet shall be served as ordered. 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 interview and record review, the facility failed to implement their system to prevent neglect for one individual who has not received thorough and timely fall risk assessment, and timely implementation of safeguards, regarding	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING _____ B. WING _____	C 08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W9999	Continued From page 21 his known unsteady gait, and known repeated falls, which have resulted in physical injury and risk of additional injuries (R1); and for one individual who did not receive his diet in a form consistent with physician's orders, resulting in choking, cardiac arrest, hospitalization and ventilator assisted breathing (R1). The facility failed to implement their own policies and procedures for neglect, when the facility failed to: > ensure thorough and timely fall risk assessment for R1. > implement fall prevention safeguards in a timely manner after R1's falls that resulted in serious injuries. > re-assess, and provide any needed additional safeguards regarding R1's mobility safety after his new Seizure diagnosis. > ensure that R1's physical therapy assessments and Individual Service Plans provide specific instructions regarding R1's level of supervision and supports regarding R1's mobility safety across all environments. > ensure that R1 received his physician prescribed pureed diet, resulting in a choking episode that required emergency services, hospitalization and ventilator assisted breathing. Findings include: 1) In review of R1's 6/17/10 Individual Service Plan (ISP), R1 functions in the profound range of mental retardation, with additional diagnoses of Anemia, Cerebral Palsy, Hearing Loss, Dysphagia, Chronic Bronchiectasis, Pulmonary Fibrosis, and Organic Brain Syndrome with Aggressive Features.	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING _____ B. WING _____	C 08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W9999	Continued From page 22	W9999		

R1's birthday is 10/13/40 (70 years of age). R1 is non-verbal. This ISP states that R1 sometimes has an unsteady gait, but does not need adaptive devices for ambulation and walks independently.

Under the needs section of this ISP, it documents that R1 requires corrective glasses, but needs to increase his glasses wearing time, and is on a formal program to wear his glasses for 15 minutes at a time.

His 5/9/10 Leiter documents an intelligence quotient (IQ) of 23. His 6/17/10 ISP documents an adaptive age score of 2 years and 10 months.

R1 receives Risperdal to assist in behavior control and has a legal guardian.

At this 6/17/10 ISP, R1 received a pureed diet with pudding thick liquids. His 5/18/11 ISP documents that R1 was hospitalized from 3/6/11 to 3/29/11 after an upper airway obstruction, and returned to the facility with G-tube feedings, and NPO (nothing by mouth).

A 4/21/11 physical therapy evaluation documents that R1's stride is decreased to the left side and his posture is stooped, with good balance.

In an interview with E2 (Director of Nursing - DON), on 8/10/11, at 10:30 a.m., E2 stated that R1 has an, "awkward gait all the time."

In an interview with Z2 (day training staff), on 8/10/11, at 1:10 p.m., Z2 stated that R1's gait does vary and that makes us a little nervous. R1 sometimes drags his feet. If R1 comes in "that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING _____ B. WING _____	C 08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W9999	Continued From page 23 way," it will be an all day thing. In review of facility nursing notes (2/14/10-8/6/11), and facility incident investigations (12/10/10-8/4/11), R1 has experienced falls as follows: >2/14/10 to 12/23/10 R1 experienced 4 falls. For 3 of the falls, R1 experienced injury - hit his head - fell to his knees, knocking scab off and causing bleeding - abrasion to upper mid back. On 5/26/10, when R1 fell up against his bed and received the back abrasion, nursing notes state that R1 was assisted up and noted an "unsteady gait." R1's Individual Service Plan (ISP) of 6/17/10 does not document or review R1's falls. >8/14/10 to 12/23/10 R1 experienced 6 falls - 3 falls with injury. 8/14/10 - fell to buttocks in hallway - no injury. 9/2/10 - tripped in hallway and fell to knees - hitting head on floor - right temple abrasion-neurological's initiated. 9/9/10 nursing notes document that staff have reported R1's increased difficulty ambulating, getting in and out of bed and chairs. Nursing sent a fax to physician for possible Arthritis medication, which was implemented on an as needed basis. R1 was hospitalized from 10/13/10-11/5/10. Nursing notes document the use of a wheelchair and ambulation with staff assistance from 11/9/10-11/18/10. No falls are documented within this time period while R1 was being assisted with	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING _____ B. WING _____	C 08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W9999	Continued From page 24	W9999		

ambulation. (In an interview with E2 (Director of Nursing - DON), on 8/10/11, at 10:30 a.m., E2 stated that when individuals are hospitalized, they often return in a weakened state, as the hospital does not get them up or ambulate them. Therefore, the facility utilizes a wheelchair or other type of mobility chair when they first come home, until their strength returns).

12/1/10 - R1 slid off bed to floor - 12/5/10 nursing notes document an aged yellow/purple bruise on R1's right buttock and left lower back.
12/10/10 - fell to ground in driveway at day training site - two abrasions on left palm.
12/10/10 - lost shoe - tripped and fell to floor onto buttocks - no apparent injury.
12/11/10 - fell to buttocks outside - no apparent injury.

R1's six month staffing review was held on 12/23/10 (06/17/10 - 12/23/10). Per this staffing, there is no review of nursing's 9/9/10 documentation regarding staff reporting R1's increased difficulty with ambulation, and getting out of bed and chairs; no evidence of reviewing R1's falls or injuries for this time period (6 falls - 3 with injury - hit head on floor/buttocks and lower back bruising and abrasions to palm); no evidence of a fall risk assessment; no evidence of an updated physical therapy assessment; and no recommendations regarding R1's continued falls.

In an interview with E2 (Director of Nursing - DON), on 8/10/11, at 10:30 a.m., E2 stated that the facility does not conduct fall risk assessments. E2 stated that regarding falls, the facility would convene a special staffing if needed, and have physical therapy evaluate the individual.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING _____ B. WING _____	C 08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W9999	Continued From page 25 In an interview with E3 (Qualified Mental Retardation Professional - QMRP), on 8/9/11, at 4:20 p.m., E3 confirmed that R1's 6/17/10 annual ISP and R1's 12/23/10 six month review, were the only IDT meetings held during this time period, without any evidence of a review of falls for R1. > 12/24/10 to 4/28/11 - 4 falls - one resulting in a visit to the emergency room and a Hematoma, another with abrasions and 2 without injury. 12/24/10 - fell to his left side while ambulating - no complaints of pain. R1 was hospitalized from 3/6/11-3/29/11 due to a choking incident. 3/10/11 physician consult notes document seizure activity while in the hospital. R1 was prescribed Keppra for seizure control. R1's 7/31/11 physician's orders document that R1 still receives the medication for anticonvulsant control. After his return from the hospital, nursing notes state that R1 utilized a high backed movable chair, ambulating with staff assistance and stand by assistance through 4/17/11. No falls are identified from 3/29/11-4/17/11 while R1 was being assisted with ambulation. (In an interview with E3 (QMRP), on 8/9/11, at 4:20 p.m., E3 stated that when R1 returned from the hospital on 3/29/11, nursing instructed staff on how to walk with R1. E3 stated this was not permanent, and ended on or about 4/17/11. E3 stated it was after this date, when R1 started walking alone again, that R1 started falling again). In an 8/10/11, 10:30 a.m., interview with E2 (DON), E2 stated that since R1's return from the hospital on 3/29/11, no seizure activity has been observed for R1. E2 did state that not all of R1's	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING _____ B. WING _____	C 08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W9999	Continued From page 26	W9999		

falls were witnessed falls. There is a possibility that R1 could be having seizures, and this could be contributing to his falls and injuries. E2 further stated that R1 received an electroencephalography (EEG), on 8/2/11, but that the results have not yet been received.

In review of R1's personal chart, there is no evidence that the IDT convened, or that any continuing safeguards were put in place, after R1's hospital release on 3/29/11 (relative to R1's already known gait disturbance, known fall history, known injuries and his new Seizure diagnosis).

In an interview with E3 (Qualified Mental Retardation Professional - QMRP), on 8/9/11, at 4:20 p.m., E3 confirmed that after R1's annual ISP of 6/17/10, and the six month review of 12/23/10, the next IDT meeting was held 4/28/11, relative to R1's return to the day training site after his gastrostomy tube (g-tube) placement.

It was not until 4/21/11 (R1 released from hospital on 3/29/11 with new Seizure diagnosis), that R1 received a physical therapy assessment. Per this assessment, R1 has decreased left side stride, stooped posture and good balance. Under the recommendations section, it states, "Resident has recently returned from hospital and needs some assist for ambulation." There are, however, no specific instructions for staff regarding what methods are to be utilized in assisting R1 in his mobility needs throughout his environments, or specific recommendations regarding R1's new Seizure diagnosis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING _____ B. WING _____	C 08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W9999	Continued From page 27 In an interview with E2 (DON), on 8/10/11, at 10:30 a.m., E2 agreed that the 4/21/11 physical therapy instructions were not clearly defined, and that direct care staff are mainly responsible for R1's ambulation safety and activities of daily living needs. In an interview with E1 (Administrator), on 8/10/11 at 4:00 p.m., E1 also agreed that he had "no idea" what the 4/21/11 physical therapy recommendations mean relative to how staff should assist R1 in his mobility. 4/22/11, at 5:35 a.m. - R1 was found on the floor in his room, gesturing that he had tripped over a mat on the floor. (In an 8/10/11, 10:30 a.m., interview with E2 (Director of Nursing - DON), E2 stated that R1 has a low bed, with a mat positioned by the bed, in case R1 falls out of bed.) Nursing notes document that R1 had a "lg (large) hematoma" to his left temple area. "Pupils reactive to light but unequal....to ER (emergency room) for eval (evaluation per ambulance...was not moved - res (resident) left on floor)...." Nursing notes document that R1 returned to the facility the same day, with neurological checks to continue. Nursing notes of 4/23/11, 10:00 a.m., document that R1 is ambulating on his own. 4/24/11, at 10:35 p.m. nursing notes (2 days after the fall which resulted in the Hematoma), document that R1 lost his balance in the bathroom and was "lowered" to his right side. "Several abrasions noted to rt (right) {lower}extremity. Staff stated that R1 did not hit his head."	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING _____ B. WING _____	C 08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W9999	Continued From page 28 4/27/11, 8:00 a.m. - nursing notes document that bruising (from 4/22/11 fall), continues to the left eye area. On this same date R1 was trying to rock in a non-rocking chair and fell to his buttocks with no injury. 4/28/11 nursing notes document that bruising to R1's left outer eye (4/22/11 fall) is still apparent but decreased. In review of R1's personal chart, there is no evidence that the facility convened the IDT, completed a fall risk assessment, assessed R1's room environment for possible changes, provided an updated physical therapy assessment, or put any safeguards into place for R1, after the 4/22/11 Hematoma. In an interview with E3 (QMRP), on 8/10/11, at 10:01 a.m., E3 confirmed that the IDT did not convene after this incident. In an interview with E2 (DON), on 8/10/11, at 10:30 a.m., E2 stated that regarding environmental assessments/adoptions, the investigative committee addresses this issue when completing their investigations. In review of the 4/22/11 facility investigation, R1 tripped over the mat next to his bed, and the mat was in the position that it was supposed to be in at the time of R1's fall and resultant Hematoma. Per this investigation, there is no evidence of any recommendations regarding prevention of this type of occurrence again. The investigation recommends that staff encourage, "(R1) to ask for assistance if needed and that staff will	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING _____ B. WING _____	C 08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W9999	Continued From page 29 continue to monitor R1 for safety." The next IDT held was 4/28/11, regarding R1's return to the day training site after his g-tube placement. In review of this IDT, R1's new g-tube placement is discussed, and states that R1 may use a wheelchair as needed for outings and long distances. There is no evidence of discussing R1's new Seizure diagnosis, and no evidence of implementing any safeguards relative to this new diagnosis, as related to R1's mobility safety at the day training site. Z2 (day training staff) stated (8/10/11, at 1:10 p.m.) that since R1 returned to the day training site after 4/28/11, he has consistently required extra help getting out of chairs. > 4/30/11 to 5/18/11 - 2 falls, 1 with injury 4/30/11 - R1 fell in shower onto buttocks, with no injury. 5/15/11 - fell outside of his room - redness to left side of back. In review of R1's 5/18/11 ISP, R1's Seizure diagnosis is documented and is noted as a new diagnosis. Regarding R1's ambulation, it states, "R1 does not need adaptive devices for ambulation. He sometimes has an unsteady gait, but walks independently." R1's 4/21/11 physical therapy evaluation is documented and states that no physical therapy program is required at this time. In review of the entire ISP, there is no evidence that R1's falls have been reviewed; no evidence of a fall risk assessment; and no evidence of putting safeguards in place, regarding his	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING _____ B. WING _____	C 08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W9999	Continued From page 30	W9999		

mobility safety in all of his environments. This was confirmed on 8/9/11, at 4:20 p.m., in an interview with E3 (QMRP).

> 5/19/11 to 6/10/11 - 3 falls - 2 with injury - (12 SUTURES)
5/25/11, at 8:15 p.m. - R1 was found on the floor. A raised bump was noted to the left side of his forehead. Nursing notes state this was "possibly from past fall," but neurologicals were initiated at 8:00 p.m. Neurologicals were continued through 5/26/11 and notes document a small raised area continues to R1's left forehead.

6/2/11, at 5:00 p.m. - R1 was found on the floor in the hallway in a supine position. Nursing notes state, "moderate amount of blood draining from 3 cm (centimeter) laceration to right side of forehead. R1 was sent to the emergency room, where he received 12 sutures to the right side of his forehead. Per the facility investigation of 6/2/11, there were no witnesses to the actual fall, but staff had just spoken to R1, and observed R1 walking into his room. This staff person then heard a thump and discovered R1 as above.

Nursing notes of 6/3/11, 7:30 a.m., document that R1 is in a wheelchair this a.m. and R1 is "very unsteady."

6/6/11, 4:30 p.m. nursing notes document that R1 fell to his buttocks, with no injuries - R1 still has 12 sutures from last fall.

6/8/11 nursing notes at 4:30 a.m., document that R1 is "up amb (ambulating) in hall very unsteady put in w/c (wheelchair) for safety."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING _____ B. WING _____	C 08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W9999	Continued From page 31	W9999		

There is no evidence of any facility action to prevent falls and serious injuries for R1, after his 6/2/11 fall resulting in 12 sutures, until 6/10/11 when a special IDT was convened. Per this IDT, R1's room will be moved closed to the central area of the floor. "This would allow him to ambulate short distances to get to designated areas on the floor. This will allow staff to monitor R1 more closely since most of his falls have not been witnessed. It was also noted during the staffing that (R1) has an added diagnosis of seizures while in the hospital in March 2011." In review of the document, there is no evidence of a fall risk assessment, an updated physical therapy evaluation and no evidence of specific safeguards to prevent further falls and serious injuries for R1.

> 6/10/11 to 7/26/11 - 5 falls - 4 with injuries
7/5/11 - fell to the floor near the shower room - redness to his bottom left shoulder blade and redness below his right armpit.
7/6/11 - nursing notes -fell to buttocks - small scratch to right buttock.
7/18/11 - fell in room - pulled over dresser - shoes untied - no injury.
However, 7/21/11 nursing notes state that R1 presents with a large purple/yellow bruise on his right forearm, possibly from the previous fall.
7/22/11 - stood up from chair and lost balance, fell onto buttocks - no injuries.
7/26/11 - found on floor in bedroom on back, nurses notes state "somewhat shakey (shaky)." Small abraded area on left buttock and one small abraded area on mid back noted.

On 7/26/11 an IDT was held regarding R1's falls.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING _____ B. WING _____	C 08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W9999	Continued From page 32	W9999		

Per this document the team discussed whether the new Seizure Disorder diagnosis could be contributing to the falls. Recommendations from this meeting were as follows: refer to neurologist to be considered for an electroencephalogram (EEG), evaluation on 8/2/11; and refer to the physical therapist for review on 8/3/11. In review of this special staffing, there is no evidence of a fall risk assessment, or evidence of specific safeguards put in place to keep R1 from continued falls and injuries.

On 8/3/11, R1 received a physical therapy evaluation. Per this evaluation it states, "Pt (patient) to be assisted with transfers possible use of bed alarm for transfer from bed." There are no further directions from this evaluation, and no specific recommendations/instructions for staff to implement across all of R1's environments.

In an interview with E2 (DON), on 8/10/11, at 10:30 a.m., E2 agreed that the physical therapy recommendations were not clearly defined, and could not further define what the expectations would be for direct care staff.

In an interview with E3 (QMRP), on 8/10/11, at 10:01 a.m., E3 could not further clarify the 8/3/11 physical therapy recommendations. E3 stated that R1 has been having a hard time getting out of bed, out of chairs and walking in general. Staff, "keep an eye on him," but does not think that staff are with him all of the time when ambulating. E1 was "not sure" of R1's level of assistance during showering, but "would assume" that he has staff help him. "Toileting is becoming 1:1 recently." Later in the same interview, E3 stated that for all residents, staff are in the room

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING _____ B. WING _____	C 08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W9999	Continued From page 33	W9999		

to assist during showers/bathing. E3 once again confirmed that this information is not contained in R1's ISP's, and later brought an addendum to the surveyor (dated 8/10/11), further defining R1's level of supervision. Per this addendum it states "(R1) has staff supervision while in the shower. He should be encouraged to ask for assistance as much as possible. (R1) should be assisted from a sitting position as much as possible. (R1) will frequently complete these tasks on his own. He should be assisted from positions that includes but are not limited to toileting, showering, getting out of bed, up from a chair or any other seated position."

> 7/27/11 to 8/4/11
8/4/11 - R1 found with blood on the left side of his face and forehead. A laceration was noted on the left side of his forehead above his left eyebrow area. Neurologicals initiated and sent to the emergency room. R1 returned with 3 sutures. An abrasion was also noted to the left shoulder.

On 8/5/11 at 7:30 a.m., R1 was alert and utilizing a wheelchair, "for his own safety."
On 8/5/11 at 11:30 p.m., R1 noted to be ambulating on his own.
On 8/5/11 at 11:45 p.m., R1 was taken to the emergency room and admitted to the intensive care unit with a diagnosis of Pneumonia. In an 8/17/11, 3:30 p.m. phone interview with E1, R1 remains in the hospital at this time.

The facility's 1/10/03 policy entitled "Administrator's Investigative Committee" was reviewed.
Per this policy, it states, "The facility shall ensure that all residents are free from abuse,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING _____ B. WING _____	C 08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W9999	Continued From page 34	W9999		

mistreatment, and neglect." Neglect is defined as, "Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness."

The facility's 2/13/01 policy entitled, "Quality Assurance Committee," states that all incidents and accidents, including injuries will be reviewed and action will be taken when necessary to prevent future incidents or accidents.

2. R1's 6/17/10 ISP documents that during this time period R1 received a pureed diet with pudding thick liquids. A 12/23/10 Six Month Staffing Review states that there are no dietary changes.

A 3/6/11, facility investigation, documents that on 3/6/11, at 5:59 p.m., while eating his meal, R1 was noted to be choking. The Heimlich maneuver was initiated and 911 was called. At 6:03 p.m., the First Responders attempted to clear R1's airway. At 6:06 p.m., paramedics retrieved a small shred of a brown substance, described as approximately pea-sized. Paramedics made several attempts before retrieving a ball of food from his throat. The AED (automated external defibrillator) showed a flat-line reading. R1 was intubated and chest compressions continued.

Per the Prehospital Care Report Summary, dated 3/6/11, R1's airway was completely obstructed, R1 was unresponsive, pupils fixed, speech non-verbal, pulseless and non-breathing, prior to removing a "large piece of meat."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G049	A. BUILDING _____ B. WING _____	C 08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W9999	Continued From page 35 A 3/6/11 hospital patient disposition documents R1's presenting complaint as, "Cardiac Arrest, S/P (Status Post) Code Blue." A 3/10/11 physician consultation for R1 documents that R1 had an airway obstruction, resulting in Aspiration Pneumonia and Hypoxemia, was on a ventilator for a period of time and appeared to have ongoing seizure activity. R1 was prescribed Keppra and the report states that his seizures may be a post hypoxic event. (R1's ISP of 5/18/11 documents that the Seizure diagnosis is new. In an 8/10/11, 10:30 a.m. interview with E2 {Director of Nursing - DON}, E2 further confirmed that R1's Seizure diagnosis was new, and that R1 did not have a history of diagnosis of Seizures prior to the 3/6/11 incident.) Facility nursing notes of 3/29/11 document R1's return to the facility on this date. In an 8/10/11, 12:38 p.m., phone interview with Z1 (Paramedic), Z1 stated that he retrieved a "solid piece of meat" from R1, that was "half-dollar" in size. During the event, Z1 stated that one of the attending staff (unidentified by Z1), stated that R1 was supposed to be on a pureed diet. (A)	W9999		